Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

WEDNESDAY, 21 SEPTEMBER 2022 AT 10.00 AM

COUNCIL CHAMBER - THE GUILDHALL, PORTSMOUTH

Telephone enquiries to Anna Martyn Tel 023 9283 4870
Email: anna.martyn@portsmouthcc.gov.uk

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

Public health guidance for staff and the public due to Winter coughs, colds and viruses, including Covid-19

- Following the government announcement 'Living with Covid-19' made on 21 February and the end of universal free testing from 1 April, attendees are no longer required to undertake any asymptomatic/ lateral flow test within 48 hours of the meeting; however, we still encourage attendees to follow the public health precautions we have followed over the last two years to protect themselves and others including vaccination and taking a lateral flow test should they wish.
- We strongly recommend that attendees should be double vaccinated and have received any boosters they are eligible for.
- If unwell we encourage you not to attend the meeting but to stay at home. Updated government guidance from 1 April advises people with a respiratory infection, a high temperature and who feel unwell, to stay at home and avoid contact with other people, until they feel well enough to resume normal activities and they no longer have a high temperature. From 1 April, anyone with a positive Covid-19 test result is still being advised to follow this guidance for five days, which is the period when you are most infectious.
- We encourage all attendees to wear a face covering while moving around crowded areas of the Guildhall.
- Although not a legal requirement, attendees are strongly encouraged to keep a social distance and take opportunities to prevent the spread of infection by following the 'hands, face, space' and 'catch it, kill it, bin it' advice that protects us from coughs, colds and winter viruses, including Covid-19.
- Hand sanitiser is provided at the entrance and throughout the Guildhall. All attendees are encouraged to make use of hand sanitiser on entry to the Guildhall.
- Those not participating in the meeting and wish to view proceedings are encouraged to do so remotely via the livestream link.

Health and Wellbeing Board Members

Councillors Gerald Vernon-Jackson CBE, Suzy Horton, Matthew Winnington and Lewis Gosling
Dr Linda Collie (Joint Chair), Helen Atkinson, Roger Batterbury, Sarah Beattie, Andy Biddle, Sarah Daly, Penny Emerit, Prof Anita Franklin, David Goosey, James Hill, Clare Jenkins, Maggie MacIsaac, Frances Mullen, Lorna Reavley, Paul Riddell, Suzannah Rosenberg, Dianne Sherlock, David Williams and Jo York

Dr Linda Collie (Joint Chair)

(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

Meeting information: Risk assessment for Council Chamber

1 Apologies for absence

2 Declarations of interest

3 Minutes of previous meeting held on 22 June 2022 (Pages 7 - 14)

RECOMMENDED that the minutes of the previous meeting held on 22 June 2022 be approved as a correct record.

4 University of Portsmouth Medical School

A presentation on this item will be given at the meeting.

5 Portsmouth Safeguarding Adults Board - Homelessness Thematic report (Pages 15 - 52)

To highlight to Health and Wellbeing Board members the findings of the Thematic Review following the deaths of Mr G, Mr H, Mr I and Mr J (see Appendix A) which was commissioned by the Portsmouth Safeguarding Adults Board.

6 Health & Wellbeing Strategy - Tackling Poverty (Pages 53 - 62)

1. To provide an update to the Board on the tackling poverty priority area of the strategy.

2. To outline areas where Board member organisations can contribute to this priority, as key local anchor institutions.

7 Public Health Annual Report (Pages 63 - 132)

To note that the Director of Public Health is publishing her statutory Annual Report 2021/22, attached as Appendix A and available on the JSNA page of the PCC website. This year's report provides a Joint Strategic Needs Assessment (JSNA) Annual Summary for Portsmouth.

8 Pharmaceutical Needs Assessment (Pages 133 - 254)

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). The new PNA must be approved by the HWB and published by 1 October 2022.

9 Better Care Fund Plan 2022/2023 (Pages 255 - 284)

To update Health and Wellbeing Board members on the Better Care Fund (BCF) for 2022/23 and seek formal Health and Wellbeing Board sign-off for the BCF plan that will be submitted to NHS England and NHS Improvement.

10 Autism and Neurodiversity

A presentation on this item will be given at the meeting.

11 Health & Wellbeing Board - Revised Terms of Reference

Report to follow

12 GP Summit update (Pages 285 - 286)

To update the Health and Wellbeing Board on the GP Summit event hosted by the Leader of the Council in August.

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.

Whilst every effort is made to webcast this meeting, should technical or other difficulties occur, the meeting will continue without being webcast via the Council's website

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Coronavirus Risk Assessment for the Council Chamber, Guildhall

Date: 1 April 2022 (based on Living safely with respiratory infections, including COVID-19, 1 April 2022)

Review date: Ongoing

Author: Lynda Martin, Corporate Health and Safety Manager, Portsmouth City Council

Coronavirus Risk Assessment for the Council Chamber, Guildhall

Manager's Name and Job Title completing Risk Assessment:	Lynda Martin Corporate Health and Safety Manager	**Risk Assessment Dept:** **Location:**	Corporate Services Council Chamber, Guildhall	**Date:**	1 April 2022	**Signature:**	

Hazard	Who could be harmed and how	All controls required	How controls will be checked	Confirmed all in place or further action required
Risk of exposure to Covid-19 virus - Ventilation	Staff, contractors and attendees	• There are no longer capacity limits for the Guildhall Chamber. • We encourage all attendees to wear a face covering when moving around crowded areas of the Guildhall and the council chamber. • The mechanical ventilation system works efficiently and the South Special Rooms Supply and Extract fans are fully operational during times when the Council Chamber is in use. • Pedestal fans - positioned in each of the wing areas and along the back wall behind the pillars, maximum speed and modulation setting.	Staff will ensure ventilation system and fans are operational.	In place
Risk of transmission of virus - Risk mitigation	Staff, contractors and attendees	The Guildhall has the following measures in place: • Face Coverings – as per government guidance, we encourage you to continue to wear a face covering whilst in the venue & crowded places especially when walking around the building. • Enhanced Sanitisation & Cleaning – we will carry out enhanced cleaning procedures between meetings and we encourage you to sanitise your hands on entry and regularly throughout your visit at the sanitisation points provided.	The Guildhall Trust and PCC Facilities Team to implement and monitor.	In place
Risk of transmission of virus - Hygiene and prevention		• Updated government guidance from 1 April advises people with a respiratory infection, a high temperature and who feel unwell, to stay at home and avoid contact with other people, until they feel well enough to resume normal activities and they no longer have a high temperature. From 1 April, anyone with a positive COVID-19 test result is being advised to follow this guidance for five days, which is the period when you are most infectious. • Although not a legal requirement attendees are strongly encouraged to keep a social distance and take opportunities to prevent the spread of infection by following the 'hands, face, space' and 'catch it, kill it, bin it' advice that also protects us from other winter viruses. • Wash hands for 20 seconds using soap and water or hand sanitiser. • Maintain good hygiene particularly when entering or leaving. • Hand sanitiser and wipes will be located in the meeting room. • No refreshments will be provided. Attendees should bring their own water bottles/drinks. • All attendees should bring and use their own pens/stationery. • Attendees are no longer required to undertake an asymptomatic/ lateral flow test within 48 hours of the meeting however we still encourage attendees to follow the Public Health precautions we have followed over the last two years to protect themselves and others including vaccination and taking a lateral flow test should they wish. It is strongly recommended that attendees should be double vaccinated and have received a booster.	The Guildhall Trust and PCC Facilities Team to implement and monitor.	In place
Financial Risk	Staff, contractors and attendees	• The council meeting may need to be cancelled at short notice if the Covid-19 situation changes due to local outbreaks, local sustained community transmission, or a serious and imminent threat to public health. • Technology in place to move to virtual council meeting if required and permitted by legislation.	Financial commitments minimised wherever possible.	In place

OF THE MEETING of the Health and Wellbeing Board on Wednesday, 22 June 2022 at 10.00 am in the Guildhall, Portsmouth

Present

Dr Linda Collie, PCCG, (Joint Chair) in the Chair

Councillor Matthew Winnington (Joint Chair)
Councillor Lewis Gosling
Councillor Suzy Horton
Councillor Gerald Vernon-Jackson

Andy Biddle, Director of Adult Care, PCC
Helen Atkinson, Director of Public Health, PCC
Roger Batterbury, Healthwatch Portsmouth
Penny Emerit, Portsmouth Hospitals University Trust
Hayden Ginns, Children's Social Care, PCC
Councillor Terry Norton, in capacity as Deputy Police & Crime Commissioner
Clare Jenkins, Portsmouth Police
Jackie Powell, Portsmouth CCG
Paul Riddell, Hampshire Fire & Rescue Service
Terri Russell, Solent NHS Trust
Dianne Sherlock, Age UK
David Williams, Chief Executive, PCC
Jo York, Health and Care Portsmouth

Non-voting members

Officers present
Matthew Gummerson, Jane Lamer, Kelly Nash, Lisa Wills

12. Chair's introduction and apologies for absence (AI 1)

Dr Linda Collie, Clinical Lead, Clinical Executive NHS Portsmouth Clinical Commissioning Group, as Chair, opened the meeting. All present introduced themselves.

Apologies for absence were received from Sarah Beattie and Jennifer Humphray (Probation Service), Sarah Daly (Children's Social Care, represented by Hayden Ginns), Professor Anita Franklin (University of Portsmouth), James Hill (Housing, Neighbourhood & Building Services), Frances Mullen (City of Portsmouth College) and Suzannah Rosenberg (Solent NHS, represented by Terri Russell).

Apologies were received from: Councillor Jason Fazackarley (Cabinet Member for Safety in the Community) as he had some urgent casework; Councillor Norton as he left the meeting at 10.45 am for another meeting; Jane Lamer as she arrived at 11 am due to an earlier meeting.

13. Declarations of Interests (AI 2)
There were no declarations of interest.

14. Minutes of previous meeting - 9 February 2022 (AI 3)

RESOLVED that the minutes of the Health and Wellbeing Board held on 9 February 2022 be approved as a correct record.

Matters arising
Councillor Vernon-Jackson mentioned that last year representatives from all opposition groups on the council (as well as the largest one) were co-opted and suggested doing likewise this year to be inclusive. Dr Collie advised the matter would be discussed in agenda item no.4.

15. Health & Wellbeing Board membership and review of partnership (AI 4)
Kelly Nash, Corporate Performance Manager, introduced the report.

Jackie Powell said that today's meeting was her last attendance at the Board as the Integrated Care System (ICS) has no lay members. She agreed with the proposals in the report and said it had been a pleasure to be a Board member. Dr Collie thanked her for contribution to Board meetings.

David Williams noted that after the demise of the CCG the Board was one of the few statutory multi-agency bodies in the health and care structure. While the relationships between the replacement bodies and entity of place are not known yet the Board should keep its dynamic and influence alive on the wider stage as well as in the city.

RESOLVED that the Health and Wellbeing Board
1. **Agree proposed adjustments to the membership of the Board as set out in section 5, and received revised Constitution at the September meeting**
2. **Note the need for balance across children's and community safety issues on the agenda**
3. **Agree to dedicating more developmental space to relevant matters where collaborative working would be beneficial, particularly those arising from the revised Health and Wellbeing Strategy 2022-2030.**

16. Local Outbreak Engagement Board (information item) (AI 5)
Helen Atkinson, Director of Public Health, introduced the report, noting that Covid cases were increasing and could have an impact in winter. She thanked the Local Outbreak Engagement Board (LOEB) for its work during the pandemic; although it is being stood down the measures are not. The Heath Protection Board, created during the pandemic, still meets. Public Health are waiting for a contingency framework from the Department of Health & Social Care as to how the NHS, national and local government will manage future outbreaks of infectious diseases, including restrictions. The LOEB management plan is currently in its 12th version which shows how much government regulations have changed.

Dianne Sherlock thanked Ms Atkinson and the five agencies who worked with the HIVE during the pandemic: Pompey in the Community; Salvation Army; Citizens' Advice Bureau; You Trust; Age UK. They are all ready to step up and support again if necessary.

Dr Collie extended her thanks on behalf of the Board to who all supported the city during the pandemic.

RESOLVED that the Health and Wellbeing Board:

1. **Stand down the Local Outbreak Engagement Board and note thanks to all members for their important and valuable work in steering and assuring the local pandemic response.**
2. **Build on the relationships and learning developed in the Health Protection Board to retain the forum in a slightly different format to provide a wider health protection function for the city, with revised Terms of Reference to return to the September Health and Wellbeing Board**.

17. Health and Wellbeing Strategy update (AI 6)

Helen Atkinson, Director of Public Health, introduced the report, noting that the Strategy is fairly unusual in that it examines the "causes of the causes" (the wider determinants of health) as they affect the population's health. Everyone needs to engage with the Strategy, not just the board level sponsors for the five priorities. In addition, organisations represented on the Board are the anchor institutions and their actions have an impact on residents.

Councillor Winnington thanked everyone involved in the Strategy. When he was asked at a recent meeting with the Integrated Care System (ICS) about priorities the reply was easy as Portsmouth had just adopted the Strategy. It gives the direction of travel in the wider health and care system and will show the ICS Portsmouth's priorities so it can understand where Portsmouth is coming from. Having the Strategy as a basis of what Portsmouth does will help the city to be in a good place within a truly integrated system. He is looking forward to updates.

As a counsellor for young people, Jackie Powell was concerned about parents being threatened with fines for school non-attendance when children have acute anxiety. Hopefully the Strategy will minimise this response and take a less punitive approach. Hayden Ginns said new national attendance guidance coming into effect from September 2023 aims to strike a balance between high challenge and high support. Where children have significant mental health concerns schools would not be expected to issue fines in these cases. There is 100% coverage by the Mental Health Support Teams (MHST) in schools as a result of a successful bid to the CCG although the pathway into MHST is not quite in place yet. As of today there are 463 children with chronic absence (over 50%), each of whom have different stories accounting for non-attendance; mental health is often a major factor, including parental mental health. Education will use the MHST pathways to see fines are not issued in these cases. Councillor Horton found the "one size fits all" approach to attendance worrying. In Portsmouth officers know their families and there is

considerable emphasis on relational practice. She does not want to lose the individual attention provided by the Link Co-ordinators (roles created in the pandemic to work with schools, children's social care and the attendance team). She would monitor the situation.

Councillor Norton, who is on Hampshire County Council's Health & Wellbeing Board, has been asked by them to write a letter about children's mental health, which is one of the biggest challenges faced today. He asked the Board if they agreed that children's mental health was a priority and would join him in writing to the ICS along with other HWBs about CAMHS (Child and Adolescent Mental Health Service). Mr Ginns works with the ICS on children's strategy and mental health will be included as a priority. He is trying to work beyond "how do we fix CAMHS?" to a whole system approach. Demand for CAMHS has increased by about 30 to 35% but where Portsmouth has invested in early help in schools it has reduced. Councillor Norton said Hampshire's HWB would forward the letter. Those present agreed that children's mental health was a priority and were happy with writing the letter.

Mr Williams said it was interesting to see how other HWBs were influencing the ICS. It is important to find the right ways to influence the ICS while avoiding being divided by the lowest common denominator of other HWBs' strategies, which would not be meaningful to Portsmouth. Finding the level of influence to enable discretion to target local needs and ensure Portsmouth has the capacity and spend to deliver is an ongoing journey.

RESOLVED that the Health and Wellbeing Board:

1. **Note the delivery plans attached at Appendix 1**
2. **Agree the work programme for the Health and Wellbeing Board set out in section 4.4.**

18. Integrated Care System and Clinical Commissioning Group update (AI 7)

Jo York, Managing Director of Health & Care Portsmouth, introduced the report.

She explained that the Governance Handbook gives more opportunity to make changes without having to consult NHS England so it is important to realise arrangements are not set in stone from 1 July. More national guidance is expected. There is a huge amount of scope for local partners to determine autonomy and how they operate together with the opportunity to develop place-based leadership. The Section 113 agreements will continue. The Joint Commissioning Board is likely to continue under the Integrated Care Board; the terms of reference are being considered now. It could become a truly joint committee but is likely to be a partnership. Existing agreements will be updated into a single framework. The main focus now that the Section 75 schedule is in place is working through plans and objectives in each schedule and how they feed back into the refreshed blueprint. Discussions will also include how the budget is overseen.

Jackie Powell asked how confident Portsmouth could be in getting the delegation it needs. Ms York said delegation was one of the issues organisations were still grappling with and would be affected by what the

financial instructions would look like for the ICB. An important scenario is how organisations make decisions together. Having joint open discussions on difficult decisions such as finances or reconfiguring services, for example, Discharge to Assess, has helped progress the partnership. How the partnership will work, including any unintended consequences, needs to be discussed. Ms York is confident Portsmouth will get the necessary delegation; it is just a matter of how.

Ms Sherlock said the voluntary sector's involvement in what were hugely inclusive discussions was fabulous and commended the extraordinary understanding shown by different organisations - the understanding of the NHS' remit with what everyone expects compared with the voluntary sector's "ground floor" experience. The voluntary sector might have an update on their proposals in July.

Councillor Winnington said it was an excellent and helpful report. Portsmouth is trying its best to continue the considerable integration it already has. The work is worth it as it can be a template for other areas to show them what integration means. It is one way Portsmouth can have influence as it is ahead of the game. Dr Collie noted the importance of having the relationships in place to make the ICS work.

RESOLVED that the Health and Wellbeing Board note the report.

Councillor Norton left the meeting at 10.45 am.

19. Community Safety annual report (AI 8)

Superintendent Clare Jenkins, Portsmouth Police, introduced the report and thanked all those involved, particularly Bruce Marr, Lisa Wills, Sam Graves, Caroline Hopper and Alan Knobel at the council. She advised that crime figures need to settle as the country emerges from the pandemic and it is clearer what the "new normal" looks like. Recording methods have changed, for example, one incident might account for two or three crimes. Furthermore, legislation is changing and policing needs to support the City Vision.

Lisa Wills, Strategy & Partnership Manager, updated the Board on progress against the three priorities. One of the outcomes of a national review of the role of Police & Crime Commissioners was that a robust review of Community Safety Partnerships is needed.

Superintendent Jenkins advised that with regard to the community safety survey, much crime is unreported so it was commendable that 1,200 face-to-face surveys have been completed. A final report is being proofread now and will be brought back to the Board shortly.

Dr Collie thanked all involved and commended the report.

RESOLVED that the Health and Wellbeing Board note the report.

20. Autism and Neurodiversity (AI 9)

The Board noted that the presentation on autism and neurodiversity would be presented at the next meeting due to the unavailability of the presenter.

21. Policing National Race Action Plan (AI 10)

Superintendent Clare Jenkins, Portsmouth Police, gave a verbal update.

She explained that disproportionality affects service delivery across the city and the pandemic has shown that some sections of society are affected more than others. The National Police Chiefs' Council and College of Policing have launched a national race action plan which starts with all staff signing a statement of intent based on being on proactive and honest in facing unconscious bias. A survey has tested officers' knowledge and confidence. A one-day "Inclusion Matters" course has been rolled out to frontline staff to encourage people to talk openly about their experiences. It is particularly important as there are many new student officers. There is a positive action campaign to attract and retain a more diverse workforce. The most recent student intake was more ethnically diverse.

A strategic independent advisory group focuses on increased scrutiny of police powers. Each district has an independent advisor who analyses use of stop and search processes and body-worn cameras, hate crime and domestic abuse, and challenges use of police powers. There is awareness of the high numbers of strip searches with children, particularly in the light of the recent Metropolitan police Child Q incident. It is an issue in Hampshire but the data may not give a true picture as it may be that searches on white youths are less likely to be recorded. From now on all strip search requests on children go to Superintendent Jenkins who has to think carefully if there are grounds to grant the request; there are very few instances when she would. The police are working on systems to make recording of stop checks mandatory so they can accurately record what they are achieving.

Mr Williams agreed that disproportionality was an important issue. The insights from the police will benefit organisations across the city. The council has a network on equality, diversity, inclusion and disproportionality. The shocks of expectation are telling and everyone should explore, analyse and tackle disproportionality so they can learn from one another.

Those present welcomed the initiative and the transparent approach. Ms Sherlock is on a Hampshire police networking group and noted that representation is middle-class and white; it is difficult getting more diverse members so the network is doing something wrong and preventing people joining. Breaking down barriers is paramount.

RESOLVED that the Health and Wellbeing Board note the update.

22. Multiply Funding (AI 11)

Jane Lamer, Business Manager, Regeneration, introduced the report and said that progress updates could be brought back to the Board.

Dr Collie welcomed money coming into Portsmouth for improving education.

RESOLVED that the Health and Wellbeing Board note the report.

23. Dates of future meetings (AI 12)

The dates of future meetings for 2023 were confirmed as 15 February, 28 June, 27 September, 29 November (all Wednesdays at 10 am).

The remaining meetings in 2022 are 21 September and 23 November (both Wednesdays at 10 am).

RESOLVED that the Health and Wellbeing Board note the dates.

The meeting concluded at 11.04 am.

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Councillor Matt Winnington and Dr Linda Collie
Chair

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Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Date of meeting:	21 September 2022
Subject:	Portsmouth Safeguarding Adults Board: Thematic Review following the deaths of Mr G, Mr H, Mr I and Mr J
Report by:	Alison Lawrence, Portsmouth Safeguarding Adults Board Manager
Wards affected:	All
Key decision:	No
Full Council decision:	No

1. Purpose of report

1.1. To highlight to Health and Wellbeing Board members the findings of the Thematic Review following the deaths of Mr G, Mr H, Mr I and Mr J (see Appendix A) which was commissioned by the Portsmouth Safeguarding Adults Board.

2. Recommendations

2.1 **The Health and Wellbeing Board is recommended to:**

a. Note the findings and recommendations from the Thematic Review.
b. Write to the Hampshire and Isle of Wight Integrated Care Board (HIOW ICB) to request that the ICB review the health-related actions in the action plan and consider whether these actions are relevant across the HIOW ICB.
c. Ask the HIOW ICB to consider the provision of care and support to residents of HIOW who are homeless as part of the ICS responsibility for acting to minimise health inequalities, and request the ICB confirm to the Portsmouth HWB Board the actions the ICB intends to take.

3. Background

3.1 Section 44 of the Care Act 2014 places a statutory requirement on the Portsmouth Safeguarding Adults Board (PSAB) to commission and learn from Safeguarding Adults Reviews (SARs) in specific circumstances (see Appendix A section 2) and confers on the PSAB the power to commission a SAR into any other case.

3.2 The PSAB identified that there had been an increase in the number of deaths of homeless adults during 2020, in the context of the Covid-19 pandemic. The PSAB decided that the reasons for the increase in the number of deaths should be explored to see what could be learned and to identify improvements in the way services in the city support homeless people. To do this, the PSAB's Safeguarding Adults Review subgroup chose four deaths which seemed representative to be the focus of a Thematic Review. An independent reviewer was engaged and an independent report was produced. This report highlighted the unprecedented challenges experienced by individuals and services at the height of the Covid-19 pandemic, and also identified a number of findings and recommendations (see Appendix A sections 7 and 8).

4. Progress and next steps

4.1 The PSAB has accepted the findings of the thematic review and has noted significant progress has already been made by agencies to improve services in the city to support homeless people, including the introduction of a healthcare team based in Portsmouth City Council's homeless day service; strengthened links between housing and social care services; new housing pathways; and recommissioned substance misuse services.

4.2. A multi-agency action plan has been developed to address the recommendations. The action plan contains 17 actions for Adult Social Care, Housing, Health and Public Health services and includes actions on the commissioning of services, staff training, improving coordination between services, and highlighting the wider issues identified by the review at a national level. The action plan will be monitored by the PSAB's Quality Assurance subgroup.

5. Reasons for recommendations

5.1 The learning identified by the thematic review and recommendations made have wide ranging implications for health, social care, housing and other services within Portsmouth. It is important that the whole system learns from the review and responds effectively to improve the support available for those experiencing multiple exclusion homelessness in Portsmouth.

6. Integrated impact assessment

6.1 As the recommendations within this report do not give rise to any changes to policies or services an Integrated Impact assessment is not required.

7. Legal implications

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

8. Director of Finance's comments

8.1 There are no direct financial implications arising from the recommendations contained within this report.

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Signed by: David Goosey, Independent Chair, Portsmouth Safeguarding Adults Board

Appendices: Appendix A Thematic Review following the deaths of Mr G, Mr H, Mr I and Mr J

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
Thematic Review following the deaths of Mr G, Mr H, Mr I and Mr J	https://www.portsmouthsab.uk/scrs-2/

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

……
Signed by:

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PORTSMOUTH SAFEGUARDING ADULTS BOARD

THEMATIC REVIEW FOLLOWING THE DEATHS OF Mr G, Mr H, Mr I and Mr J

2022

Patrick Hopkinson

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THEMATIC REVIEW FOLLOWING THE DEATHS OF Mr G, Mr H, Mr I and Mr J

Portsmouth Safeguarding Adults Board

1. INTRODUCTION

1.1 This Safeguarding Adult Review concerns four men, Mr G, Mr H, Mr I and Mr J who died between 7th April 2020 and 3rd July 2020.

1.2 This is thematic review, which means that it focuses on themes rather than on each individual and identifies similarities and differences between the lives of the four men and the approaches taken by services to engage and support them. Consequently, it will only consider chronological events where these show a meaningful pattern from which lessons can be learned or the value of alternative approaches can be illustrated.

1.3 A summary of the lives of the four men is as follows:

1.4 Mr G

1.5 Mr G was a white British man who was 53 years old when he died. It appears that he arrived in Portsmouth in 2017, fleeing drug related threats in London. Mr G had been living in private rented accommodation in 2018 and there were reports that he had twice assaulted his partner in December 2019 at her address. Mr G was arrested following this and imprisoned. Mr G was released from prison on 19th March 2020 after serving slightly over two months in prison.

1.6 Between 23rd March and 30th March 2020, Mr G attended the Queen Alexandra Hospital twice for suspected opiate overdoses (an overdose was confirmed during only one attendance) and for facial injuries and arm lacerations.

1.7 Between 1st April and 5th April 2020, the Solent Mental Health Team became involved with Mr G since he said that he felt suicidal. An assessment was made but no current suicide plans or intent were identified, but there was a history of self-harming. It was concluded that there were no current symptoms to indicate severe or enduring mental illness requiring treatment from mental health services. Mr G moved into a hotel as part of the “Everyone In” programme on 2nd April 2020.

1.8 On 7th April 2020. Mr G was found dead in public toilets approximately 2 miles away from the hotel in which he was living.

1.9 Mr H

1.10 Mr H was a white British man who was 41 years old when he died. He had extensive previous contact with the police from at least 2003 and had served several terms of imprisonment. Mr H was admitted to the ANA Treatment Centre (a service which supports people who rely on drugs and alcohol) on 19th February 2020 for Methadone Detoxification and was reported to have fully engaged in the programme. Mr H was due to graduate from the ANA recovery

programme on 1st April 2020. Unfortunately, the graduation ceremony, to which he had invited a member of the Substance Misuse Team and a support worker from the Society of St James, was cancelled as part of the "lockdown". From the ANA Treatment Centre Mr H then moved to Society of St James (SSJ) supported housing. This accommodation was for people who are abstinent from, and for those who choose to use, alcohol.

1.11 Mr H was disappointed that services had closed and was worried about returning to his SSJ accommodation. He wanted to know if anyone there had Covid-19. He was also reported by practitioners to be concerned about living with other people who might be using drugs or alcohol. Substance misuse team staff became concerned when Mr H made no contact with them after he left the ANA treatment centre. Mr H was not at home in the independent accommodation managed by SSJ in which he lived when welfare checked by the substance misuse team.

1.12 On 29th May, Mr H contacted the substance misuse team and explained that he had tried to come off his mental health medication (he claimed that he had been given the wrong medication at the ANA Treatment Centre) but had realised that his mental health had deteriorated as a result. Mr H said that he wanted to reengage with Community Day Rehabilitation and the Substance Misuse Team agreed to contact him in a week about this. This was the last contact by services with Mr H.

1.13 Mr H died between 30th May and 3rd June 2020 in his room. He was discovered by a fellow resident and is believed to have died of a drug overdose.

1.14 Mr H had previously had a long-term relationship with the mother of his son.

1.15 Mr I

1.16 Mr I was a White British man who was 52 years old when he died. Mr I had intermittent contact with the Portsmouth City Council Housing Needs Advice and Support Service between 2014 and 2020. Mr I had been involved in pushbike thefts and in supplying drugs. He moved into a hotel as part of the "Everyone In" programme. The support staff there became increasingly concerned about his physical health. Mr I was not eating and appeared under-nourished. Half hourly welfare checks were conducted.

1.17 Between 13th June and 15th June 2020, the support staff telephoned for an ambulance three times for Mr I. Mr I was not taken to hospital on two of these occasions despite signs and symptoms of weight loss, self-neglect, shortness of breath and physical instability. On 15th June, however, the ambulance crew took Mr I to the Queen Alexandra Hospital where he died the next day (16th June 2020).

1.18 Mr I had a sister and he told services that he visited his mother every day.

1.19 Mr J

1.20 Mr J was a White British man who was 53 years old when he died. Until c.8th April 2020, Mr J lived with his sister in Portsmouth. He moved out due to non-

compliance with the “lockdown” restrictions, reportedly due to his alcohol intake. It is thought that Mr J moved in with another tenant of Portsmouth City Council. (see reference to S17 “Child in Need” assessment, below). The extent of his relationship with this person is, however, unclear.

1.21 On 21st March, Mr J was taken to the Queen Alexandra Hospital by Ambulance following a fall whilst under the influence of alcohol. He was discharged “home” on 22nd March 2020 with no follow up required.

1.22 On 4th May 2020 checks on Mr J were requested by Portsmouth Children’s Services Department as part of its s17 “Child in Need” assessment since Mr J was believed to have been living at the same address as the mother and child who were the subjects of this assessment. Mr J does not appear to have been involved in the assessment or the circumstances leading to it.

1.23 On 17th May 2020, Mr J attended the Queen Alexandra Hospital by Ambulance after having been found by a member of the public outside a library, difficult to rouse and breathing noisily. Upon admission, Mr J became verbally aggressive and refused all investigations. Once Mr J was more sober, he asked for support with alcohol dependency and was discharged. No medical follow up was required but the Emergency Department staff referred Mr J to the Alcohol Specialist Nursing Service. The outcome of this referral is unknown.

1.24 Mr J had been a member of a library, making use of its computers. It appears, from evidence of drinks cans and litter that he had been sleeping rough outside the library at some point after its closure, in response to Covid-19, from 17th March 2020, and possibly in the last week or weeks leading up to his death.

1.25 Mr J was found dead outside the library on 3rd July 2020.

1.26 Whilst Mr G, Mr H, Mr I and Mr J differed from each other, their individual circumstances and the nature of their deaths shared certain similarities and patterns. There are some individual concerns that will be explored further in this review.

2. SAFEGUARDING ADULT REVIEWS

2.1 Section 44 of the Care Act 2014 places a statutory requirement on the Portsmouth Safeguarding Adults Board (SAB) to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on Portsmouth Safeguarding Adults Board the power to commission a SAR into any other case:

2.2 ‘A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

2.3 there is reasonable cause for concern about how the PSAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

2.4 the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

2.5 the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

2.6 The SAB may also arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

2.7 If the criteria appear to be met, Safeguarding Adults Boards may agree to proceed with an alternative and more appropriate Review. These Reviews remain statutory Reviews.

2.8 The Portsmouth Safeguarding Adults Board agreed that a Thematic Review rather than individual SARs was the most appropriate way to consider the systemic factors and processes, which may have impacted on the circumstances of the deaths of four homeless people in Portsmouth during the 2020 calendar year.

2.9 A Thematic Review promotes effective learning, improvement actions and recommendations, which contribute to the improved safety and wellbeing of adults with care and support needs, therefore, reducing the risks of future deaths or serious harm occurring again.

2.10 As with a SAR, Thematic Reviews are required to reflect the six safeguarding adults' principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership, and accountability.

2.11 Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), the recommendations to improve services and to reduce the risk of repeat circumstances and, a shared action plan to implement these recommendations. It was not the purpose of the Review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

2.12 The Review has followed due process, which has involved: the Independent Reviewer chairing an initial panel meeting to agree the Review terms of reference; conducting research by analysing Individual Management Reports, chronologies and relevant records held by involved agencies; interviewing representatives of agencies; holding a Practitioner Learning Event, using a questionnaire and interviewing homeless people in Portsmouth and holding Thematic Review panel meetings and finally a presentation to the Portsmouth Safeguarding Adults Board. Twelve homeless people completed the questionnaire and four agreed to be interviewed face-to-face by the reviewer.

2.13 Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –

a) identifying the lessons to be learnt from the adult's case, and

b) applying those lessons to future cases.

2.14 Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (s44(5), Care Act 2014).

2.15 The purpose and underpinning principles of this Review are set out in the Portsmouth Multi-Agency Safeguarding Adults Policy and Procedures:

2.16 All PSAB members and organisations involved in this Review, and all Review panel members, agreed to work to these aims and underpinning principles. The Review is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.17 All four cases were referred to the SAR Sub-group of the PSAB between May and July 2020 and were considered for a Safeguarding Adult Review/Thematic Review at the meeting on 9th September 2020.

2.18 The SAR Sub-group considered that together rather than separately, these cases met the criteria for a SAR/Thematic Review, and the Independent SAB Chair ratified this on 20th September 2020.

2.19 The report writer, Patrick Hopkinson, is an independent safeguarding adults review writer, a chair and writer of domestic homicide reviews, and a trainer and consultant in adult safeguarding. He had no connection with any of the organisations that worked with Mr G, Mr H, Mr I and Mr J.

2.20 This Thematic Review used, chronologies, combined scoping documents and other submissions from partner organisations, a practitioner learning event, results from a questionnaire completed by homeless people and interviews with staff members and with homeless people themselves.

2.21 Family involvement

2.22 Letters were sent to relatives of the four homeless people who died in Portsmouth inviting them to participate in this Review. The independent report author met Mr J's sister as part of this thematic review. Mr J's sister provided information about Mr J's background.

2.23 Overview of the case and circumstances leading to the Thematic Review

2.24 During 2020, twelve homeless people are known to have died in Portsmouth. This compares with five people who are known to have died during 2019.

2.25 The deaths in 2020 happened within the context of the world-wide coronavirus pandemic and the consequent "Everyone In" project to temporarily house all homeless people and the "lock down" restrictions placed on people, services and businesses from 24th March 2020.

2.26 Non-essential shops reopened on 15th June 2020, with increased lifting of restrictions from 18th July until 14th August. Restrictions were reintroduced from 14th September and a second “lockdown” began from 5th November 2020.

2.27 The Portsmouth Safeguarding Adults Board decided that the reasons for the increase in the number of deaths in 2020 should be explored to identify both the reasons for the increase and any lessons that might be learned for the future.

2.28 To do this, the Board’s Safeguarding Adults Review Sub-Group chose four deaths to be the focus of a Thematic Review. Commonalities between the four cases included:

- Homelessness;
- substance and/or alcohol abuse;
- male and middle aged;
- known to agencies;
- attempts to provide support had met with occasional and sometimes frequent disengagement;
- low level offending and repeated physical injuries and/or physical/mental health concerns resulting in contact with health services.

2.29 The review aimed to identify systems-based learning by a variety of methods to assess service design and commissioning, and how agencies:

- Engaged with the individual
- Understood the individual’s life experiences
- Assessed risk
- Assessed Mental Health and Mental Capacity
- Identified Care and Support Needs
- Provided Safeguarding
- Managed transition (where appropriate)
- Identified circles of support within friends and family
- Used temporary accommodation and how suitable this accommodation was.

3. CONNECTING THEMES

3.1 Mr G, Mr H, Mr I and Mr J were in contact with various services. Throughout this report acronyms are sometimes used, the most prominent of these being:

3.2 PCC – Portsmouth City Council

3.3 HNAS – Housing Needs, Advice and Support (PCC)

3.4 SSJ – Society of St. James

3.5 QAH – Queen Alexandra Hospital

3.6 Connecting themes present in childhood

3.7 Two of the four men reported they had been the victims of traumatic childhood experiences.

3.8 Mr G disclosed to Solent Mental Health services on 5th April 2020 that he had a history of childhood sexual abuse. Mr G also disclosed being the victim of sexual abuse to Two Saints (night shelter) saying he was aged nine at the time.

3.9 The Solent Mental Health Services' assessment of Mr G on 5th April 2020 identified "dynamic risk factors including unresolved trauma following a history of childhood sexual abuse." The assessment resulted in a plan for Mr G to seek a "self-referral" to the Portsmouth Abuse and Rape Counselling Service (PARCS) for sexual abuse trauma support and for Mr G to engage with drug and alcohol services, to continue with prescribed medication and to contact the Samaritans and or SHOUT (a free, confidential 24/7 text support service) if and when necessary. It was explicitly noted that Mr G's willingness to engage with substance and alcohol misuse services was poor. Although this was identified as a "dynamic" risk factor, it is not clear if it was therefore entirely realistic and appropriate to expect Mr G to then begin engaging with services on his own volition, as part of his post-discharge plan.

3.10 At an Access to Intervention Team (Solent NHS Mental Health Services) assessment appointment on 10th January 2020, Mr J disclosed that he was affected by anxiety, low mood and traumatic childhood experiences. The details of the childhood trauma have not been made available to the Review author.

3.11 Connecting themes present in adulthood

3.12 All four men experienced homelessness and change(s) in accommodation in the last months of their lives.

3.13 All four men were drug and / or alcohol dependent. Some had received treatments and interventions.

3.14 Mr G spent time in prison from 10th January to 19th March 2020. During that time, he underwent alcohol detoxification. Mr G was advised about the dangers of mixing drugs and alcohol, and that his tolerance would be reduced after detoxification. However, on 23rd March 2020, Mr G was taken by ambulance to the QAH with a suspected opioid overdose. Mr G was referred to the Alcohol Specialist Nurse Service *(*ASNS*)* (part of the alcohol team at Queen Alexandra Hospital) for assessment.

3.15 Mr H had been addicted to heroin for 20 years and had recently been through rehabilitation at the ANA Treatment Centre. On completion of the six-week programme Mr H tested negative for both drugs and alcohol. Mr H was concerned about moving to SSJ (Society of St James) accommodation because people who still used alcohol lived there. Mr H wanted to relocate to Bognor Regis to enable him to access the Sands Project. The Sands Project is a service for people who are abstinent from substances and require stabilisation, as well as for people who have completed a rehabilitation programme who request a further support. The service is also able to support

clients who experience mental health problems and works with local mental health teams to deliver support to them. Mr H did not relocate to Bognor Regis, but instead, moved to SSJ supported housing on 1st April 2020. It is not clear why Mr H did not move to Bognor Regis and what was done, if anything, to support and advise him in a potential relocation there. It appears that Mr H relapsed to drug taking in the last days of his life. He was found dead with drug paraphernalia around him.

3.16 Mr I was well known to the substance misuse team and had irregularly been on a methadone prescription for several years. Mr I saw a doctor at the Recovery Hub on 27th December 2019. Mr I was opiate dependent at the time and appeared to feel strongly that he should stop using heroin completely. Between December 2019 and May 2020 the police received twelve pieces of intelligence that suggested that Mr I was involved in using and supplying controlled drugs in the Portsmouth area.

3.17 At the Access to Intervention (the entry point for mental health services provided by Solent NHS Trust Mental Health Services) assessment appointment for Mr J on 10th January 2020, it was identified that Mr J would obtain support via the Recovery Hub and would therefore be discharged. It does not appear that Mr J contacted the Recovery Hub, but he engaged with the Alcohol Specialist Nurse Service *(*ASNS*)*, part of the alcohol team at Queen Alexandra Hospital). A SSJ support worker based within the team met Mr J and discussed his drinking and homelessness situation, and the value of making a housing referral, with him in June 2020. They agreed that Mr J would contact the support worker again, but no contact was made despite the worker having tried to contact Mr J several times without success.

3.18 All four men had mental health needs, the detail of these is known to varying degrees.

3.19 Mr G had a history of suicidal ideation and of self-harm. For example, on 31st March 2020, Mr G was found in a railway lineside hut with a broken bottle neck that he had used to make a deep cut in his forearm. Solent Mental Health Services identified that Mr G had apparently served a prison sentence in 2018 for trespass on a railway line while attempting to end his life.

3.20 Mr H was on anti-depressants (no further information is available to the SAR author).

3.21 Mr I was referred to the Single Point of Access Solent NHS Trust Mental Health Services in January 2018. However, Mr I did not attend his scheduled assessment appointment with this service in February 2018, and it appears that there was no further engagement with services regarding his mental health.

3.22 Mr J was referred to Solent NHS Trust Mental Health Services in December 2019 and at the assessment appointment on 10th January 2020 was described as affected by anxiety, low mood and traumatic childhood experiences. The outcome was that Mr J would access the Recovery Hub and that he was motivated to engage with the group activities that may be offered there for people with problems with substance misuse). On this basis Mr J was discharged from Solent NHS Mental Health Trust Services. However, it

appears that Mr J did not engage with the Recovery Hub, and that there was no further engagement to support Mr J with his mental health needs.

3.23 Three of the four men were reported to be involved in criminal activity or domestic abuse.

3.24 Mr G arrived in Portsmouth in 2017, fleeing drug related threats in London. On 24th September 2019 Mr G was arrested for assault and criminal damage following a domestic incident with his partner. Mr G was charged and ordered to pay a fine and compensation. According to police reports Mr G was later "shown" to be the aggrieved party when he was assaulted with a spade and a piece of wood at his partner's address (then his home address). Mr G's partner and a member of her family were arrested but there was no prosecution due to lack of independent evidence.

3.25 On 16th October 2019, Mr G was released from prison (reason not given) whereupon he attempted to gain entrance to his partner's property by trying to kick down the front door and threatened violence to the occupants whilst holding a bat. Mr G was arrested and sentenced to a term of imprisonment and a referral was made to the domestic violence MARAC. In December 2019, there were reports that Mr G had twice assaulted his partner at her address, where he was living. Following the second assault, the Police issued Mr G with a Domestic Violence Protection Notice (DVPN) to prevent him returning to his partner's address on 8th December 2019. Mr G was recalled to prison on 13th December 2019 and then released on 20th December 2019. The following day he was arrested for breaching the DVPN. On 8th January 2020, police were called to reports of Mr G causing damage at his partner's property. He was arrested and, in the process, assaulted two police officers.

3.26 Mr G was in prison from 10th January 2020 to 19th March 2020. Upon release, Mr G attempted gain entry to his partner's house and left before the police arrived. He returned later in the evening and caused property damage attempting to gain access again.

3.27 In early hours of 26th March, Mr G assaulted a staff QAH and later that day, the police were called to a report that Mr G was drunk and was trying to assault people. Mr G then attempted to assault a police officer. On the night of the 27th/ 28th March 2020, Mr G violently assaulted his partner again in a public place. Mr G was arrested and subsequently bailed to allow for completion of the investigation. Mr G died before the return bail date.

3.28 Mr H had extensive previous contact with the police from at least 2003 and had served several terms of imprisonment. There were also two reported breaches of curfew imposed in a court order with electronic tagging in 2020.

3.29 Mr I had been involved in pushbike thefts and in supplying drugs.

4. THE EVIDENCE BASE FOR THE REVIEW

4.1 Preston-Shoot (2020) argues that, "Drawing on existing evidence about effective practice would mean that reviewers are not starting out with a blank canvas. What is proposed here is that SARs begin explicitly with the available

evidence-base, using it as a lens with which to scrutinise case chronology and explore through panel meetings, interviews and learning events with practitioners and managers what facilitates good practice and what presents barriers to effective practice".

4.2 The advantage of this approach is that, "The emphasis then is less on description and more on immediate reflection and systemic analysis of facilitators and barriers, across nationally determined policy, legal and financial systems as well as local arrangements and staff values, knowledge and skills" (Preston-Shoot, 2017).

4.3 Reinforcing this, The Local Government Association Analysis of Safeguarding Adult Reviews April 2017 – March 2019 section 3.4 "Type of Reviews" describes a number of "methodological" requirements and related shortcomings of SARs, which can be summarised as follows:

4.4 SARs should connect their findings and proposals to an evidence base. Few SARs compare actual practice with that suggested in guidance and few explore the reasons why there was a difference between the two.

4.5 SARs should be based on research. Over 50 Safeguarding Adults Boards have carried out SARs on the same set of circumstances on more than one occasion but have treated each discreetly. The SARs do not refer to each other, build on each other, or ask why it happened again.

4.6 SARs should be analytical. There is too much description and not enough analysis.

4.7 SARs should not shy away from difficult or sensitive topics. Few SARs engage in the legal and financial context of practice or decision making and should raise the impact of funding cuts, government strategy and reductions in services.

4.8 Consequently, a study was made of both the research evidence and practice evidence that provides insight and guidance when working with men like Mr G, Mr H, Mr I and Mr J.

4.9 Literature Review referencing Local and National learning

4.10 A literature review was undertaken to understand the deaths of Mr G, Mr H, Mr I, Mr J and other homeless people in Portsmouth during 2020 within a wider context.

4.11 The impact of COVID-19

4.12 First phase of the COVID-19 pandemic began in 2020. On 16th March 2020, the Government advised against non-essential travel and encouraged working from home in all but exceptional circumstances. On 20th March 2020, entertainment venues were also ordered to close.

4.13 On 23rd March 2020, the government restricted contact between households and the UK population was ordered to "stay at home". The only permissible

reasons to leave home were food shopping, exercise once per day, meeting medical needs and travelling for work when absolutely necessary. All shops selling non-essential goods were told to close and gatherings of more than two people in public were banned. These 'lockdown' measures legally came into force on 26th March 2020.

4.14 In response to the threats posed by COVID-19, on 26th March 2020, Baroness Casey of Blackstock announced the "Everyone in" project and issued an instruction to local authorities to ensure that all rough sleepers were "*inside and safe*". According to Neale et al (2021), the "Everyone In" project was a ground-breaking UK Government policy initiative to provide temporary accommodation for everyone experiencing rough sleeping and a range of other forms of homelessness during the COVID-19 pandemic. Nationally, approximately 15,000 people were placed into emergency accommodation.

4.15 On 2nd April 2020, rough sleepers in Portsmouth and the 57 individuals who were using shared Night Bed spaces were relocated to a hotel which provided self-contained rooms. The existing Homeless Night Bed and Day Services, provided by two commissioned providers, were collapsed and relocated at the hotel. The providers worked together with the Homeless Health Care Team, hotel staff, and a safety team to support and manage the accommodation. Health screening was provided for all residents on arrival and in conjunction with Portsmouth City Council and the voluntary sector, residents were provided with three meals per day. A Hotel Management Group, comprising Housing, Public Health, the commissioned support providers, hotel and safety teams, the Police and the Community Wardens Service, provided oversight.

4.16 Approximately 100 people were expected to be housed under "Everyone In" in Portsmouth. Exceptional efforts, however, were made to accommodate 444 people who presented themselves as homeless (this included people who had no fixed abode and were "sofa surfing" as well as people who were street homeless). This was a notable achievement.

4.17 The Museum of Homelessness report on the Impact of COVID-19 (Coronavirus) on homelessness published in April 2021 identified that the "Everyone In" project represented an "*internationally significant effort across the UK, from central and local government, charities and community groups to accommodate people who were homeless during the pandemic*"

4.18 Three main achievements were identified by the Museum of Homelessness. Only 3% of homeless deaths in 2020 were COVID-19 related; there were formal changes in practices for some local authorities and there was a shift from dormitory provision to individual rooms. In addition, the Museum of Homelessness found that "Everyone In" brought people off the street who had not been accommodated for years and that some homeless people interviewed declared that "Everyone In" had saved their lives and were committing to methadone treatment as a component of being accommodated.

4.19 Despite these successes, the Museum of Homelessness found that the number of deaths of homeless people during 2020 had increased by 37%. These were related to several, "*Systemic challenges during the year*", which included:

- A collapse in the supply chain and in services in the early stages of the pandemic, with community groups filling gaps in provision.
- Failings in the provision of accommodation, specifically related to more marginalised people within the homeless population.
- Failures with Street Link – the primary channel for referrals through the year
- Failures of support services when people received accommodation – including around food provision and PPE use.

4.20 The Museum of Homeless also identified that there were, "*Widening inequalities, stigma and isolation*", which included:

- Counter-productive public messaging about the success of activity from authorities and charities resulting in the abuse of homeless people
- Aggressive enforcement from local authorities and police
- Increased risk to homeless migrant people
- Evidence of an increase in homelessness caused by COVID-19
- Structural problems with homelessness and housing
- Evidence of an increase in deaths of homeless people from factors other than COVID19
- Evidence of spikes in suicides around the lockdowns.

4.21 The accuracy of official figures for the number of deaths of homeless people during the COVID-19 pandemic is acknowledged by the Office for National Statistics (ONS, 2021) to have been affected by difficulties in identifying people as homeless.

4.22 COVID-19 restrictions began to be lifted from 10th May 2020, but local lockdowns were introduced from 29th June.

4.23 Other deaths of homeless people in 2020 in Portsmouth

4.24 Whilst the four people who are the focus of this review were chosen at random, they are, except for gender, representative of the other eight homeless people who are known to have died in Portsmouth in 2020 and of the five who are known to have died in 2019 and the two who had died in 2021 by the time this review began. The following is a breakdown of their characteristics.

4.25 Out of the other fifteen homeless people known to have died, five were women and ten were men. One was Black British, two were White Other and ethnicity was unknown for two. Their average age was 42 years old. The youngest was 21 and the oldest was 60 years old.

4.26 Two had been known to be the victims of domestic violence and abuse, one was known to have been the perpetrator.

4.27 The following table summarises the other demographic characteristics:

4.28 Table 1: *Known characteristics of the other 19 homeless people who died between 2019 and February 2021.*

Known characteristics	Yes	No	Unknown
Alcohol use	9	5	5
Substance Use	7	4	8
Past Trauma	3	4	12
Criminal Justice System Involvement	5	6	8
Change of accommodation	13	5	2
Physical and/ or mental health needs	12	4	3

4.29 The strongest correlation between the sample of four people in this Thematic Review and the other homeless people who died is in a change of accommodation (which may be a result of the "Everyone In" project) and in the presence of physical and mental health problems. Unfortunately, only a little is known about the lives of some homeless people so there may be other similarities which have not been detected.

5. EVIDENCE FROM RESEARCH, PRACTICE AND GUIDANCE AND ANALYSIS OF THESE WITH THE LIFE EXPERIENCES AND CONTACT WITH SERVICES OF Mr G, Mr H, Mr I AND Mr J

5.1 Adverse childhood experiences and the impact of trauma

5.2 There are strong evidential, as well as logical and intuitive, links between child sexual abuse, physical abuse and trauma and the experience in adulthood of mental health problems, excessive use of drugs and/ or alcohol, self-neglect and chaotic and abusive personal relationships (Lewis et al, 2021; Maniglio, 2019; Greenfield, 2010). These traumatic events in childhood are often referred to, somewhat euphemistically since the term barely captures their extremely disturbing nature, as adverse childhood experiences (ACE) (Felitti et al, 1998).

5.3 ACEs include growing up in a household with someone who has mental health needs, misuse substances or has been incarcerated in the criminal justice system. They include exposure to child maltreatment or domestic violence and losing a parent through divorce, separation or death (WHO, 2012).

5.4 Exposure to such ACEs has been associated with poor health outcomes including substance use, mental ill-health, obesity, heart disease and cancer, as well as unemployment and continued involvement in violence.

5.5 Importantly, the impact of ACEs appears to be cumulative, with risks of poor outcomes increasing with the number of ACEs suffered. Significantly, people who have been exposed to multiple ACEs are more likely to die at a young age from natural causes, suicide or homicide (Bellis et al, 2013).

5.6 Both Mr G and Mr J reported traumatic childhood experiences. Although these do not appear to have been explored in depth, the research evidence suggests that they are likely to have impacted negatively on their adult lives. Mr G and Mr J do not appear to have accessed services to support them with the effects of trauma.

5.7 Not everyone who has experienced trauma will be affected by it in the long term. However, there is considerable practice and research evidence that people with a history of trauma struggle to engage with the services that try to help and support them. Of the two men known to have suffered childhood trauma Mr G was described as hard to engage with services. Mr J was keen to join activities offered by the Recovery Hub, but these were not available because of the COVID-19 lockdown.

5.8 Adult experiences and themes connecting Mr G, Mr H, Mr I and Mr J

5.9 Non-engagement with services

5.10 The 2020 East Sussex Safeguarding Adults Board safeguarding adults review following the death of Adult C, found that, "*Current service set ups locally are not joined up or tailored to the needs of a small cohort of women who struggle with a combination of needs related to chronic trauma, drug and alcohol dependencies, homelessness and domestic violence and abuse. This leaves some of the most vulnerable women either excluded from services altogether based on eligibility criteria, or unable to access them because of the lack of proactive, flexible and intensive outreach support*". It is likely that this finding can be applied to the men in this Portsmouth Thematic Review too.

5.11 Other Safeguarding Adults Reviews (for example, the Thematic Review following the deaths of four women, West Sussex Safeguarding Adults Board, 2022; the Safeguarding Adults Review following the death of Adult D, London Borough of Camden, 2022; Mary and Graham, Leicester Safeguarding Adults Board, 2019) have identified the challenge faced by services when working with hard to engage, or "involuntary", clients. These reviews highlighted that services often waited for periods of stability or for a spontaneous change in engagement. Unfortunately, these opportunities rarely arose and instead, people who found it difficult to engage with services, to attend meetings or to comply with requirements were discharged from the services that might support them.

5.12 The report Alcohol Change UK report, "Safeguarding Vulnerable Dependent Drinkers England and Wales (Ward and Preston-Shoot) states that, "*if a person is vulnerable, at risk of abuse and neglect (including self-neglect) or having a significant impact on the community, it is unhelpful, if not self-defeating, to require someone to leap a hurdle like attending an appointment with a stranger in a distant part of town. Assessment structures need to accommodate the difficulties faced by the client rather than be convenient for the worker. In particular, assessment should not be seen as a point in time, but rather as a process whereby services work with someone to enable an assessment to be undertaken. Without a process focus, services will fail the most challenging clients*".

5.13 While two of the men, Mr H and Mr J, were motivated to engage with services, Mr G and Mr I were described as difficult to engage. For example, Mr I was referred by his GP to the Single Point of Access in January 2018. Mr I did not attend his scheduled assessment appointment with the service in February 2018 and did not respond to attempts to contact him by telephone. Mr I was then sent an 'opt-in' letter on 21st February 2018, but did not respond to it, and was therefore discharged from the service on 28th February 2018.

5.14 Even though Mr J appeared to be motivated to engage, there was a reliance on him to contact services, which failed, for example, when Mr J did not remake contact with SSJ member Alcohol Specialist Nurse Service (ASNS) (the alcohol team at Queen Alexandra Hospital) after June 2020.

5.15 The practice of discharge following missed appointments does not fit well with people who behave in a chaotic way because of their traumatic life experiences and is a factor that has been identified in other Safeguarding Adults Reviews and in published guidance.

5.16 The Blue Light Project Manual (Alcohol Concern 2014), for example, challenges the assumption that if the person who uses substances does not want to change, or does not believe that change is possible, no treatment programme is likely to yield positive results and that there is little that services can do to help them. The Manual sets out alternative approaches that can be used with this client group, including motivational and harm reduction interventions built around assertive outreach and multi-agency working.

5.17 There was one reference to assertive outreach with Mr I, when he was sofa surfing. There are no other references to assertive outreach for any of the other three men, although there were some attempts to engage with them before referrals were closed or services were shut down because of the COVID-19 lockdown.

5.18 The false conflict between freedom and protection

5.19 Most of the contacts with Mr G, Mr H, Mr I, Mr J took place within a policy context that emphasises choice, independence and personal control (essentially the Article 8 Rights set out in the European Convention on Human Rights) and which form part of an overall neo-liberal approach to adult health, social care and welfare (Ward et al, 2020).

5.20 Safeguarding Adults Reviews (amongst others Adults B and C, South Tyneside; Mr I, West Berkshire and W, Isle of Wight) have increasingly focused on the challenges of practicing in a way which balances the principles of freedom of choice and self-determination with the duties, public expectations and moral imperatives of public services. These take place within a legislative framework which includes the Human Rights Act 1998, the Care Act 2014, the Mental Capacity Act 2005 and the Mental Health Act 1983.

5.21 At the intersection of all these factors is the question of the extent to which adults should be left by public services to behave in a way that is objectively detrimental to their health and wellbeing, or which threatens their lives. More fundamentally it is question of prioritising freedom of choice or prioritising

protection from harm (essentially Article 2 of the European Convention on Human Rights).

5.22 Self Neglect

5.23 There was a recognition that Mr I might be self-neglecting, but this was not identified for Mr G, Mr H and Mr J. Despite this, guidance on working with people who self-neglect is relevant since it provides insights into approaches to working with people who can be hard to engage.

5.24 Self-neglect is one of the ten categories of abuse and neglect specified in the adult safeguarding sections of the Care and support statutory guidance. Self-neglect can be defined as, "*the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglecter and perhaps even to their community*" (Gibbons et al, 2006, p.16).

5.25 There is extensive research into and guidance on working with people who self-neglect, which was available during the time period for this Review. For the purposes of this Review, it is sufficient to focus only on a summary of this guidance. Practice with people who self-neglect is more effective where practitioners:

- Seek to understand the meaning and significance of the self-neglect, taking account of the individual's life experience
- Work patiently at the pace of the individual, but know when to make the most of moments of motivation to secure changes
- Keep constantly in view the question of the individual's mental capacity to make self-care decisions
- Communicate about risks and options with honesty and openness, particularly where coercive action is a possibility
- Ensure that options for intervention are rooted in a sound understanding of legal powers and duties
- Think flexibly about how family members and community resources can contribute to interventions, building on relationships and networks
- Work proactively to engage and co-ordinate agencies with specialist expertise to contribute towards shared goals

5.26 To do this, the following approaches should be used:

- History taking. Explore and ask questions about how and when self-neglect started.
- Be proactive and identify and address repeated patterns of behaviour

- Try different approaches, use advocates and concerned others, raise concerns, discuss risks, maintain contact, avoid case closure

- Ongoing assessment review of mental capacity.

5.27 Substance Use, Mental Capacity and Lifestyle Choice

5.28 The Mental Capacity Act sets out the process for assessing and determining whether or not someone with an "*an impairment of, or a disturbance in the functioning of, the mind or brain*" is able to make a specific decision at a specific time. Impairments and disturbances in functioning can include drug and alcohol use and addictions to them.

5.29 Mr G was assumed to make mentally capacitous decisions, even though the results of these decisions were potential harmful to him.

5.30 The guidance on working with people who self-neglect helpfully challenges the either / or nature of the question of the right to protection and the right to autonomy by asking practitioners to consider:

5.31 Is a person really autonomous when

- They do not see how things could be different.
- They do not think they are worth anything different.
- They did not choose to live this way, but adapted gradually to circumstances
- Their mental ill-health makes self-motivation difficult.
- They have impairment of executive brain function.

5.32 Is a person really protected when:

- Imposed solutions do not recognise the way they make sense of their behaviour.
- Their 'sense of self' is removed along with the risks.
- They have no control and no ownership.
- Their safety comes at the cost of making them miserable.

5.33 Decisional and Executive Capacity

5.34 Whilst the Mental Capacity Act does not explicitly recognise the difference between decisional capacity (the ability to make a decision) and executive capacity (the ability to turn that decision into action), it is an important distinction in practice.

5.35 There is growing evidence of the impact of both long-term trauma and of alcohol and substance use on cognitive ability and especially on executive brain function (which includes working memory, mental flexibility, and self-control and regulation) which in turn impacts on mental capacity. Approximately 50% of dependent drinkers have frontal lobe damage; another reason for practitioners to be thorough in carrying out mental capacity assessments. Of

particular relevance is that, compared with control groups, people with frontal lobe damage caused by alcohol use and traumatic experiences:

- Are significantly slower and less accurate at problem solving when it involves planning ahead.

- Persisted with riskier behaviours for longer and were less responsive to negative outcomes.

- Were no different when identifying what the likely outcome of an event would be.

5.36 As a result, people with frontal lobe damage caused by alcohol use and traumatic experiences might have the mental capacity to predict what might happen but are less likely to be able to take action to prevent it from happening. Significantly, these cognitive deficits are unlikely to be detected using the verbal reasoning tests frequently used in mental capacity assessments.

5.37 The report Alcohol Change UK report, "Safeguarding Vulnerable Dependent Drinkers England and Wales (Ward and Preston-Shoot) identifies that at times dependent drinkers may be wrongly believed to have mental capacity to make decisions about their safety, for example. The Mental Capacity Act defines the ability to make a decision requires that a person can understand information about the decision to be made, retain that information in their mind, use or weigh that information as part of the decision-making process, or communicate their decision. If a person is unable to do at least one of these, then they are unable to make the decision.

5.38 However, for dependant drinkers, "*their compulsion to drink means that they are unable to use the information they are given, even if they understand it*" (Ward and Preston-Shoot). Cognitive impairments caused by long term alcohol and drug use are often not recognised.

5.39 The Alcohol Change Report also highlights that a long-term view should be taken when assessing capacity, which includes the history of decisions that a person has made, based on the lack of understanding of risks, or inability to weigh up information. The approach described by Alcohol Change UK is to consider mental capacity as a "video" rather than as a "snapshot". This recognises that all interventions need to be within the context of an understanding that people addicted to substances will often not have the mental capacity to make free decisions that are unaffected by the controlling and coercive influence of their addiction.

5.40 All four men had a history alcohol and/or drug misuse. There are references to mental capacity for two of the men: Mr G on five occasions was considered to have capacity to make decisions against medical advice. On the one occasion in which mental capacity was noted for Mr J, the conclusion was that he did not have capacity because he was intoxicated at the time.

5.41 On 23rd December 2019, Mr G was brought into the Emergency Department (ED) via ambulance with a reported head injury. Mr G discharged himself. The hospital completed a mental capacity assessment, which deemed Mr G to have

capacity to make an informed decision regarding his treatment. The risks of self-discharge were explained to Mr G, documented, and witnessed by two members of staff. It is not clear from the documentation provided to the SAR author if Mr G was intoxicated at the time, or whether the hospital was aware that Mr G had problems with alcohol dependency.

5.42 On 26th December 2019, Mr G attended the ED alleging that he had been assaulted four days previously. X-rays were taken and multiple fractures to Mr G's ribs were identified. Mr G required a surgical chest drain and was admitted to QAH for ongoing monitoring and pain relief. Mr G discharged himself on 31st December 2019, against medical advice, following several episodes of verbal aggression towards staff and after consuming alcohol on the ward with his current partner. The hospital noted that Mr G was deemed to have the capacity to make an informed choice about the risks of discharging himself against medical advice. It was clear that Mr G had been drinking. There does not appear to have been any consideration of whether Mr G's drinking affected his ability to make capacitous decisions.

5.43 On 8th January 2020, Mr G attended the ED at QAH via ambulance. Mr G was reported to be intoxicated with alcohol and presented with a head injury, reporting that he had hit his head on a door frame. Mr G refused care and treatment. The hospital deemed that Mr G had mental capacity and gave advice to Mr G to return to the ED if there was any change in how he felt. Mr G discharged himself from the hospital and went back into police custody. Again, it is clear that Mr G was intoxicated, but that does not seem to have been considered in the mental capacity assessment.

5.44 On 23rd January 2020, Mr G attended the ED at QAH with a suspected opiate overdose. He received some treatment and left, but was admitted to a ward later that day. On 25th January 2020 Mr G repeatedly threatened to discharge himself if he was not given diazepam. Mr G said that he would "throw himself on the railway tracks". Hospital notes document numerous attempts by medical staff to offer support and help to Mr G. Advice was sought from the Mental Health Liaison Team (MHLT) because Mr G was known to Elmleigh Hospital (an Acute Mental Health Crisis Hospital). The hospital completed and documented a mental capacity assessment, which deemed Mr G to have capacity to make decisions about his care, support and treatment needs, and noted that he could self-discharge if he chose to.

5.45 On 30th March 2020, Mr G attended ED with a wound to his arm. Medical staff explained the risk of not having treatment, which included the risk of losing his arm. Mr G reportedly said, "I don't care if I die", and discharged himself against medical advice. The hospital deemed that Mr G had the capacity to make this decision.

5.46 Conversely on 17th May 2020, Mr J attended the ED at QAH, having been found by a member of the public. He was reported to have been intoxicated. Upon admission he was verbally aggressive and refused all investigations. Medical staff acted in Mr J's best interests since he was deemed to lack mental capacity to make decisions about his care, support and medical needs due to alcohol intoxication. Medical staff administered intravenous fluids and made observations. It is not clear why Mr J was treated differently from Mr G.

5.47 It does not appear that Mr H and Mr I's mental capacity was assessed in any of their contacts with services. Whilst a principle of the Mental Capacity Act is the presumption of capacity unless demonstrated otherwise, there were opportunities when a capacity assessment might have been useful. Examples include when appointments were not attended, and there were repeating patterns of behaviour.

5.48 There does not appear to have been an operational understanding of the impact of substance addiction upon decision making, particularly for Mr G, Mr H and Mr I. Their dependence on alcohol and drugs could have been considered to have a coercive and controlling influence on their mental capacity, even when they were sober. This approach is promoted by the Alcohol Change UK December 2020 report, "Safeguarding Vulnerable Dependent Drinkers".

5.49 Housing and Homelessness

5.50 There is substantial, as well as intuitive, evidence that the well-being of both individuals and families is substantially affected when the need for satisfactory housing is not met. According to the United Nations (UN) Committee on Economic, Social and Cultural Rights, satisfactory housing consists of: legal security of tenure; availability of accessible services, facilities and infrastructure; habitability; accessibility (e.g. access to employment, health services, schools, etc); cultural adequacy; and affordability.

5.51 The Homelessness Reduction Act 2017 requires that local authorities must offer early intervention and prevention to avoid homelessness, must assess housing need, offer advice and information, work with other agencies and develop personalised housing plans. Mr G, Mr H, Mr I and Mr J were all in intermittent contact with housing services but appear to have remained living without any form of security or stability.

5.52 Mr G had lived at the same address as his partner, but after altercations, and DVPN and time in prison, Mr G used the Night Service (managed by SSJ) on 29th and 30th March 2020 and another night service managed by Two Saints on 31st March and 1st April 2020. Mr G moved to a hotel on 2nd April 2020 when the Night Service was relocated in response to the COVID-19 pandemic. Following enquiries with Mr G's GP, a decision was made that no statutory housing duty was owed under the 1996 Housing Act on 18th March 2020. There was no further contact with the Housing Needs Advice and Support service.

5.53 Mr H, who did not stay in a hotel, had completed the ANA Treatments Centre recovery programme and returned to his homeless hostel accommodation. He did not want to return there because he was trying to remain drug free.

5.54 Mr I accessed the Portsmouth Night Bed Service on six occasions between 18th December 2019 and 7th January 2020. Mr I then accessed Night Beds continuously between 8th January 2020 and 5th February 2020 except for two nights. Mr I sofa-surfed with a friend for a couple of months, who then told him to leave, and he was placed at a hotel as part of "Everyone In".

5.55 Mr J had lived at his sister's address, but had to leave due to his drinking and non-compliance with lockdown rules. It appears the Mr J then moved in with another person, but in the last weeks of his life was living rough in the grounds of the library.

5.56 Housing is also included in the Wellbeing Principle, set out in section 1 of the Care Act 2014, and the provision of suitable accommodation should be considered when making decisions about care and support needs (Ch.15 of the Care Act statutory guidance). Meeting a housing need, however, does not mean that care needs are met (s.23, Care Act 2014).

5.57 There is a strong interrelationship between mental health and homeless, such that housing can be considered to be "foundational" to good mental health and wellbeing (Padgett, 2020). Without stable and secure housing, other efforts to support people with their mental health needs, their drug and alcohol use, their chaotic and dangerous behaviours are unlikely to be successful.

5.58 Homelessness is also often combined with other problems in living. Multiple Exclusion Homelessness is the term used to describe people who have been homeless (including the experience of temporary, unsuitable accommodation as well as sleeping rough) and who have also experienced one or more of the following additional domains of social exclusion:

5.59 Institutional care (prison, local authority care, psychiatric hospitals or wards); or

5.60 Substance misuse (drug problems, alcohol problems, abuse of solvents, glue or gas); or

5.61 Participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work).

5.62 People who meet this definition are likely to be homeless for longer, have escalating health and care needs and have a reduced life expectancy compared with other homeless people who do not have multiple exclusions.

5.63 Given what is known of Mr G, Mr H, Mr I and Mr J's substance misuse and life experiences it would seem that they met the definition of Multiple Exclusion Homelessness.

5.64 The "Everyone In" project developed overtime and took homeless people off the street and from other temporary or unsuitable accommodation to protect them from Covid-19. People were accommodated in two hotels. Despite the great success in housing homeless people, practitioners and homeless people identified that this also meant that they were brought together with each other and were surrounded by other chaotic people with serious problems (including physical and mental health needs; drug addictions; violent behaviours etc). Some homeless people were also taken away from their familiar environments.

5.65 As a result of the unprecedented level of demand it was sometimes difficult to practice a therapeutic environment in the hotels due to the number of residents and the capacity of staff. Practitioners argued that a therapeutic environment was an essential component of any effective intervention with homeless

people. Just putting roofs over people's heads was insufficient and a trauma informed approach, which placed clear boundaries on behaviours, was required.

5.66 Unless this was done, there was a risk that hierarchies could be established in which bullying, coercion and control and violence often featured. People with significant physical and mental health needs were housed with people with extensive criminal histories who were still involved in crime. Several homeless people carried weapons (usually knives).

5.67 Some people had come forward to report themselves as homeless and had previously been staying with friends but did not have a background of street homelessness. Some practitioners considered that the milieu in the hotels was unsafe for these people so that they were quickly moved on. This revealed an environment which created an alternative definition of "vulnerability", in which people who had not experienced institutions and street homeless were identified to be more at risk than those who had.

5.68 Mr G, Mr I and Mr J were accommodated in hotels, but it appears that Mr J did not stay there. The findings from the interviews with and questionnaires completed by homeless people was ambiguous and reflected the different personal circumstances and experiences of those who participated. For example, three questionnaire respondents who did not want to be interviewed said that they had also been accommodated in hotels. Of these, one said that they had felt safe there whilst the other two said that they felt unsafe but all reported that they had received some support from staff. Of the small sample of four homeless people interviewed face to face, two said that they stayed at a hotel and said that it had been worse than staying at a hostel for homeless people. They said that support staff working at the hotels were often too busy to provide help. A further seven questionnaire respondents, one of whom was also interviewed, had stayed in homeless hostels rather than in hotels. Three said that they had felt safe whilst three had not and one had felt safe at times. Six said that they had felt supported.

5.69 These concerns must be set within a wider context, however. Covid-19 was an unknown, unpredictable, and dangerous threat and services made tremendous efforts to adapt to it in the face of restrictions, staff illness and isolation and changing guidance. Accommodation became limited and options, including hotels, reduced as they closed in response to Covid-19. The "Everyone In" project resulted in closer liaison at a strategic leadership level between adults social services and housing services, including regular meetings between directors and the consensus was that the environment of cooperation and joint working had improved beyond the pre-Covid level.

5.70 The challenges faced by homeless people were also not just confined to the services provided as a result of "Everyone In". Pressure to conform and take drugs can have an impact of homeless people in any shared accommodation. Mr H, for example, who did not stay in a hotel, had completed the ANA Treatments Centre recovery programme did not want to return to his homeless hostel accommodation since he was trying to remain drug free. Practitioners identified that the only accommodation where abstinence was enforced was that accessed through the criminal justice system. Any other accommodation in

which homeless people were supported might include people who were using drugs or alcohol. There are practical reasons for this: making licence agreements contingent upon abstinence increases the number of homeless people who are evicted only to be offered accommodation again. This “revolving door” is known by practitioners to be disruptive, wasteful and to undermine therapeutic relationships.

5.71 Practitioners were unaware of any accommodation for those who have completed recovery programmes and were committed to remaining drug and alcohol free. However, Mr H had talked of his desire to relocate to Bognor Regis in order to access the Sands Project, which does appear to be for people who are abstinent. It is not clear why he was not supported to achieve his desire. Lockdown may have made this more difficult.

5.72 There has, however, been significant development in the services provided. Following a successful Portsmouth City Council led bid to the Department for Levelling Up Housing and Communities, moves of formerly homeless people into more settled housing was progressed. Throughout August and September 2020, residents assessed as having lower support needs moved into shared housing in the private rented sector or into properties leased to provide 'move on housing'. On 15th September 2020 residents assessed as needing more supported housing moved into new accommodation in the Rough Sleeping Pathway. The Pathway comprised of three buildings, formerly student accommodation, totalling 105 units of housing. The buildings were initially leased and subsequently purchased by Portsmouth City Council. The two commissioned services continued to work together to provide support whilst the new service was commissioned.

5.73 The three buildings form a Pathway with an intensive support property and medium support property, both of which are staffed 24 hours a day, 7days a week. A third property is for individuals with lower support needs and has visiting support. It is a temporary Pathway for rough sleepers and those at risk of rough sleeping, with flexibility for people to enter and move within the Pathway according to their level of support need. There is a full time social work post funded to work within the Pathway. There is also support from services commissioned by Public Health providing recovery support, psychology support, a mental health worker, health care services and wellbeing services.

5.74 Working in conjunction with Housing, residents move on from the Pathway into more settled housing either within existing commissioned services or to private rented housing. There is a Rough Sleeping Hub which provides advice, support and practical help for rough sleepers in the day and an Outreach Service engaging with individuals at their rough sleeping locations in the city. This service was subject to a tender process, and the contract for the newly commissioned service commenced on 1st October 2021.

5.75 Lockdown, isolation and services

5.76 The “lockdown” in response to the Coronavirus pandemic also led to the closure of support services (including homeless day centres), safe places (libraries etc) and a lack of distractions from drugs and alcohol. One person

interviewed said that they had wanted to attend Recovery College but that it was closed. Some people, afraid of Covid-19, stayed in their rooms.

5.77 Homeless people said that there was nothing to do and nowhere to go during the “lockdown”. Access to mental health services and counselling were also severely limited. Out of twelve returned questionnaires, seven homeless people identified difficulties accessing GPs and two identified difficulties accessing dentists. Problems included not being able to see doctors in person and doctors not visiting, difficulties in obtaining medication, and having to wait 6 months for an appointment.

5.78 Staff were self-isolating, in accordance with government guidance, reducing the number of staff available to meet increasing demand. This included providing food for clients who were also self-isolating. Face-to-face contact decreased yet demand for services, sometimes to replace those that had been closed or limited by other agencies’ responses to coronavirus, increased.

5.79 Practitioners also referred to the impact of the stigma of homelessness and drug and alcohol use, especially upon health service use. Homeless people had refused treatment because they did not like how they had been treated and had felt blamed for their health needs (such as the treatment of infected injection sites). In some cases, homeless people had refused to even attend. Some homeless people also mentioned that they had felt more identifiable as homeless when they were living together in the hotels. There were, however, no mentions of unfriendly encounters with the public like those included in the Museum of Homelessness Report.

5.80 The closure of, and restrictions, on services affected people who were keen to engage with services. Mr J and Mr H were described as ‘motivated to engage’. Mr J was keen to join the group activities offered through the Recovery Hub and Mr H had completed the recovery programme. Neither was not able to attend further sessions due to the lockdown.

5.81 These closures and restrictions may have also affected people who were harder to engage, but the evidence is more ambiguous. Mr G was described as unwilling to engage with services for substance misuse and alcohol dependence and Mr I was described by practitioners as “hard to engage”. Practitioners reported, however, that there were some benefits from the replacement of face-to-face meetings with telephone appointments, which were noted to have been useful for chaotic clients.

5.82 To an extent separate from this, there were concerns about Mr I’s physical health and delays in taking him to hospital. No safeguarding concerns were raised about him due to his apparent self-neglect, which does not appear to have been recognised at the time.

5.83 Drugs and alcohol supply

5.84 The only “services” still available were those offered by drug dealers who greatly appreciated having their customers gathered in one or two places rather than dispersed throughout the city.

5.85 All four people in this review were drug and/ or alcohol dependent for which they had received treatments and interventions but, as far as is known, were continuing to use until their deaths.

5.86 Homeless people said that the three most common drugs were Spice, which some believed had become stronger, heroin and crack cocaine. Of these, the malevolent effects of Spice and the desire to be free from it were referenced most frequently. Whilst from the perspective of homeless people and of practitioners, the availability and the range of drugs on offer appears to have increased during lockdown, it was difficult to obtain a clear picture from homeless people about the extent to which being served by different dealers affected the strength and purity of drugs. Practitioners, however, considered that this may have been a factor in the deaths of homeless people. Mr H, for example, appears to have been abstinent for some time prior to dying from a drug overdose and this may have been a consequence of a change in drug strength and a reduction in his resistance to it. It appears that some effects are continuing to have an impact in 2021. According to the homelessness lead nurse at Queen Alexandra Hospital, there were more admissions for drug overdose after “lockdown” than during it.

5.87 Some changes, however, were more positive. Practitioners also identified that there were some therapeutic advantages in that methadone monitoring by support staff had improved since methadone was delivered reliably rather than collected by the people who used it.

6. Summary.

6.1 Mr G, Mr H, Mr I and Mr J shared several similarities in their backgrounds. Mr G and Mr J were known to have experienced childhood trauma, which in Mr G’s case included sexual and physical abuse. Mr I and Mr H’s backgrounds are less well understood but the research and practice evidence would suggest that they are also likely to have survived traumatic experiences.

6.2 These adverse childhood experiences appear to have impacted on Mr G and Mr J in a way that is predicted by the research evidence since they and Mr H and Mr I’s adult lives which involved violence, loss, physical assaults, homelessness, unstable and temporary housing, mental health problems, self-harm and suicide attempts, drug and alcohol use and a lack of safety in their homes.

6.3 Mr G, Mr H, Mr I and Mr J struggled to engage with services and services struggled to find ways to engage with them.

6.4 Mr G, Mr H, Mr I and Mr J appear to have been assumed to have the mental capacity to make decisions about their welfare and safety, but given what is known of their backgrounds, life experience and use of alcohol and drugs, this may not always have been the case.

6.5 The specific circumstances of Mr G, Mr H, Mr I and Mr J’s contact with services during the last months of their lives were affected in various ways by the COVID-19 pandemic and the introduction of the lockdown in response to it. Services closed or access to them was restricted, homeless people were

brought into accommodation as part of “Everyone In” but this sudden change overwhelmed the ability of services for homeless people to manage their needs.

6.6 Whilst extraordinary efforts were made to house people safely, the bringing together of homeless people in large groups as part of “Everyone In” also appears to have placed people with significant levels of different needs together. This increased both the risk of harm and demands on services at a time when they faced capacity problems due to the pandemic.

7. Learning and development opportunities

7.1 The following learning and development opportunities were identified during the review. These include areas for development by single agencies.

7.2 There are several areas for development in the provision of health services for homeless people. For example, Queen Alexandra Hospital does not routinely record whether patients are homeless, which can lead to difficulties in identification and in prioritising interventions for them. This is also significant since, whilst the South-Central Ambulance Service works across 16 Safeguarding Adults Board areas, the Portsmouth area has the most ambulance call outs for homeless people (**Recommendation 8.2**)

7.3 There is also a need to strengthen community mental health support for homeless people. For example, the community mental health team that works with homeless people and visits street homeless people, lost its GP member from April 2021 onwards. Developments are already underway, however and a new peer crisis team is being piloted to facilitate timely crisis support. A new complex needs team is also now in place, which could have supported clients like the four homeless people in this thematic review.

7.4 Supported accommodation for homeless people is not commissioned to provide high levels of support, so there is a need for a cohesive approach between housing, homeless services, social services and health services to meet the wide range of needs presented by homeless people (**Recommendation 8.3**).

7.5 Support services for homeless people were described by practitioners as hard to navigate. Some homeless people become used to not getting what they want and therefore do not contact services, are easily put off or have low expectations of the help that can be provided (**Recommendation 8.4**).

7.6 This is compounded by the low status of services for homeless people and there are misapprehensions and misunderstandings about roles, responsibilities, and powers between voluntary and statutory organisations. It can also be difficult to identify what services are available. Services for homeless people are fragmented with multiple providers. Practitioners identified a need for a directory of services and the need to increase the familiarity of staff with the services available. This perception is being responded to by the enabling SSJ workers, for example, to be trusted assessors who can make assessments under the Care Act (**Recommendation 8.4 and 8.5**).

7.7 The impact of long-term alcohol and drug use on mental capacity, either because of the coercive and controlling influence of addiction, or through cognitive impairment needs to be recognised in assessments of mental capacity. Services such as CABIS (Sunderland and Gateshead Community Acquired Brain Injury Service) operate a flexible model of engagement for people who find it hard to comply with the demands of other therapeutic services and may provide ideas that could be developed in Portsmouth. Similarly, the Plymouth Creative Solutions Group provides a model for senior managers to lead on coordinating and managing interventions with people who are hard to engage (**Recommendations 8.6**)

7.8 Links with the criminal justice system could also be improved. Prisons have a statutory obligation to refer homeless people to housing services before their release but providers such as the Society of St James do not always have good information about clients when they leave prison to enable them to manage risks. Some people are released from prison with little notice. Some prisons have employed housing specialists but there is a need for improved coordination with the Probation Service, for example (**Recommendation 8.7 and 8.8**)

7.9 Housing for people who are abstaining from using drugs and alcohol is only available through the criminal justice system, as part of a condition of release from prison. Due to the need to reduce evictions for relapsing into drug and alcohol use, support providers do not otherwise require abstinence. As shown by Mr H's case, this risks exposing people who have completed recovery programmes and want to remain drug and alcohol free to other people who are still using them (**Recommendation 8.10 and 8.11**)

7.10 The Centre for Homelessness Impact "What Works Evidence Notes 01 Drugs and Alcohol" (2021), highlights a range of service models including MAPS (Managed Alcohol Programmes) to stabilise drinking patterns and reduce the use of liquids containing alcohol which are not meant for consumption and Supervised Consumption Facilities to reduce the risk of, monitor and control the use of alcohol and other drugs. Housing led interventions such as therapeutic communities and approaches such as Intentional Peer Support and Intensive Care Management offer alternative ways of meeting the needs of people who use drugs and alcohol may provide options for further research and development in Portsmouth (**Recommendation 8.10 and 8.11)**

7.11 The four homeless people interviewed and the seven who completed the questionnaire but did not agree to be interviewed, also identified the need for more support from GPs for example, to be listened to and respected, easier access to housing and other services and more personal care and face to face support (**Recommendation 8.12**)

7.12 Homeless people are often estranged from their families, but as in the case of both Mr I and J, family members had tried to support them. A "Think Family" approach might help to support engagement, risk assessment and family support. This approach builds the resilience and capabilities of families to support themselves (Wong et al, 2016) and recognises that individuals rarely if ever exist in isolation and that whole-family approaches are often necessary to

meet individual and family wide needs. The core principles of the "Think Family" approach are that practitioners (**Recommendation 8.12 and 8.13**):

- Consider and respond to the needs of the whole family; including the poverty, drug and alcohol use, domestic abuse and mental health difficulties of everyone in the home (including frequent visitors) in all assessments and interventions

- Work jointly with family members as well as with different agencies to meet needs

- Share information appropriately according to the level of risk

- Escalate concerns if they are not otherwise being responded to.

7.13 Family members could also be offered Carer's Assessments under the Care Act. These could assist family members to have their own needs for support met to better enable them to support their homeless relatives (**Recommendation 8.12 and 8.13**)

8. Recommendations

8.1 Building on the learning points set in section 7, the following recommendations are made:

8.2 Health services should routinely record the homelessness to assist in identifying and prioritising interventions to improve the health of homeless people (**L&D 7.2**)

8.3 Commissioners of services for homeless people should review the levels of support available in accommodation-based services and ensure that these services can meet the wide needs of homeless people (**L&D 7.4**)

8.4 Commissioners (local authority, NHS and public health), and homelessness service providers (both statutory and commissioned) in Portsmouth should identify joint working opportunities to adapt their services to make them easier for homeless people to engage with, based on the principles identified by Alcohol Change UK. (https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf**)** and in the Blue Light Manual (https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project) These include creating a directory of services, training specialist and non-alcohol specialist staff in the Blue Light approach (Take every opportunity; Not everyone will change; Change is not the only option; use a whole system and holistic approach; record unmet need and learning lessons); developing a multi-agency operational group to ensure a joint identification and ownership of the highest impact clients, developing assertive outreach approaches by designing and evaluating services, improving the response of local alcohol services through staff training and pathway development (**L&D 7.5 and 7.6**)

8.5 The Portsmouth Safeguarding Adults Board should continue to monitor the number of deaths of homeless people in Portsmouth. The Board should bring the need for longer term funding for rough sleeping and homelessness services and the need for long term rather than short term service provision to the safeguarding adults board chairs' network to raise the profile of homelessness services with central government and the need to recruit, retain and professionally develop skilled staff. (**L&D 7.6)**

8.6 The PSAB should seek assurance that workforce development plans address the need for staff to understand the Mental Capacity Act, and the assessment of mental capacity particularly for adults who are dependent on drugs or alcohol. (**L&D 7.7)**

8.7 Homelessness service providers (both statutory and commissioned) in Portsmouth, the Probation Service and Hampshire Police should agree a process for sharing information about risk and accommodation needs before release from prison. This should form part of prison release planning and should also include sharing information on potential domestic abuse risk. (**L&D 7.8**)

8.8 The PSAB should raise the need to agree a process for sharing information about risk and accommodation needs before release from prison with the Prison Service at national level (**L&D 7.8**)

8.9 PSAB should seek assurance across all services that the Duty to Refer under the Homelessness Reduction Act 2017 (https://www.gov.uk/government/publications/homelessness-duty-to-refer/a-guide-to-the-duty-to-refer) is understood and that workforce development plans (including legal literacy, think family, trauma informed approaches) are in place to equip staff to identify, support and refer on homeless people. (**L&D 7.8)**

8.10 The PSAB should lead the development of a multi-agency forum to explore what can be done to improve access to, and expand, service options (wet/ dry accommodation etc) and how to use resources most effectively. (**L&D 7.9 and 7.10**)

8.11 Homelessness service providers in Portsmouth which support homeless people who are substance dependent but want to recover and commissioners should review the opportunities for supporting people who have successfully completed recovery programmes to remain abstinent and to have move on plans in place before treatment begins so that there is a seamless follow on between recovery and abstinence. **(L&D 7.9 and 7.10)**

8.12 The PSAB should seek assurance that services have put plans in place to identify and reduce barriers to accessing services for people experiencing multiple disadvantage (**L&D 7.11)**

8.13 Services that work with homeless people should implement "Think Family" approaches to maximise the support options available for homeless people and to offer Carer's Assessments to family members to assess their support needs to better enable them to support their homeless relatives (**L&D 7.12 and 7.13**)

References

Alcohol Change UK report, “Safeguarding Vulnerable Dependent Drinkers England and Wales (https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf)

Bellis, M. A., Lowey, H., Leckenby, N., Hughes, K. and Harrison, D. (2013) Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. *Journal of Public Health*, 36 (1), 81–91

CABIS (Sunderland and Gateshead Community Acquired Brain Injury Service) https://www.cntw.nhs.uk/services/sunderland-gateshead-community-acquired-brain-injury-service-cabis-sunderland/

Centre for Homelessness Impact “What Works Evidence Notes 01 Drugs and Alcohol” (2021) at https://www.homelessnessimpact.org

Gibbons, S., Lauder, W. and Ludwick, R. (2006) Self-Neglect: A Proposed New NANDA Diagnosis. *International Journal of Nursing Terminologies and Classifications*, 17(1), 10-18

Greenfield, E.A. (2010) Child abuse as a life-course social determinant of adult health. *Maturitas*, 66(1), 51 – 5.

Felitti, V.J., Anda, R.F., Nordenberg, D. et al. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine*, 14(4), 245 – 258.

Lewis, S. J., Koenen, K. C., Ambler, A., Arseneault, L., Caspi, A., Fisher, H. L., Moffitt, T.E. and Danese, A (2021) Unravelling the contribution of complex trauma to psychopathology and cognitive deficits: a cohort study. *British Journal of Psychiatry*. 219, 448–455

Local Government Association Analysis of Safeguarding Adult Reviews April 2017 – March 2019 (https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019)

Maniglio, R. (2019) The impact of child sexual abuse on health: a systematic review of reviews. *Clinical Psychology Review*, 29(7), 647 – 57.

Museum of Homelessness report on the Impact of COVID-19 (Coronavirus) on homelessness published in April 2021 (https://museumofhomelessness.org)

Neale et al (2021), the “Everyone In” project (https://kclpure.kcl.ac.uk/portal/en/publications/experiences-of-being-housed-in-a-london-hotel-as-part-of-the-everyone-in-initiative-part-1-life-in-the-hotel(7621e3de-ff93-4076-9d99-54a5f7414fb5).html)

ONS (Office for National Statistics) (2021) (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/previousReleases)

Padgett, D. K., (2020) Homelessness, housing instability and mental health: making the connections. *British Journal of Psychiatry Bulletin,* 44(5), 197 - 201

Preston-Shoot, M. (2017) On self-neglect and safeguarding adult reviews: diminishing returns or adding value? *Journal of Adult Protection* 19(2) 53-66

Preston-Shoot, M. (2020), Safeguarding adult reviews: informing and enriching policy and practice on self-neglect, *Journal of Adult Protection* 22(4), 199-215.

United Nations (UN) Committee on Economic, Social and Cultural Rights, (https://www.ohchr.org/en/housing)

World Health Organisation. Adverse childhood experiences inter- national questionnaire (ACE-IQ). http://www.who.int/violence_ injury_prevention/violence/activities/adverse_childhood_ experiences/en/index.html (19 December 2012, date last accessed).

Ward, E., Ray. M. and Tanner, D. (2020) Understanding the Social Care Crisis in England Through Older People's Lived Experiences in Urban, P. and Ward, E. *Care Ethics, Democratic Citizenship and the State*. Heidelberg: Springer

Wong, O. L., Wan, E. S. F. and Ng, M. L. T. (2016) Family-centred care in adults' mental health: Challenges in clinical social work practice. *Social Work in Mental Health*. 14(5), 445-464

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Portsmouth CITY COUNCIL

THIS ITEM IS FOR INFORMATION ONLY
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Title of meeting:	Health and Wellbeing Board
Subject:	Tackling poverty in Portsmouth
Date of meeting:	21st September 2022
Report by:	Helen Atkinson, Director of Public Health
Report Author:	Mark Sage, Tackling Poverty Coordinator
Wards affected:	All

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1. Requested by Director of Public Health

2. Purpose

2.1. To provide an update to the Board on the tackling poverty priority area of the strategy.

2.2. To outline areas where Board member organisations can contribute to this priority, as key local anchor institutions.

3. Information Requested

3.1. The Health and Wellbeing Strategy outlines why tackling poverty underpins health improvement outcomes, building on the work of the Marmot Review[1] to identify the wider determinants of health.

3.2. Social inequality is considered the fundamental underlying cause of poor health outcomes and therefore tackling poverty is central to addressing health inequalities.

[1] https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

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3.3. The Strategy includes a shared commitment across the services represented by the Board to take action to help local residents to escape poverty, and to reduce the impact of poverty for those affected.

3.4. This report provides an update on the work of Portsmouth's tackling poverty steering group, a multi-agency partnership that informs and oversees action to tackle poverty.

3.5. This report also highlights the significant role for Board member organisations working collectively to take action to tackle poverty.

4. Poverty in Portsmouth

4.1. On the English Indices of Deprivation 2019[2], Portsmouth is ranked 59th most deprived of the 326 local authority districts across the aggregated domains of deprivation. This puts Portsmouth into the fifth most deprived areas in the country.

4.2. 13.4% of the local population is income deprived under this index, and Portsmouth also shows a high level of internal disparity, the difference in the proportion of people who are income deprived between the least and most deprived small areas in the city.

4.3. Portsmouth is in the highest 5% of local authority districts for clustering of deprivation, indicating a high level of inequality between neighbourhoods and clear pockets of deprivation.

4.4. Between 2015 and 2021, the proportion of children living in relative low income families (below 60% of median household income) steadily increased from 15.7% to 21.4%[3]. There continues to be wide variation between wards, from 10.3% of children living in Drayton and Farlington, to 33.7% in Charles Dickens ward.

4.5. Of children in Portsmouth aged under 16 living in relative low income families in 2021, 77.6% were living in families in work, and 22.4% were in out of work families[4].

4.6. Data from the Department of Work and Pensions shows that almost half of the families with children claiming Universal Credit in Portsmouth were earning less than £935 per month (net earnings), the threshold for free prescriptions[5].

4.7. Although Portsmouth has longstanding inequalities, these have been exacerbated by recent economic and social shocks, firstly the impact of the COVID-19 pandemic, and now the cost of living crisis.

5. Cost of living

[2] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019
[3] Source: Stat-Xplore
[4] Source: Stat-Xplore
[5] Source: DWP monthly data share with Portsmouth City Council to support Local Welfare Provision May 2022

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5.1. The cost of living crisis is driven by a rapid rise in inflation far outstripping any increase in incomes (primarily earnings, pensions and welfare benefit entitlements).

5.2. Key drivers of inflation have been increases in the costs of energy, food and household essentials, housing costs and transport[6], particularly for lower income households who spend a higher proportion of their income on essential expenditure.

5.3. The household energy price cap rose from £1,042 per year for the average household in April 2020 to £1,971 in April 2022[7], and was due to rise to over £3,500 from October.

5.4. A government announcement on 8 September indicates that action will be taken to limit the cap to £2,500 for two years, but this remains almost double the cost that households were paying last winter, continuing historically high prices for household energy. The NICE guidance on Excess winter deaths and illness and health risks associated with cold homes[8] highlights the impacts on health (and on other issues including workplace and school absence) of fuel poverty in a 'normal' winter. Work is being undertaken by Health and Care Portsmouth to ensure a joined up approach within the health and care system that is linked to the broader tackling poverty and cost of living agenda. Portsmouth's Energy and Water at Home Strategy 2020-2025[9] outlines the council's approach to tackling fuel poverty, with services delivered to residents in partnership under the Switched On Portsmouth brand.

5.5. The annual CPI inflation rate for all foods and non-alcoholic beverages was 0.3% in August 2021, but has since increased every month to 12.6% in July 2022[10]. However, price inflation was not even across food categories, ranging from 7.0% for sugar, jam and confectionery, to 19.4% for milk, cheese and eggs, and 23.4% for oils and fats[11]. This variation is likely to impact on purchasing decisions and nutritional intake for low income households.

6. Action to tackle poverty

6.1. The Health and Wellbeing Strategy highlights the need for good quality employment for Portsmouth residents that can enable everyone to fulfil their employment potential and increase their earning power. A development session for Board members is planned for 12th October to explore how the organisations represented on the HWB are already doing this and what further opportunities there are to do more. This could include partnership with Portsmouth City

[6] https://www.ons.gov.uk/economy/inflationandpriceindices/articles/priceseconomicanalysisquarterly/march2022
[7] https://www.ofgem.gov.uk/energy-policy-and-regulation/policy-and-regulatory-programmes/default-tariff-cap
[8] https://www.nice.org.uk/guidance/ng6
[9] https://switchedonportsmouth.co.uk/wp-content/uploads/2020/10/10.477-Energy-and-water-at-home-strategy-accessible.pdf
[10] https://foodfoundation.org.uk/news/food-prices-tracking-july-update
[11] https://foodfoundation.org.uk/news/food-prices-tracking-august-update

Council's unemployment programmes which currently support over 1,200 adults in and around Portsmouth.

6.2. The Strategy also outlines three areas for key activity in the short term: providing immediate support to people in financial hardship; helping people access the right employability support at the right time; and supporting a community-level response to local needs.

6.3. These three areas form the basis of the tackling poverty action plan overseen by the tackling poverty steering group (TPSG) (appendix 1).

6.4. The action plan cannot capture all of the work taking place in the city that can help to tackle poverty. Instead, the purpose is to focus on key areas of activity where TPSG members can add value through working in partnership, to understand needs and where there are gaps, and to understand the impact of action to tackle poverty.

6.5. By sharing information, the TPSG can identify trends in need; at the September meeting one organisation noted an increase in approaches from families worried about children's mental health and bullying. The TPSG provides a forum to understand whether trends are more widespread, consider how the system currently responds to those needs, and how organisations can respond in partnership, recognising the impact these issues will have on other priorities and outcomes.

6.6. The Director of Public Health's Annual Report for 2022/23, which will be presented at the Health and Wellbeing Board in September 2023, will focus on poverty and the cost of living crisis. It will provide a broad needs assessment to underpin further work on this issue, drawing together evidence about the impact on Portsmouth residents, the support that is in place, and the opportunities and evidence for further action.

6.7. Portsmouth City Council is urgently developing its response to look at how it can support residents affected by the cost of living crisis, building on existing services and communication channels. This response recognises that more people will be impacted by this crisis, with people who are already experiencing poverty being greatly impacted.

7. The role of the Health and Wellbeing Board in tackling poverty

7.1. Board member organisations are anchor institutions in the city; large organisations rooted in the local area with significant assets that can contribute to health and wellbeing outcomes[12].

7.2. Collectively, Board member organisations have significant impact in the local economy, and can help to tackle in-work poverty so that every employee:

7.2.1. Receives a real living wage;

7.2.2. Has the security of sufficient working hours to meet their needs;

[12] https://www.kingsfund.org.uk/publications/anchor-institutions-and-peoples-health

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7.2.3. Can work flexibly, to ensure those with additional needs or caring responsibilities can maintain employment;

7.2.4. Can progress into and through work, with training and support, to fulfil their potential and increase their earning power.

7.3. Board member organisations should consider what action they are already taking in these areas, and how they can work in partnership with other organisations and communities to increase their positive contribution to tackling poverty.

7.4. Alongside their role as employers, Board member organisations have potential through their procurement and contract management processes to create added social value through employment, training and skills, and support for communities.

7.5. Board members provide a wide range of services to residents, and through this activity have the opportunity to identify those at risk of poverty and how they are affected, and intervene to provide support and mitigate those risks.

8. The challenge

8.1. Portsmouth has longstanding economic and health inequalities, and the current economic outlook is expected to increase the breadth and depth of poverty in the city.

8.2. Board member organisations are asked to consider what action they are taking currently, and how they can respond accordingly to the scale of the cost of living crisis and the likely impact on residents. From the action plan at appendix 1, Board members may wish to consider how these activities could be further promoted within their organisations:

- Building on the October development session to ensure that training, development and employment opportunities maximise the organisation's contribution to tackling poverty in Portsmouth.
- Ensuring relevant front-line staff have access to the 'Cost of Living Checklist' and suitable training and support to assist service users who present with issues related to the current crisis.
- Using communications teams to promote income maximisation campaigns developed by Portsmouth City Council and partners.
- Supporting interventions to tackle fuel poverty including identification of residents at risk and promotion of the freephone Switched On Portsmouth helpline and online resources.
- Identifying opportunities to contribute to the development and delivery of the warm rooms / welcome places scheme.
- Promoting the 'With Thankful Hearts' campaign encouraging residents and organisations to support local food support services.

8.3. Working collectively, the Board can share best practice, gain maximum value from our efforts by working in partnership, and strengthen communities to respond to

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long-standing inequalities in the city and the urgent crisis arising from the current economic conditions.

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Signed by Helen Atkinson FFPH, Director of Public Health

Appendices:

Appendix 1 - Tackling poverty action plan

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
Health and wellbeing strategy 2022-2030	https://www.portsmouth.gov.uk/wp-content/uploads/2022/05/health-and-wellbeing-strategy-january-2022-accessible.pdf
Energy and water at home strategy 2020-2025	https://switchedonportsmouth.co.uk/wp-content/uploads/2020/10/10.477-Energy-and-water-at-home-strategy-accessible.pdf

7Appendix 1 - Tackling poverty action plan

Priority	Purpose	Task	Action	Outcome measures	Progress update
Providing immediate support to people in financial hardship	Cost of living crisis action plan	Income maximisation campaign	Portsmouth City Council (PCC) and partner communications campaigns	Social media analytics. Customer feedback	
			Benefits uptake campaigns	Applications submitted. Additional income achieved	Delivery of Live Well events. Money advice outreach opportunities
		Information for frontline teams and service users	Cost of living checklist development and distribution	User feedback, customer outcomes	Checklist distributed to some frontline agencies, included in PCC intranet resources for staff
			Inform and upskill frontline staff - how to support and/or have conversations about the cost of living	Training developed, delivered, user feedback	HIVE working with Food Support Network to upskill volunteers
	Increase access to money advice	Additional money advice provision in the community	Provide money advice in community settings	Number of clients assisted, financial and non-financial outcomes, understand barriers to access and how to increase uptake	12-month grant funding agreed with Advice Portsmouth and Citizens Advice Portsmouth. Citizens Advice Portsmouth outreach support at Portsmouth Foodbank

Priority	Purpose	Task	Action	Outcome measures	Progress update
Providing immediate support to people in financial hardship (continued)	Providing essential items	Develop local welfare provision	Delivery of Household Support Fund (HSF)	Number of people supported, amount of support, feedback from recipients and stakeholders, case studies	HSF delivery Apr-Sep 22: Grant funding for food support services. Free school meals and early years vouchers. Pensioner Energy Costs Payments. Discretionary grants for vulnerable households. Exceptional support with housing costs
	Action on energy bills	Support and interventions to tackle fuel poverty	Redress bid submitted. Maintain and extend the Switched On Portsmouth (SOP) offer for people in fuel poverty. Re-launch SOP partnership and sub-groups, under the Energy and Water at Home Strategy 2020-2025	Uptake of support and home improvement measures. Impact of SOP offer	Freephone helpline extended. Home energy advice visits re-started. Warmer Homes offer
Helping people access the right employability support at the right time	Accessible info on employability support	Ensure all residents and frontline staff have access to suitable resources when needed	Promote use of HIVE Directory for voluntary sector provision. Mapping employment support provision to promote access and identify gaps. Promote the existing programmes (including those delivered by PCC) through all communication and partnership channels	Uptake of support. Employment and training outcomes	

Priority	Purpose	Task	Action	Outcome measures	Progress update
Helping people access the right employability support at the right time (continued)	Reduce the risk of benefit sanctions	Increase awareness of highest causes of sanctions and how to prevent	Inform and upskill frontline staff working with residents who may be at risk of sanction. Promote engagement with DWP funded employment support programmes	Monthly sanction rates for Portsmouth	Universal Credit partnership looking at reasons for sanctions and opportunities for prevention
	Access to adult learning including digital skills and language skills	Promote and extend offer to adults at risk of poverty seeking to extend their skills	HIVE Reducing Digital Exclusion project. Promotion of digital support learning (including that delivered through PCC and skills partners)	Uptake of support. Skills outcomes	
Supporting a community-level response to local needs	Reduce daily living costs	Support the development of community larders / pantries	Use Household Support Fund and other resources to strengthen offer	Capacity and demand data. Uptake and feedback from service users	Grant funding from HSF provided to 5 larders/pantries Apr-Sep
		Access to essential clothing and household items	Increase and improve referrals to appropriate resources	Directory of provision. Uptake and feedback from service users	Developing pilot scheme to provide free carpet tiles to PCC tenants in need
	Strengthening community	Promoting free community provision, e.g. after school	HAF Fun Pompey	Uptake and feedback from service users	

Priority	Purpose	Task	Action	Outcome measures	Progress update
Supporting a community-level response to local needs (continued)		Warm rooms / welcome places scheme	Explore community centres, church etc - consider suitability of offer and safeguarding	Advertised network of warm places. Uptake of provision. Feedback from service users	HIVE leading on development of warm / welcome places project
		With Thankful Hearts - citywide harvest campaign	Encourage residents and organisations to 'adopt' a local food support service (foodbank, larder/pantry, or community meal)	Increase donations and volunteers	With Thankful Hearts campaign launched on 7 September

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Title of meeting:	Health and Wellbeing Board
Subject:	Public Health Annual Report 2021/22
Date of meeting:	21st September 2022
Report by:	Director of Public Health
Wards affected:	All

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1. Requested by Director of Public Health

2. Purpose

2.1 To note that the Director of Public Health is publishing her statutory Annual Report 2021/22, attached as Appendix A and available on the JSNA page of the PCC website. This year's report provides a Joint Strategic Needs Assessment (JSNA) Annual Summary for Portsmouth.

2.2 The Public Health Annual Report 2021/22 sets out the key demographic and health characteristics of Portsmouth. It also provides a baseline position to inform our recovery plans as we move out of acute phase of the pandemic and begin 'Living With Covid'. An Executive Summary highlighting key data about health needs in the city is being produced to provide an accessible overview for wider audiences. It will be available on the JSNA website.

The full report at Appendix A provides detailed data and analysis of the population of Portsmouth and their health needs. This in effect acts as a summary of the city's JSNA and can be used by a range of stakeholders to inform strategies and service delivery. The report is underpinned by further analysis of specific topics that are available on request from the Public Health Intelligence team or by emailing jsna@portsmouthcc.gov.uk**.**

3. Information Requested

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Signed by (Director)

Helen Atkinson, Director of Public Health

Appendices:

Portsmouth CITY COUNCIL

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Public Health Annual Report 2021/22 Full Report

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

Director of Public Health Annual Report:

Portsmouth Population Health Summary 2021/22

Table of Contents

1. Executive Summary

This Public Health Annual Report sets out the key demographic and health characteristics of Portsmouth in 2021/22. Portsmouth is unique as a city in which the majority of the population live on Portsea Island. The 2021 CMO annual report focusses on coastal communities. As well as acknowledging the ways in which residents in communities like Portsmouth gain from living close to the sea, the report describes the stark inequalities coastal communities often face. This report summarises how those challenges are experienced by residents in Portsmouth.

This report also provides a baseline position to inform our recovery plans as we move out of acute phase of the pandemic and begin 'Living With Covid'. We do not yet know the full impact of Covid-19 on our city, and much of our data about the characteristics and health of our population predates Covid-19. However what we do know, and what the last 2 years have highlighted further, is the extent to which the circumstances of people's lives shape the health outcomes they experience. The full report describes what we know about our population in more depth but some of the key points to highlight are as follows:

Population: Portsmouth is a young city with a comparatively high proportion of people aged 20-24. It is also an ageing population, with most of the growth projected over the next 20 years being among those aged 65+.

Life expectancy: Life expectancy in Portsmouth is shorter than England and there are significant inequalities within Portsmouth. A man born in Portsmouth's most deprived areas can, on average, expect to live 9 years fewer than one born in the least deprived parts of the city. Men and women in

the city can expect to live 62 years in good health, but this varies by 15 years for men and 14 years for women between more and less deprived areas. The likelihood of dying prematurely (before 75) in Buckland, City Centre and Somerstown is twice as high as in England. This is driven by causes such as cardiovascular disease, stroke, heart disease, cancer, liver and respiratory disease.

Deprivation: Portsmouth is ranked 59th of 326 local authorities for deprivation, where 1 is the most deprived. Even before the cost of living crisis, nearly 8,000 children were in relative low-income families (before housing costs), including more than 1 in 3 children in Charles Dickens Ward. And over 6,500 people aged over 60 are estimated to live in income-deprivation. While employment rates are similar to England, the proportion of economically active people claiming unemployment has increased due to the impact of Covid-19 and is significantly higher than in England or the South East. Particular communities such as Paulsgrove have been highlighted in recent reports as being extremely vulnerable to poor health outcomes.

Long term conditions: Many Portsmouth residents experience one or more long term health conditions that limit their daily activity, including hypertension, diabetes and COPD. Prevalence increases with age. In 2021, 13% of patients registered with Portsmouth GPs reported having a long-term mental health problem, which would equate to 23,000 residents aged 16+.

Risk factors and behaviours: Lifestyle factors and behaviours, including smoking, being overweight or obese, poor diet and lack of physical activity, are also closely linked to having a high co-morbidity of three or more health conditions. Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. 14% of Portsmouth adults are estimated to be current smokers but this is significantly higher in council/social housing (41%), in routine and manual occupations (27%), and in those with a longer term mental health condition (37%), for example.

Wider Determinants: People who have good quality and secure jobs and housing in the 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. This report does not seek to describe all of these factors as the apply to Portsmouth, much of which is addressed in the city's Health and Wellbeing Strategy. However the context of health determinants is important in considering many of the issues elsewhere in this report, and examples of particular challenges Portsmouth faces are included.

Covid impact: Almost everyone in Portsmouth will know someone who recorded a positive Covid test at some point during the pandemic, or did so themselves, while everyone has been impacted in different ways by the policies introduced in response. Significant numbers of people suffered severe health outcomes resulting in hospitalisations and, sadly, hundreds of deaths. We know that older and more vulnerable populations were particularly affected, while those from ethnic minority backgrounds were disproportionately at risk. Younger people were most adversely affected by some of the policy responses to Covid-19, while again it was those in more deprived areas who experienced the greatest negative impact on outcomes.

2. Introduction

This Public Health Annual Report sets out the key demographic and health characteristics of Portsmouth in 2021/22. Portsmouth is unique as a city in which the majority of the population live on Portsea Island. The 2021 CMO annual report focusses on coastal communities. As well as acknowledging the ways in which residents in communities like Portsmouth gain from living close to the sea, the report describes the stark inequalities coastal communities often face. This report summarises how those challenges are experienced by residents in Portsmouth. The city's response is encapsulated in the Health and Wellbeing Strategy 2022-2030. Approved by the multi-agency Health and Wellbeing Board in February 2022 following extensive stakeholder and community engagement and consultation, the strategy sets out how partners will work together to address the 'causes of causes'. These are the long-term factors that underpin many of the health and wellbeing challenges faced by people in our city.

This report also provides a baseline position to inform our recovery plans as we move out of acute phase of the pandemic and begin 'Living With Covid'. We do not yet know the full impact of Covid-19 on our city, and much of our data about the characteristics and health of our population predates Covid-19. However what we do know, and what the last two years have highlighted further, is the extent to which the circumstances of people's lives shape the health outcomes they experience.

The report is broken down into seven sections:

- Population and population characteristics
- Life expectancy and mortality
- Deprivation, social economics and vulnerable communities
- Long-term conditions
- Risk factors and behaviours
- Wider determinants
- Covid-19 impacts and ongoing response,

3. Population and population characteristics

3.1 Population

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 (5,315 people per square kilometre in Portsmouth).[1]

In 2020, approximately 214,700 people are estimated to be resident in Portsmouth. The annual population estimate has been broadly similar since 2017. These estimates are largely based on births, deaths and estimated migration data and to a lesser extent changes in special populations (home armed forces, foreign armed forces and the prison population). There remain more births than deaths each year in Portsmouth, and a positive net international migration (more inflow than outflow), but this is offset by a negative internal migration (more UK outflow than UK inflow).[2] Although the population increase is estimated to have slowed since 2017 the population is projected to increase (albeit projections based on 2018 estimates) by roughly 5,000 (2.3%) between 2021 and 2030 - from

[1] Mid-2020 population estimates. Local Authorities in England, Office for National Statistics (ONS)
[2] Mid-2020 population estimates. Local Authorities in England, Office for National Statistics (ONS)

217,330 to 222,300. The projected increase between this period is largely an anticipated increase in the number of 15-24 year olds and an increase in residents aged 65 years and over. [3]

As at 1st April 2021, nearly 230,100 people were registered with Portsmouth City GP Practices[4] - although the vast majority are resident to Portsmouth (roughly 95%), 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 (i.e. either in employment in Portsmouth, or not in employment but living in Portsmouth), which was higher than the 2011 population of 205,433. 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 has a comparatively high proportion of young people aged 20-24 years, compared to England, largely due to the city's University and colleges (11.3% of Portsmouth's total population compared with 6.1% nationally). (Figure 1)

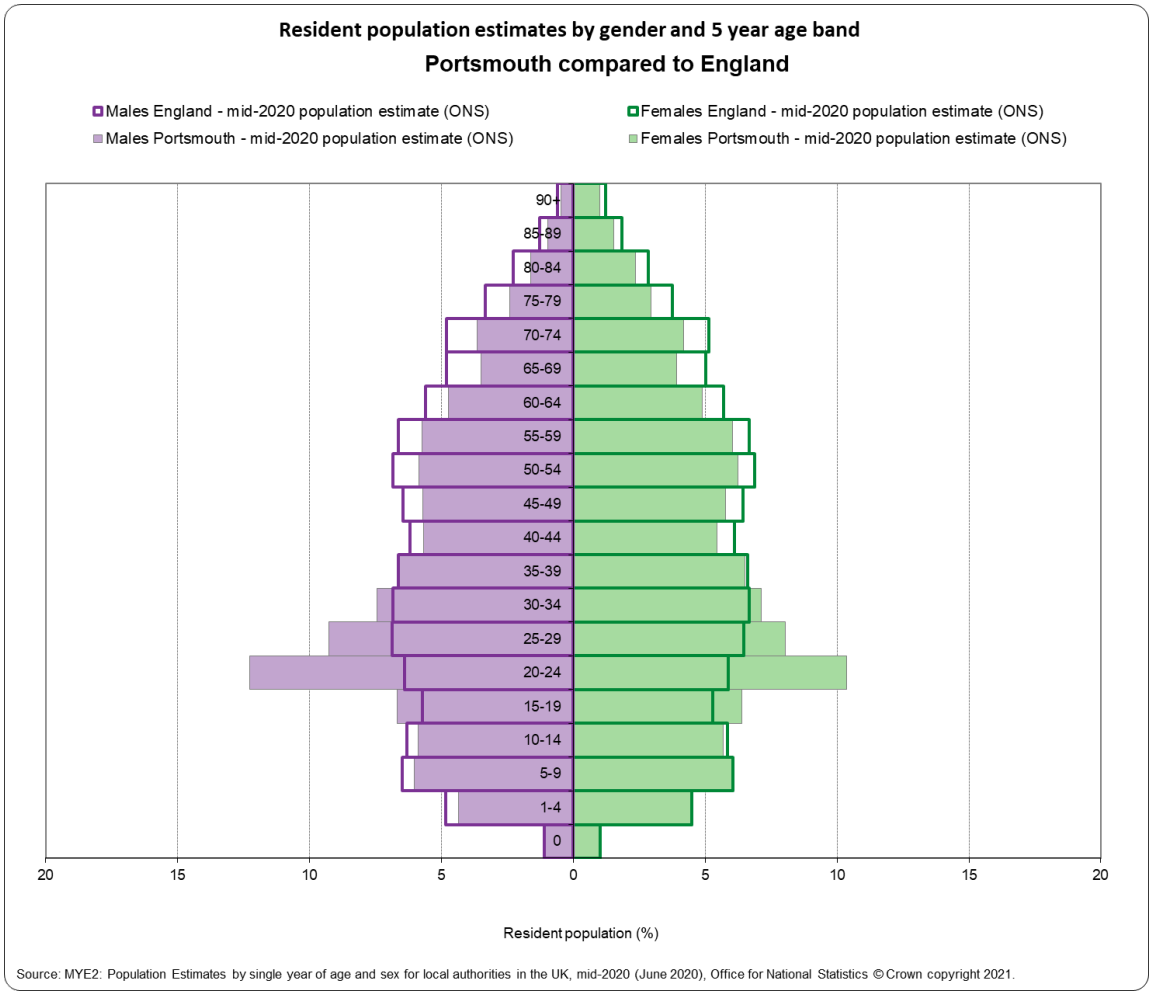

Figure 1. ONS mid-2020 resident population estimate by gender and 5 year age bands, Portsmouth City compared to England

[3] SNPP Z1: 2018-based Subnational Population Projections. Local Authorities in England, mid-2018 to mid-2043, Office for National Statistics (ONS) © Crown Copyright 2020 via Portsmouth Joint Strategic Needs Assessment (JSNA) webpage: www.jsna.portsmouth.gov.uk

[4] Number of Patients Registered with a GP Practice, NHS Digital https://digital.nhs.uk/ Accessed 22 June 2021

In 2020, approximately 140,800 people aged 18-64 years are estimated to be resident in Portsmouth; and approximately 30,600 residents aged 65 years and over (of which approximately 4,300 are aged 85 years and over). [5]

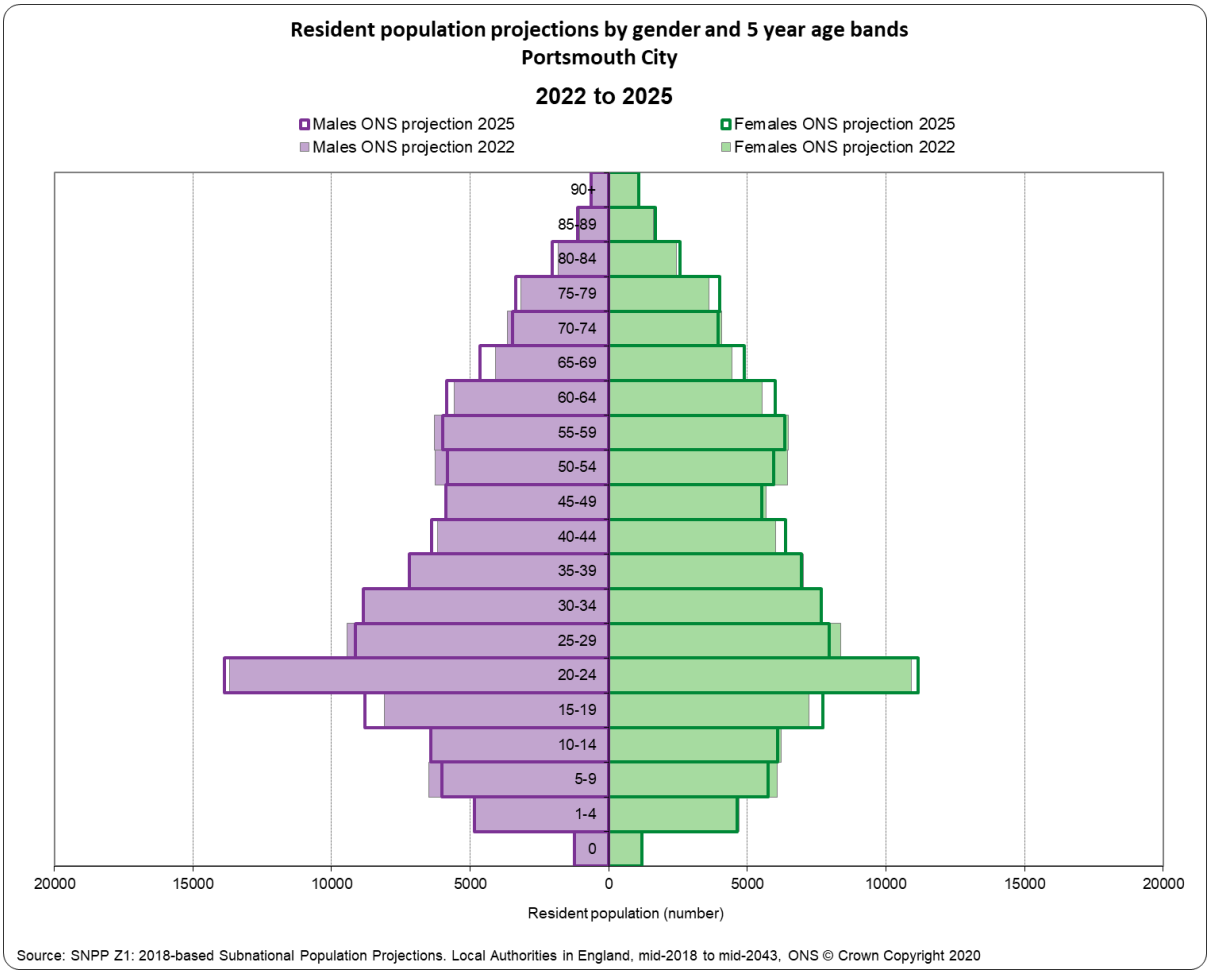

Figure 2. Resident population projections by gender and 5 year age bands, Portsmouth City, 2018-based 2022 projection compared to 2025 projection

3.1.1 Sub-national population projections

The total Portsmouth population is predicted to increase by nearly 1,500 from 2022 to 2025; and increase by roughly 9,300 between 2022 to 2043. Portsmouth is an ageing society: the largest increases are in those aged 65. Between 2022 and 2030 the population aged 65+ years is estimated to increase by 18% (5,550 people); between 2022 and 2025 the population aged 65+ years is estimated to increase by 6% (1,800 people).

3.1.1.1 Children and young persons

Between 2021 and 2043, the population aged 0-4 years is projected to remain relatively stable albeit an increase of 9% (roughly 1,000 infants).

[5] Mid-2020 population estimates. Local Authorities in England, Office for National Statistics (ONS)

The 5-11 years age group is projected to decrease by 12% by 2030 (roughly 2,100 fewer children compared to 2021) before increasing again by 2043 (an additional 600 children compared to 2030).

The 12-17 years age group is projected to remain relatively stable albeit a decrease of 8% by 2043 (roughly 1,100 children).

The 18-24 years age group is projected to increase by 16% by 2030 (roughly 5,100 more young persons compared to 2021) before decreasing again by 2043 (roughly 3,100 fewer compared to 2030). [6]

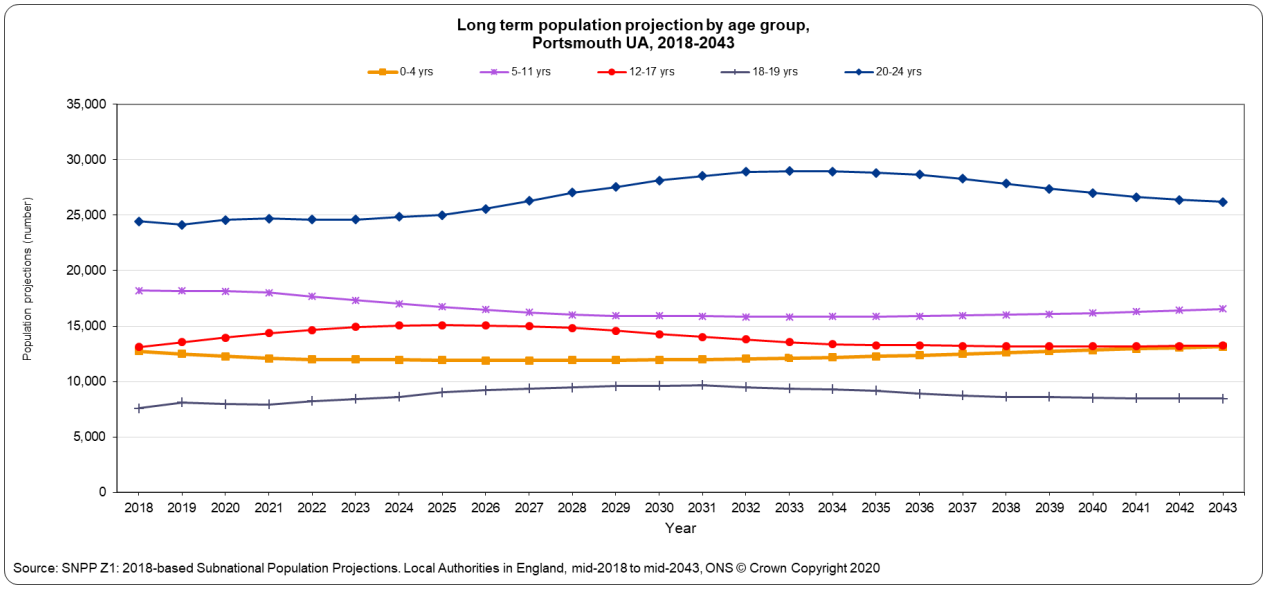

Figure 3. Long term population projections for children and young people, Portsmouth City, 2018-2043 projection

3.1.1.2 Working age population

Between 2021 and 2030, the Portsmouth working age adult population aged 18–64 years (though for the purposes of dependency ratios this is usually 15-64 which will be covered later) is projected to increase by 1% (roughly 1,300 people); but this increase is largely due to the younger age group; whereas there is a projected decrease of 14% in the 50-59 year old age group. By 2043, the working age adult population is expected to decrease to a similar total number compared to 2021. [7]

3.1.1.3 Population aged 65 and over

Between 2021 and 2030, the population aged 65+ years is projected to increase by 19% (projected population of 37,200 in 2030) and those aged 80+ years by 28% (projected population of 11,000 in 2030). It is anticipated that this will increase further with a 35% increase by 2043 (compared to 2021) - that is 19% (roughly 42,100 people aged 65 years) of Portsmouth's population is expected to be aged

[6] SNPP Z1: 2018-based Subnational Population Projections. Local Authorities in England, mid-2018 to mid-2043, Office for National Statistics (ONS) via Portsmouth Joint Strategic Needs Assessment (JSNA) webpage: www.jsna.portsmouth.gov.uk

[7] SNPP Z1: 2018-based Subnational Population Projections. Local Authorities in England, mid-2018 to mid-2043, Office for National Statistics (ONS) via Portsmouth Joint Strategic Needs Assessment (JSNA) webpage: www.jsna.portsmouth.gov.uk

65 years and over by 2043 compared to 14% (roughly 32,000 people aged 65 years) of Portsmouth's population in 2020. [8]

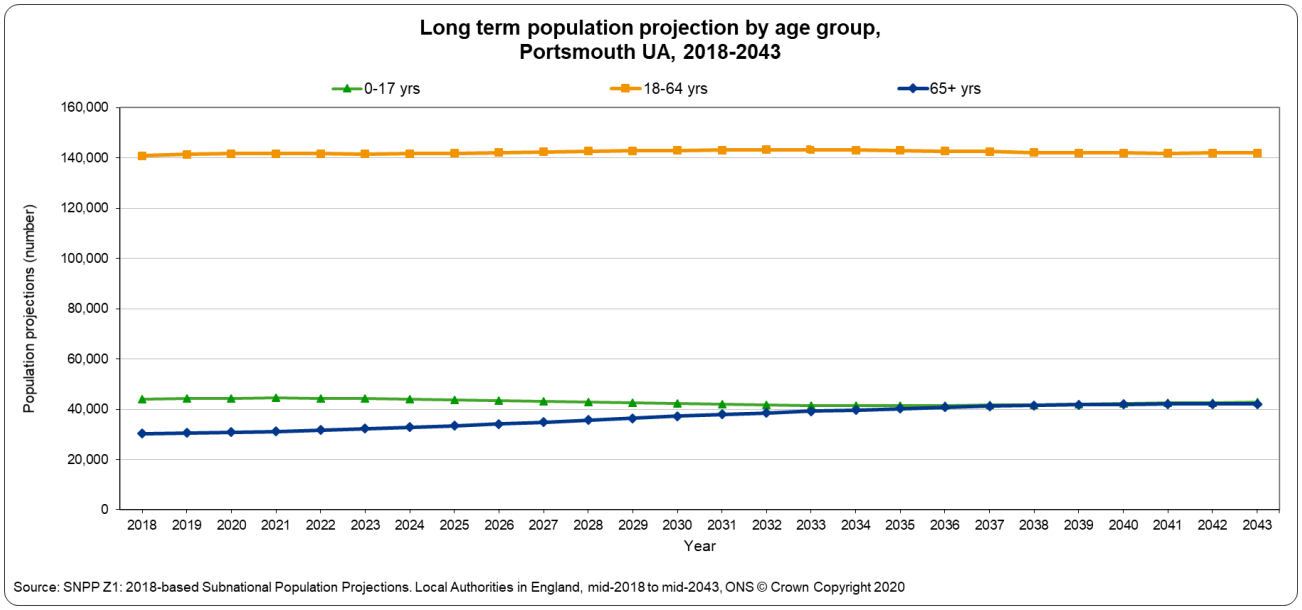

Figure 4. Long term population projections for children, working age adult population and aged 65+ years, Portsmouth City, 2018- 2043 projection

3.2 Population characteristics

3.2.1 Ethnicity

At the time of the 2011 Census, Portsmouth had a lower percentage of residents from Black and minority ethnic (BAME) 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 BAME groups (except Mixed) have a larger proportion of their group of working age than the White British group (Figure 5). Of the localities in Portsmouth, the South is the most ethnically diverse with 22% of the population belonging to BAME groups, compared to 16% of the Portsmouth population.[9]

Children and young people have a different ethnic profile with 25% of pupils of all ages being of non-White British ethnicity in January 2021. There was a change in methodology in 2018 to include all pupils at state-funded schools, rather than of compulsory school age prior to 2018, therefore 2018 onwards cannot be directly compared to earlier years. However, in 2017, 22% of compulsory school-age children were non-White British ethnicity compared to 15% in 2011.

[8] SNPP Z1: 2018-based Subnational Population Projections. Local Authorities in England, mid-2018 to mid-2043, Office for National Statistics (ONS) via Portsmouth Joint Strategic Needs Assessment (JSNA) webpage: www.jsna.portsmouth.gov.uk

[9] Portsmouth City Council and NHS Portsmouth CCG JSNA webpage. Ethnic group by broad age group (2011 Census) www.jsna.portsmouth.gov.uk

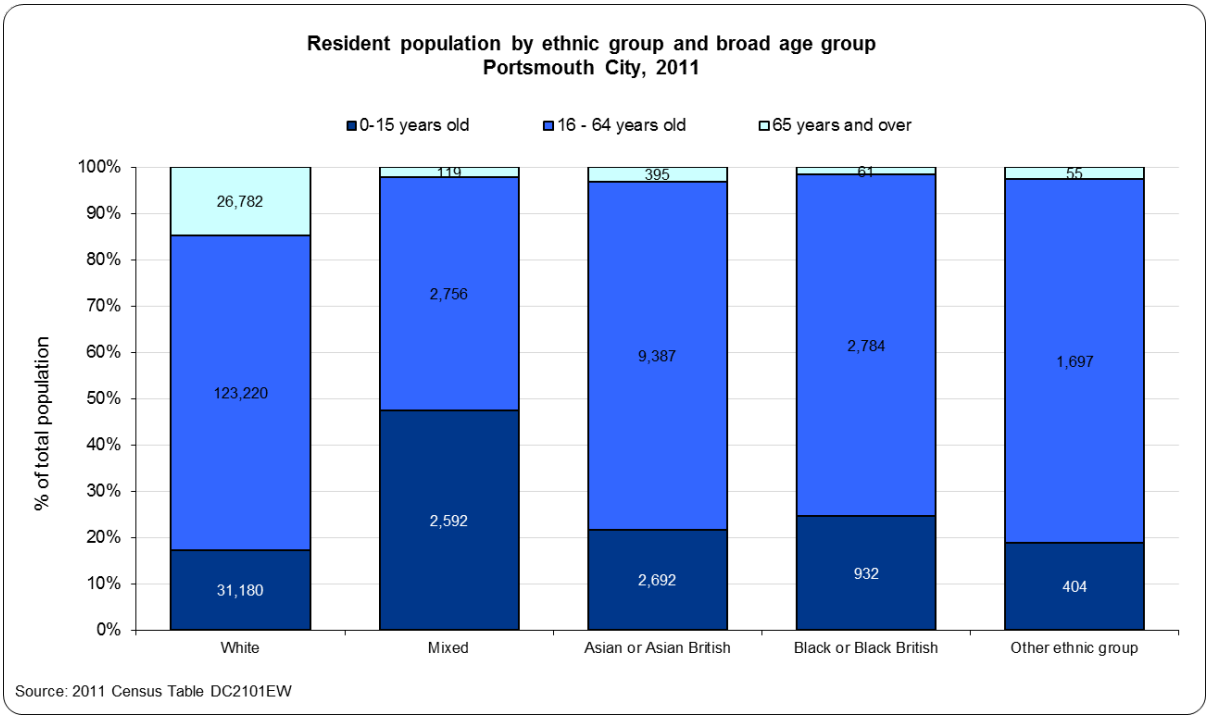

Figure 5. Proportion of population by ethnic group and broad age group, Portsmouth UA, 2011

3.2.2 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). [10] Also, the latest ethnicity data from the January 2021 school pupil census, identifies 30 pupils as 'White: Gypsy/Roma' resident to Portsmouth.[11]

Although not necessarily ethnic gypsies and travellers, as at July 2021, there were neither authorised nor unauthorised traveller caravans in Portsmouth.[12]

The 2018 Portsmouth City Council Gypsy, Traveller and Travelling Showpeople Accommodation Assessment (GTAA) sought to understand the accommodation needs of the Gypsy, Traveller and Travelling Showpeople population in the study area through a combination of desk-based research, stakeholder interviews and efforts to engage with members of the Travelling Community. However, the report found that despite all the efforts that were made during the course of the GTAA, no households were identified to interview living in bricks and mortar, despite a small number of households being identified in the 2011 Census. The 2018 assessment concluded that there is no current or future need for additional pitches or plots in Portsmouth over the GTAA period to 2036. [13]

3.2.3 Sexual orientation/identity

Prior to 2014, official statistics on lesbian, gay, transgender (LGBT) communities had not been routinely collected nationally (e.g. Censuses) or locally; and the survey findings have been mixed. In

[10] 2011 Census: QS211EW, Office for National Statistics.
[11] Department for Education Statistical First Release Schools, Pupils and their Characteristics: January 2021. © Crown Copyright via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.
[12] Tables 1 and 3: Count of Traveller Caravans, Department for Levelling up, Housing and Communities. https://www.gov.uk/government/statistics/traveller-caravan-count-july-2021 Accessed 11 March 2022
[13] Gypsy and Traveller Accommodation Assessment (GTAA), Final Report November 2018, Portsmouth City Council: https://www.portsmouth.gov.uk/wp-content/uploads/2020/05/development-and-planning-portsmouth-gypsy-and-traveller-needs.pdf Accessed 11 March 2022

2019, the Office for National Statistics (ONS) estimated that 2.7% of England's population aged 16 years and over identified themselves as lesbian, gay or bi-sexual (LGB) which is an increase compared to previous year estimates; 93.3% identified as Heterosexual or straight, which is a decrease compared to previous years[14]—however, the ONS LGB estimate could be a low estimate due to the telephone and face-to-face survey methodology used[15].

3.2.4 Students

In the academic year 2019/20, the University of Portsmouth had 26,755 registered students — 79% (21,000) came from the UK, 4% from EU and 17% from Non-EU. Of the 26,755 registered students, 22,150 were full-time (83% were full-time). Also, of the 26,755 registered students, 22,010 were undergraduate students (82%). In the academic year 2020/21, the University of Portsmouth had 28,280 registered students — 77% (21,905) came from the UK, 5% from EU and 18% from Non-EU. Of the 28,280 registered students, 24,065 were full-time (85% were full-time). Also, of the 28,280 registered students, 22,170 were undergraduate students (79%).[16] This shows an increase in student registrations during the Covid-19 pandemic, but it is not clear how many of these attend classes in person or remotely, although there was a large decrease in 'Other rented accommodation' in 2020/21 compared to 2019/20 (53% of all full-time students in 2019/20 compared to 30% of full-time students in 2020/21) as well as increases in 2020/21 in 'Provider maintained property' (28% of full-time compared to 19% in 2019/20); 'Private-sector Halls' (7% of full-time compared to 5% in 2019/20); 'Parental/guardian home' (14% of full-time compared to 10% in 2019/20) and 'Own residence' (12% of full-time compared to 10% in 2019/20)[17]. However, national data for 2020/21 indicates a large increase in students at parental/guardian home compared to previous years (456,870 in 2020/21; 379,205 in 2019/20 or 22% of full-time students compared to 19% of full-time students).[18]

Key issues identified for students nationally include sexual health, mental health, healthy behaviours and access to healthcare both for those coordinating care of long-term conditions and international students. [19]

3.2.5 Armed Forces personnel and veterans

The Ministry of Defence has a number of establishments in this area, with roughly 7,450 military personnel registered to Portsmouth (97% in Royal Navy/Royal Marines), as at April 2021. [20]

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 was Portsmouth. There were 1,251 associated people

[14] Office for National Statistics. Annual Population Survey (Experimental Statistics).
[15] 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]
[16] HESA: https://www.hesa.ac.uk/data-and-analysis/students/table-1 Date accessed 17/2/2022
[17] HESA: https://www.hesa.ac.uk/data-and-analysis/students/table-57 Date accessed 17/2/2022
[18] HESA: https://www.hesa.ac.uk/data-and-analysis/students/chart-4 Date accessed 17/2/2022
[19] Portsmouth JSNA: https://www.portsmouth.gov.uk/wp-content/uploads/2020/04/portsmouth-student-health-needs-assessment-2018.pdf Date accessed 18/2/2022.
[20] Annual Locations statistics, 1 April Edition, Ministry of Defence (Tri Service). https://www.gov.uk/government/statistics/location-of-uk-regular-service-and-civilian-personnel-annual-statistics-2021 Accessed 9 March 2022.

(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.[21]

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 2017 estimates approximately 2.4 million veterans residing in Great Britain (GB) (5% of the GB adult population)—89% of whom are male and 99% of all veterans were of White ethnicity. The APS 2017 estimates 7% of Hampshire's (including Portsmouth) adult population are veterans (higher than the 5% of GB adults). APS 2017 found UK Armed Forces veterans residing in GB aged 16-64 years and aged 65+ years are significantly more likely than non-veterans to have health problems lasting or expected to last more than 12 months. GB veterans aged 16-64 years are significantly more likely than non-veterans to have arms/hands; legs/feet; and back/neck long-term health problems; whilst GB veterans aged 65 years and over are significantly more likely than non-veterans to have difficulty seeing and difficulty hearing as long-term health problems. GB veterans aged 18-64 years and 65+ years were more likely to have ever smoked (55% and 66% respectively). GB veterans aged 18-64 years who had ever smoked were significantly more likely to report suffering from chest/breathing problem compared to non-smoking GB veterans aged 18-64 years - however, this is also the case for GB non-veterans[22]. GB veterans were as likely to have bought their home (outright or with a mortgage) as non-veterans.

Locally, the H&LS 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).[23] 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).[24]

3.2.6 Physical disability

2011 Census data shows that 11.6% of Portsmouth residents of working age (aged 16-64 years) had a long-term health problem or disability that limits their day-to-day activity a lot or a little (limiting long term illness, LLTI). At electoral ward level, Charles Dickens had the highest percentage (17.5%) of working age people with a LLTI, followed by Paulsgrove (7.1%). Central Southsea had the lowest percentage (7.1%) of working age people with a LLTI.

For persons aged 65+ years, the Census shows that 54.9% of Portsmouth residents had a LLTI. At electoral ward level, Charles Dickens had the highest percentage (65.1%) of residents aged 65+ years

[21] 2011 Census: AF001, AF003, AF004, AF005. Office for National Statistics © Crown Copyright 2014
[22] Annual Population Survey: Annual Great British Veteran Report, 2017 reference tables. Defence Statistics (Health), Ministry of Defence https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774939/20190128_-_APS_2017_Annex_A.xlsx Accessed 8 March 2022
[23] Portsmouth Health & Lifestyle Survey 2015, Ipsos MORI for Portsmouth City Council.
[24] Ipsos MORI Summary Report of findings for Portsmouth City Council. Health and Lifestyle Survey, 2015 via Portsmouth JSNA.

with a LLTI, followed by Fratton (59.0%). Copnor had the lowest percentage (45.0%) of residents aged 65+ years with a LLTI.

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%).[25]

In 2022, it is estimated that there are approximately 6,600 Portsmouth adults aged 16-64 years with impaired mobility[26] and half of these are estimated to be in the aged 55-64 age group (3,300 residents). Assuming the prevalence rate doesn't change, then the number of residents aged 16-64 years with impaired mobility are not expected to increase between 2022 to 2040[27]. However, in Portsmouth aged 65 and over, there is expected to be an increase in residents with impaired mobility (albeit a different definition: unable to manage at least one mobility activity on their own) - in 2022, it is estimated that there are approximately 5,800 Portsmouth adults aged 65+ years unable to manage at least one mobility activity on their own and half of these are estimated to be in the aged 80 years and over age group (2,900 residents). Assuming the prevalence rate doesn't change, then the number of residents aged 65 years unable to manage at least one mobility activity on their own is expected to increase to 6,900 by 2030. [28]

In terms of Years Lived with Disability (YLD), musculoskeletal (MSK) disorders - in particular, low back pain is the biggest cause of disability/ill-health in Portsmouth adults aged 15-49 years (1,160 YLD per 100,000 in 2019) and 50-64 years (2,217 YLD per 100,000 in 2019). It is also the biggest cause in England for these age groups. [29] In terms of prevalence, it's estimated that in 2020, 16.9% of Portsmouth residents aged 16 years and over, have a long-term MSK problem, which is similar to the England average (18.6%). People with a musculoskeletal condition are also likely to have another long-term condition and in 2020, 12.9% of Portsmouth residents aged 16 years and over have at least two long-term conditions, at least one of which is MSK related - similar to the England average (13.2%).

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.

During 2020/21, in Portsmouth 300 Adult Social Care clients aged 18-64 years accessed long-term 'Physical support'[30] (as their primary reason) during the year; 610 ASC clients aged 18-64 years accessed 'Other support' (e.g. Learning Disability, Sensory, Mental Health) as their primary reason. As a percentage of clients accessing Long Term Support, 9.4% of Portsmouth clients aged 18-64 years

[25] 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]
[26] Based on national Life Opportunities Survey Office for Disability Issues (2011) where respondents indicated they had the following: they experience either moderate, severe or complete difficulty with mobility, and certain activities are limited in any way as a result, such as walking or climbing stairs (source: pansi.org.uk).
certain activities are limited in any way as a result, such as walking or climbing stairs.
[27] Mobility, Projecting Adult Needs and Service Information www.pansi.org.uk Date accessed 7/3/2022
[28] Mobility, Older People Population Information System www.poppi.org.uk Date accessed 7/3/2022
[29] GBD compare, Global Burden of Disease: https://vizhub.healthdata.org/gbd-compare/. Date accessed 22/2/2022.
[30] Physical support: Access and mobility and personal care support

accessed long-term support with Physical support as the primary reason - this is lower than the England average (10.2%). [31]

During 2020/21, in Portsmouth 1,730 Adult Social Care clients aged 65 years and over accessed long-term 'Physical support' (as their primary reason) during the year; 560 ASC clients aged 65 years and over accessed 'Other support' (e.g. Learning Disability, Sensory, Mental Health) as their primary reason. As a percentage of clients accessing Long Term Support, 54.1% of Portsmouth clients aged 65 years and over accessed long-term support with Physical support as the primary reason - this is lower than the England average (48.6%). [32]

3.2.7 Autistic spectrum conditions

Autism is a lifelong developmental disability that affects how people perceive, communicate and interact with others, although it is important to recognise that there are differing opinions on this and not all autistic people see themselves as disabled.[33]

One of the 6 key themes of the national strategy for children, young people and adults is: improving autistic children and young people's access to education, and supporting positive transitions into adulthood[34]. Schools are acutely aware of children who have particular difficulties in learning and the school census covers all pupils enrolled in state-funded primary, secondary or special schools. The extent to which children are assessed in relation to SEN has changed recently. At present, nationally, not all of the pupils recognised as autistic will have been formally assessed outside the school [35]. In 2020, there were 414 children with Autism known to schools in Portsmouth, which as a rate (15.5 per 1,000 school age pupils) is significantly lower than England, the South East region and Southampton. [36]

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[37]. The APMS 2014 found 1.5% of males and 0.2% of females, averaged for all ages, are estimated to have ASD. However,

[31] Adult Social Care: Overview by Region and Local Authority Analytical Hub, NHS Digital. Date accessed 7/3/2022.
[32] Adult Social Care: Overview by Region and Local Authority Analytical Hub, NHS Digital. Date accessed 7/3/2022.
[33] National strategy for autistic children, young people and adults: 2021-2026 https://www.gov.uk/government/publications/national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026/the-national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026 accessed 10 March 2022
[34] National strategy for autistic children, young people and adults: 2021-2026 https://www.gov.uk/government/publications/national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026/the-national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026 accessed 10 March 2022
[35] Learning disabilities profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 10/3/2022.
[36] Learning disabilities profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 10/3/2022.
[37] 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.

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 2022 between 700 and 4,330 adults in Portsmouth have ASD and that by 2030 this will increase to between 740 and 4,590 people (Figure 6). [38]

Figure 6. Estimated number of adults with autism-spectrum disorders, Portsmouth, 2022 to 2030

	2022			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	1,220	500	2,970	1,240	500	3,010	1,270	530	3,150
35-54	60	20	260	60	20	260	60	20	270
55-74	390	170	880	400	180	900	410	180	900
75+	50	10	220	50	10	230	60	10	280
Total	**1,730**	**700**	**4,330**	**1,760**	**710**	**4,400**	**1,810**	**740**	**4,590**

Sources:
(1) Figure 6: 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 Copyright © 2016, HSCIC.
(2) SNPP Z1: 2018-based Subnational Population Projections. Local Authorities in England, mid-2018 to mid-2043, ONS.

3.2.8 Learning disabilities

Schools are acutely aware of children who have particular difficulties in learning and the school census covers all pupils enrolled in state-funded primary, secondary or special schools. The extent to which children are assessed in relation to SEN has changed recently. At present, nationally, not all of the pupils recognised as moderate learning difficulty will have been formally assessed outside the school [39]. In 2020, there were 890 children with moderate learning difficulties known to schools in Portsmouth, which as a rate (33.4 per 1,000 school age pupils) is significantly higher than England. In the same year, there were 97 children with severe learning difficulties and 41 children with profound and multiple learning difficulties known to schools in Portsmouth, which as a rate (3.6 and 1.5 per 1,000 school age pupils respectively) are both similar to England. [40]

In 2020/21, there were 1,279 registered patients of all ages recorded with learning disabilities on GP practice registers (0.6% of all registered patients compared to 0.5% in England). The range at GP practice level was from 0.8% of registered patients at Portsdown Group Practice to 0.3% at Trafalgar Medical Group Practice (excluding The University practice).[41]

[38] 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
[39] Learning disabilities profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 10/3/2022.
[40] Learning disabilities profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.
[41] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.

In 2019/20, 500 Portsmouth adults aged 18+ years with learning disability received long-term support from Adults Social Care which as a rate was significantly lower than England. This was a decrease of roughly 80 Portsmouth clients compared to 2018/19.

In 2018/19, 608 Portsmouth residents aged 14 years and over with learning disability received a GP health check - this was 54.7% of all eligible adults (out of those registered by their GP as having a learning disability) which was higher, but not significantly, than England (52.3%).[42]

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 2020/21, 83.2% (55.0% in 2019/20) of Portsmouth adults aged 18+ years with a learning disability known to Adult Social Care were in stable and appropriate accommodation (significantly higher than the percentage for England and the South East region) [43]. In 2020/21, the employment rate of Portsmouth adults aged 18-64 years with a learning disability known to Adult Social Care was 3.9% (this was lower than the percentage for England and the South East region). [44]

In 2019/20, the percentage point gap in the employment rate of Portsmouth adults aged 18-64 years with a learning disability known to Adult Social Care and the overall employment rate had increased to 70.7% (65.7% in 2018/19), which is similar to England (70.6%). Nationally this gap has increased annually since 2011/12. [45]

In 2016/17, Adult Social Care provided a service in the community for 449 people with a learning disability aged 18+ years (2.7 per 1,000 residents aged 18+ years). The highest number and rate of clients receiving services in the community were in Hilsea ward (5.0 clients per 1,000 resident population aged 18+ years) in the North locality, followed by Fratton (3.6 clients per 1,000 resident population aged 18+ years) in the Central locality and Eastney and Craneswater (3.5 clients per 1,000 resident population aged 18+ years) in the South locality. [46]

3.2.9 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. [47] 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 7).

[42] Learning disabilities profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.
[43] Learning disabilities profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.
[44] HSCIC Adult Social Care Outcomes 2020/21 https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof/england-2020-21 1E Accessed 11 March 2022 via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.
[45] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.
[46] Short- and Long-Term Support (SALT) database, Portsmouth City Council via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.
[47] 2011 Census: QS301EW, Office for National Statistics.

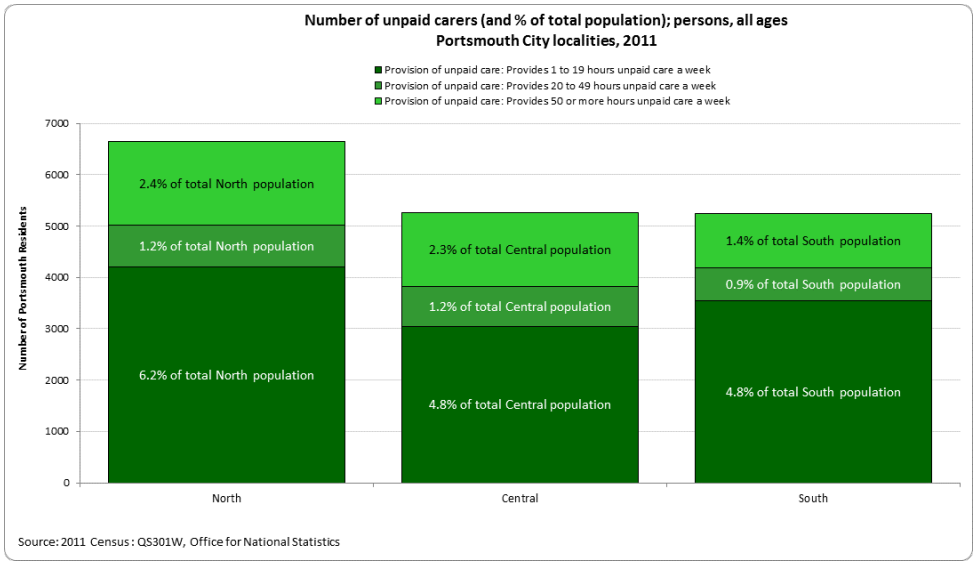

Figure 7. Number of unpaid carers (and percentage of total population); persons, all ages, Portsmouth City UA localities, 2011 Census

The H&LS 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 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%).[48]

In November 2020, 2,875 (140 more than in November 2019) residents aged 16+ years claimed Carer's Allowance. This equates to 16.4 per 1,000 residents aged 16+ years. The highest number of claimants are in Paulsgrove MSOA (294 claimants, 48.4 per 1,000 residents aged 16+ years), which is in the North locality, followed by the Buckland MSOA (277 claimants, 45.2 per 1,000 aged 16+ years), which is in the Central locality. [49]

In 2020/21, Adult Social Care provided support to about 1,155 carers (including about 5 carers receiving 'Respite or Other Forms of Carer Support delivered to the cared-for person') - similar in number to 2019/20 (1,175 carers although that includes 200 carers receiving 'Respite or Other Forms of Carer Support delivered to the cared-for person'). [50]

[48] Ipsos MORI Summary Report of findings for Portsmouth City Council. Health and Lifestyle Survey, 2015 via Portsmouth JSNA.
[49] Department for Work and Pensions, Nov 2020. https://stat-xplore.dwp.gov.uk (Claimant numbers) Accessed 11 March 2022. Rates calculated using ONS mid-2020 small area population estimates.
[50] HSCIC Adult Social Care Activity and Finance Report, England - 2019/20 and 2020/21 https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report Accessed 11 March 2022

The national survey of carers is carried out biennially. The 2018-19 postal survey of local carers aged 18+ years receiving services from Social Services was carried out in October/November 2018. The carers' survey found that, locally, 68.9% of people being cared for were aged 65+ years (65.8% in England). The three main reasons for caring for someone were physical disabilities (54.2%), dementia (36.3%) and long-standing illness (38.5%). High levels of the person being cared for had not accessed available services eg short-notice/in an emergency respite (86.0% not accessed), a break for more than 24 hours (86.8% not accessed), sitting service (72.6% not accessed), personal assistant (91.3%), home care/home help (72.1%), day centres or day activities (82.1%), lunch club (97.5%), meals services (95.6%), Lifeline Alarm (79.8%). Home equipment or adaptations (48% accessed) was most likely to have been accessed. Over half of all carers in Portsmouth themselves had at least one type of physical or mental health problem (38.8% had none). 47.5% of local carers (50.1% in England) had some social contact with people but said it was not enough; 13.8% felt socially isolated (17.4% in England). [51]

3.2.10 People threatened with homelessness

Homelessness is associated with severe poverty and is a social determinant of health. It often results from a combination of events such as relationship breakdown, debt, adverse experiences in childhood and through ill health. Homelessness is associated with poor health, education and social outcomes, particularly for children. The Homelessness Reduction Act (HRA) introduced new homelessness duties which meant significantly more households are being provided with a statutory service by local housing authorities than before the Act came into force in April 2018. [52]

The HRA introduced new prevention and relief duties, that are owed to all eligible households who are homeless or threatened with becoming homeless, including those single adult households who do not have 'priority need' under the legislation. In 2020/21, Portsmouth had 1,986 households owed a prevention or relief duty under the Homelessness Reduction Act, which as a rate (22.0 per 1,000 households) was significantly higher than England (11.3 per 1,000 households), the South East and Southampton. [53]

Young people experiencing homelessness are extremely vulnerable, and face complex and compounding challenges. Of the 1,986 households in Portsmouth owed a duty under the HRA, the main applicant was aged 16-24 years for 392 households - as a rate this is also significantly higher than England, the South East and Southampton. [54]

In recent years, nationally, there has been a significant increase in homelessness experienced by older people. Households are increasingly living in the growing private rented sector, and loss of assured shorthold tenancy is the main cause of statutory homelessness. Many older households also live in poverty. Of the 1,986 households in Portsmouth owed a duty under the HRA, the main applicant was aged 55 years and over for 184 households - as a rate this is also significantly higher than England, the South East and Southampton. [55]

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[51] Personal Social Services Survey of Adult Carers in England, 2018-19. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-survey-of-adult-carers/england-2018-19 Accessed 11 March 2022

[52] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.

[53] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.

[54] Wider determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.

[55] Wider determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.

The UN Convention on the Rights of the Child highlights the right of every child to an adequate standard of living. Of the 1,986 households in Portsmouth owed a duty under the HRA, 482 households include one or more dependent children - as a rate this is also significantly higher than England, the South East and Southampton. [56]

In addition, as a result of the HRA, local authorities must provide temporary accommodation for households in a number of circumstances, which might include pending the completion of inquiries into an application, or they might spend time waiting in temporary accommodation after an application is accepted until suitable secure accommodation becomes available. The Public Accounts Committee's December 2017 report, Homeless Households, observed that temporary accommodation is often of a poor standard and does not offer value for money. In 2020/21, Portsmouth had 144 households in temporary accommodation, which as a rate (1.6 per 1,000 households) was significantly lower than England (4.0 per 1,000 households) and the South East region; but similar compared to Southampton. [57]

Local authorities across England take an autumn single night snapshot of people sleeping rough[58]. They either use a count-based estimate of visible rough sleeping, an evidence-based estimate meeting with local agencies or an evidence-based estimate meeting including a spotlight count. As well as the Covid-19 pandemic, there are other factors that can affect the number of people who sleep rough on any given night. For example, the availability of night shelters, the weather, where people choose to sleep and the date and time chosen for the snapshot estimate. In Autumn 2021, it was estimated that there were 24 people sleeping rough, which was lower than the estimated 29 people sleeping rough in 2020. Both 2020 and 2021 were evidence based estimates, whereas the most recent count in 2019 found 26 people sleeping rough. In 2021, it was an evidence-based estimate following consultation with the Voluntary sector, Police, Outreach workers and Drug & alcohol treatment teams; but Faith groups, Mental health agencies, Substance misuse agencies and local residents/businesses were not consulted.[59]

4. Life expectancy and mortality

4.1 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.

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[56] Wider determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.

[57] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.

[58] People sleeping rough are defined as follows: People sleeping, about to bed down (sitting on/in or standing next to their bedding) or bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes' which are makeshift shelters, often comprised of cardboard boxes).

[59] Annual Rough Sleeping Snapshot in England: autumn 2021, MHCLG Annual Rough Sleeping Snapshot: https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2021 Accessed 11 March 2022

In 2018-20, male life expectancy at birth in Portsmouth (78.5 years) remained similar to previous periods and is statistically significantly longer than in 2008-10; however, it continues to be significantly shorter than England (79.4 years in 2018-20) even though life expectancy at birth decreased by over a year in England in 2020 (80.0 in 2019 to 78.7 in 2020), which would largely be due to Covid-19 related mortality. In 2018-20, female life expectancy at birth in Portsmouth (82.4 years) remained significantly worse than England (83.1 years). Whilst life expectancy at birth for females across England had been improving before 2020, female life expectancy at birth in Portsmouth had remained similar from 2011 to 2019. Unlike for the England average (where life expectancy decreased), female life expectancy at birth increased in 2020, although this was not significantly different to England. [60]

Life expectancy at birth (2018-20) for males in Portsmouth's most deprived 10% of Lower Super Output Areas (LSOAs) is 9.1 years shorter than males in Portsmouth's least deprived 10% of LSOAs - shorter, but not significantly, than the inequality gap in England (9.7 years). Life expectancy at birth (2018-20) for females in Portsmouth's most deprived 10% of LSOAs is 4.3 years shorter than females in Portsmouth's least deprived 10% of LSOAs (the slope index of inequality in life expectancy at birth for males and females) - the gap has decreased each period since 2014-16 and is significantly shorter than the inequality gap in England (7.9 years). [61]

In 2018-20, the healthy life expectancy (HLE) at birth in Portsmouth is shorter, but not significantly than England for both males and females. [62] Portsmouth males and females have a similar HLE at birth (62.1 years and 62.3 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). [63]

The scarf chart below shows, for each broad cause of death, the percentage contribution that it makes to the overall life expectancy gap between the most and least deprived quintiles in Portsmouth in 2020/21, split by gender.[64] Circulatory disease contributes nearly a third of the gap in life expectancy for both men and women, with cancer and respiratory disease the next largest factors.

[60] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.
[61] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.
[62] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.
[63] 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.
[64] Segment Tool breakdown of life expectancy gap by deprivation and cause of death, Office for Health Improvement and Disparities. Date accessed 26/06/2022

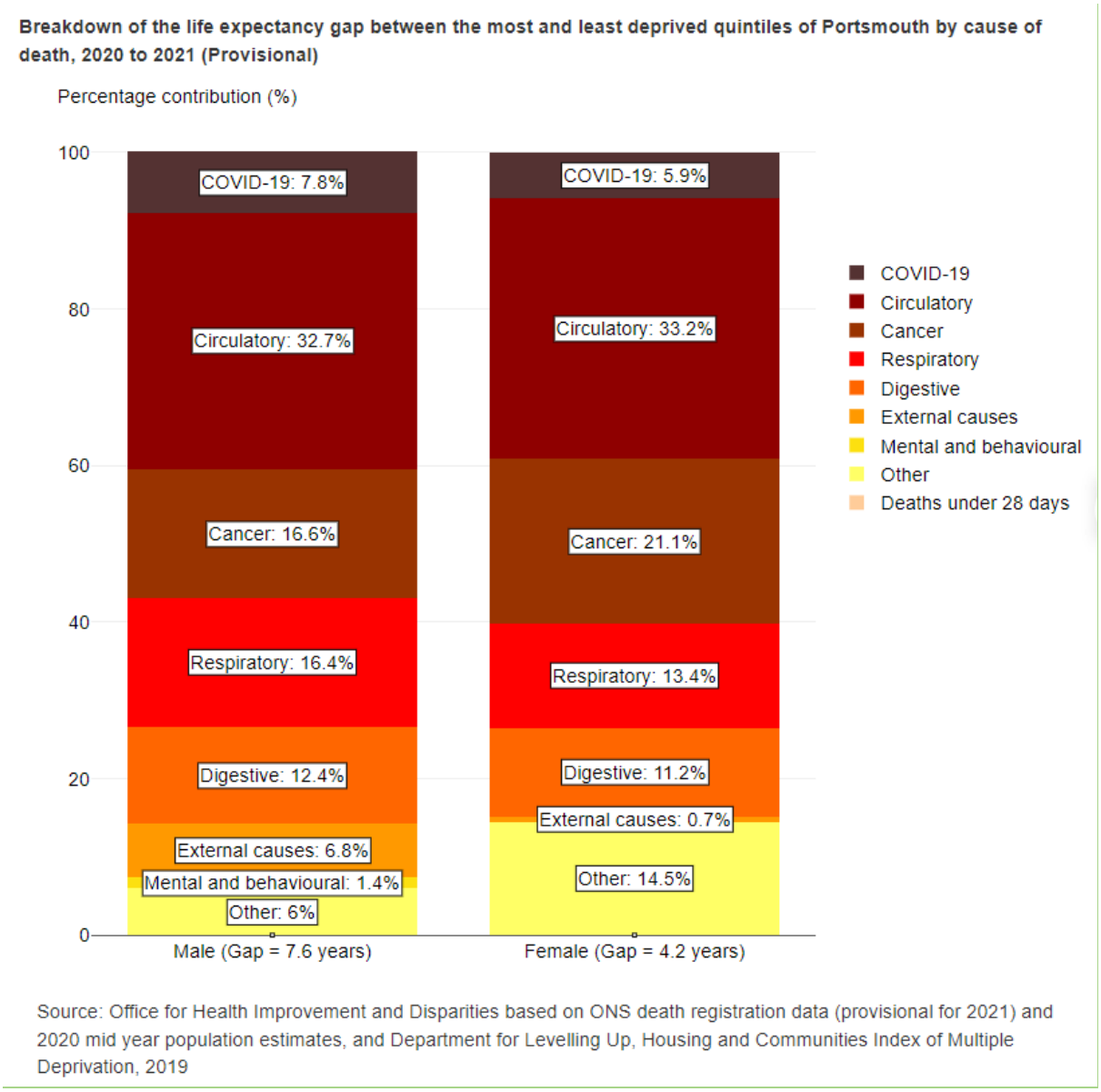

Figure 8. Summary infographic of the factors contributing to the life expectancy gap between most and least deprived quintiles by gender, Portsmouth residents, 2020/21

4.2 Mortality

Premature mortality in England is considered as deaths aged under 75 years (u75). In 2017-19, the u75 all-cause mortality rate for Portsmouth males and females (480 per 100,000 males of all ages (DSR) and 330 per 100,000 females of all ages (DSR)) was significantly higher than England (397 per 100,000 males of all ages (DSR) and 258 per 100,000 females of all ages (DSR)), the South East (351 per 100,000 males of all ages (DSR) and 229 per 100,000 females of all ages (DSR)); but similar to Southampton (465 per 100,000 males of all ages (DSR) and 316 per 100,000 females of all ages (DSR)) [65]. For small areas within Portsmouth there is variation in premature mortality for all causes - in 2015-19, the Buckland, City Centre and Somerstown middle super output areas (MSOAs) have a

[65] Public Health England. Public Health Profiles. Date accessed 4/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021' via Portsmouth JSNA www.jsna.portsmouth.gov.uk

standardised mortality ratio about twice that of the England average (if those areas had the same age specific death rate as England) [66]

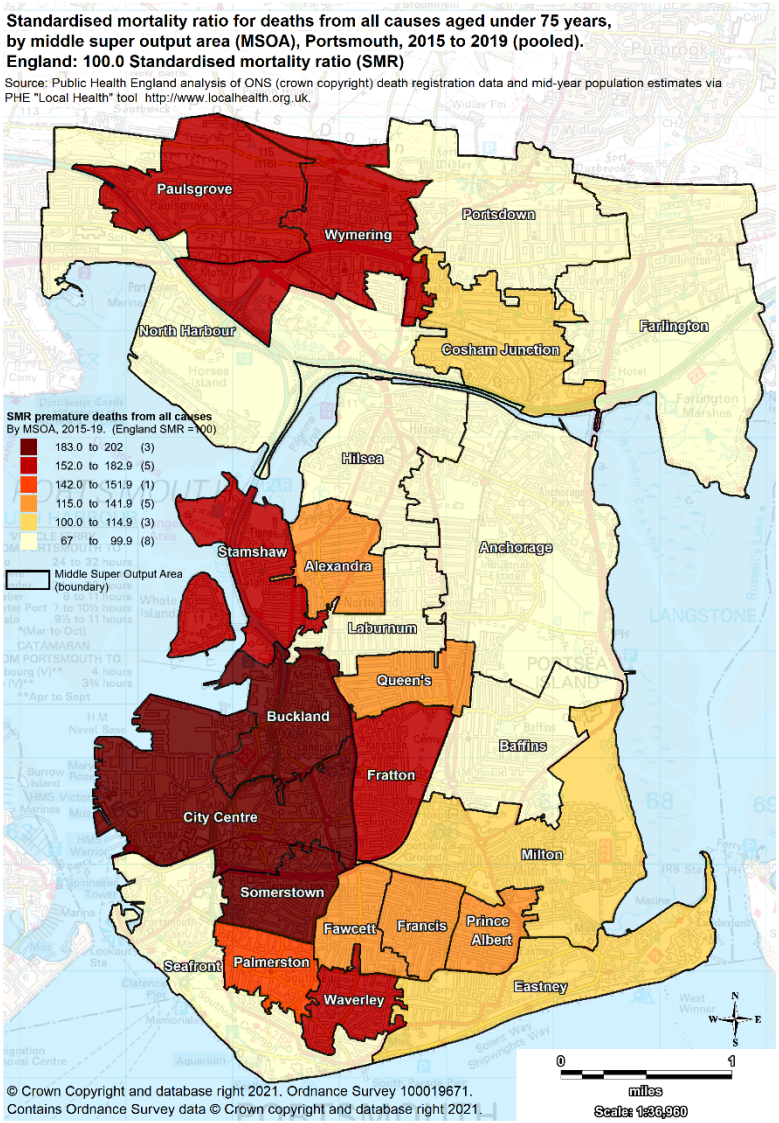

Figure 9. Map of Portsmouth with standardised mortality ratio for deaths from all causes

In 2017-19, Portsmouth's male premature mortality rates were significantly higher than England from the following major cause groups:

- U75 mortality from cardiovascular disease
- U75 mortality from stroke
- U75 mortality from cancer
- U75 mortality from respiratory disease

In 2017-19, Portsmouth's female premature mortality rates were significantly higher than England from the following major cause groups:

- U75 mortality from cardiovascular disease

[66] Local health profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 7/3/2022.

- U75 mortality from heart disease
- U75 mortality from cancer
- U75 mortality from breast cancer (the highest rate in the country and increasing since 2015-17)
- U75 mortality from liver disease
- U75 mortality from respiratory disease

The effect of the Covid-19 pandemic makes it difficult to aggregate the data over three years (which is useful for robust statistical comparisons), therefore the following major cause groups are also available for single years up to and including 2020:

- U75 mortality from cardiovascular disease
- U75 mortality from cancer
- U75 mortality from liver disease
- U75 mortality from respiratory disease

In 2020, Portsmouth's male and female premature mortality rates were not significantly different compared to England for the four major cause groups.

The Portsmouth male u75 mortality rate from cardiovascular disease in 2020 was similar to the previous year, but the England rate had increased to similar to the rate in 2013. The Portsmouth female u75 mortality from cardiovascular disease rate in 2020 was lower but not significantly to the previous year; unlike England males, the female England rate was similar to the previous two years.

The Portsmouth male u75 mortality rate from cancer in 2020 was lower, but similar to the previous year and the England rate also continued to decrease. The Portsmouth female u75 mortality rate from cancer in 2020 was lower than the previous year and lower, but not significantly compared to the England rate.

The Portsmouth male u75 mortality rate from liver disease in 2020 was lower, but similar to the previous year; whilst the England rate increased compared to previous years. The Portsmouth female u75 mortality rate from liver disease in 2020 was lower, but not significantly than the previous year; the England rate increased in 2020.

The Portsmouth male u75 mortality rate from respiratory disease in 2020 remained similar to the previous year; but the England rate decreased compared to previous years. The Portsmouth female u75 mortality rate from respiratory disease in 2020 was lower, but not significantly than the previous year; the England rate decreased compared to previous years. [67]

The leading cause death[68] for Portsmouth residents in 2020 (and since 2015 (Figure 10) for persons of all ages was Dementia and Alzheimer's disease (213 deaths; 12% of all deaths). For Portsmouth males,

[67] Public Health England. Public Health Profiles. Date accessed 4/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021' via Portsmouth JSNA www.jsna.portsmouth.gov.uk

[68] The cause of death groups used are based on a list developed by the World Health Organization (WHO), modified for use in England and Wales by ONS - the list used is based on ONS revised 2016 list. It was modified in 2016 for use on 2015 mortality data. Minor changes were made in 2017 to ensure mutual exclusivity between groupings. This involved the removal of meningitis and meningococcal diseases (A39), sepsis due to haemophilus influenzae (A41.3), rabies (A82), certain mosquito-borne diseases (A83) and yellow fever (A95) from the vaccine preventable diseases grouping.

COVID-19 is a new novel disease since March 2020, therefore has been added as an addition to the 2016 list.

the leading cause of death remained as Ischaemic heart diseases (101 deaths; 11% of all male deaths); however, deaths from Covid-19 were ranked second (98 deaths; 10% of all male deaths), but as a new disease which existed for just over 9 months of the year, if adjusted for the shorter time frame it may well be ranked as the leading cause of death over the year for males. For Portsmouth females, the leading cause of death remained as Dementia and Alzheimer's disease (142 deaths; 17% of all female deaths); deaths from Covid-19 were ranked second (67 deaths; 8% of all female deaths). [69]

Figure 10. Summary infographic of the top 10 ranking of leading causes of death by year of death by gender; all ages, Portsmouth residents. 2014 to 2020

	Males						
Cause of death groups (ICD-10)	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Ischaemic heart diseases (120-125)	1	1	1	1	1	1	1
COVID-19 (identified or not: U071-U720: MIS associated: U109)*	New	New	New	New	New	New	2
Chronic lower respiratory diseases (J40-J47)	4	3	2	3	2	3	3
Dementia and Alzheimer's disease (F01, F03, G30	3	2	3	2	3	2	4
Malignant neoplasm of trachea, bronchus and lung (C33, C34)	2	4	4	4	4	4	5
Cerebrovascular diseases (160-169)	5	5	5	5	5	5	6
Malignant neoplasm of prostate (C61)	6	6	8	7	7	6	7
Malignant neoplasm of colon, sigmoid, rectum and anus (C18-C21)	9	>10	7	10	8	9	8
Accidents (V01-X59)	>10	7	9	8	6	8	9
Influenza and pneumonia (J09-J18)	10	8	6	6	9	7	10
Malignant neoplasms of lymphoid, haematopoietic and related tissue (C81-C96)	7	9	>10	9	10	>10	>10
Aortic aneurysm and dissection (171)	>10	>10	>10	>10	>10	10	>10
Diabetes (E10-E14)	>10	>10	>10	>10	10	>10	>10
Cirrhosis and other diseases of liver (K70-K76)	8	>10	10	>10	>10	>10	>10
Heart failure and complications and ill-defined heart disease (150-151)	>10	10	>10	>10	>10	>10	>10

Sources: Civil Registration Data via Primary Care Mortality Database (PCMD), Copyright © 2021, re-used with the permission of HSCIC. All rights reserved.

*Covid-19 deaths occurred from late March 2020 onwards, so just over 9 months of the calendar year.

	Females						
Cause of death groups (ICD-10)	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Dementia and Alzheimer's disease (F01, F03, G30)	1	1	1	1	1	1	1
COVID-19 (identified or not: U071-U720: MIS associated: U109)*	New	New	New	New	New	New	2
Ischaemic heart diseases (120-125)	2	2	3	2	2	2	3
Cerebrovascular diseases (160-169)	4	3	2	3	4	4	4
Chronic lower raspatory diseases (J40-J47)	3	4	4	3	3	3	5
Malignant neoplasm of trachea, bronchus and lung (C33, C34)	5	7	6	5	5	5	6
Malignant neoplasm of breast (C50)	7	6	7	7	6	6	7
Influenza and pneumonia (J09-J18)	6	5	4	6	7	7	8
Diseases of the urinary system (N00-N39)	>10	>10	>10	>10	>10	>10	9
Malignant neoplasm of colon, sigmoid, rectum and anus (C18-C21)	8	9	8	8	8	8	10
Accidents (V01-X59)	>10	10	10	>10	8	>10	10
Cardiac arrhythmias (147-149)	>10	>10	>10	>10	>10	>10	10
Malignant neoplasms of lymphoid, haematopoietic and related tissue (C81-C96)	10	>10	9	9	>10	>10	>10
Malignant neoplasms of ovary (C56)	>10	>10	>10	10	>10	>10	>10
Hypertensive diseases (I10-I15)	>10	>10	>10	>10	10	9	>10
Malignant neoplasm of Pancreas (C25)	9	>10	>10	>10	>10	10	>10
Nonrheumatic valve disorders (134-138)	>10	8	>10	>10	>10	>10	>10

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*Covid-19 deaths occurred from late March 2020 onwards, so just over 9 months of the calendar year.

[69] Civil Registration Data via Primary Care Mortality Database (PCMD), Copyright ©2021, re-used with the permission of HSCIC. All rights reserved. Accessed via JSNA Portsmouth www.jsna.portsmouth.gov.uk

5. Deprivation, socio-economics and vulnerable communities

5.1 Indices of Multiple Deprivation

Portsmouth is ranked 59th 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 2019 (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. Thirty out of 125 LSOAs in Portsmouth are in the 20% most deprived in England. Of these 30 LSOAs (in the most deprived 20% in England), 11 (of 44) LSOAs are in the North locality; 17 (of 39) in Central locality; and 2 (of 42) are in the South[70] (Figure 11).

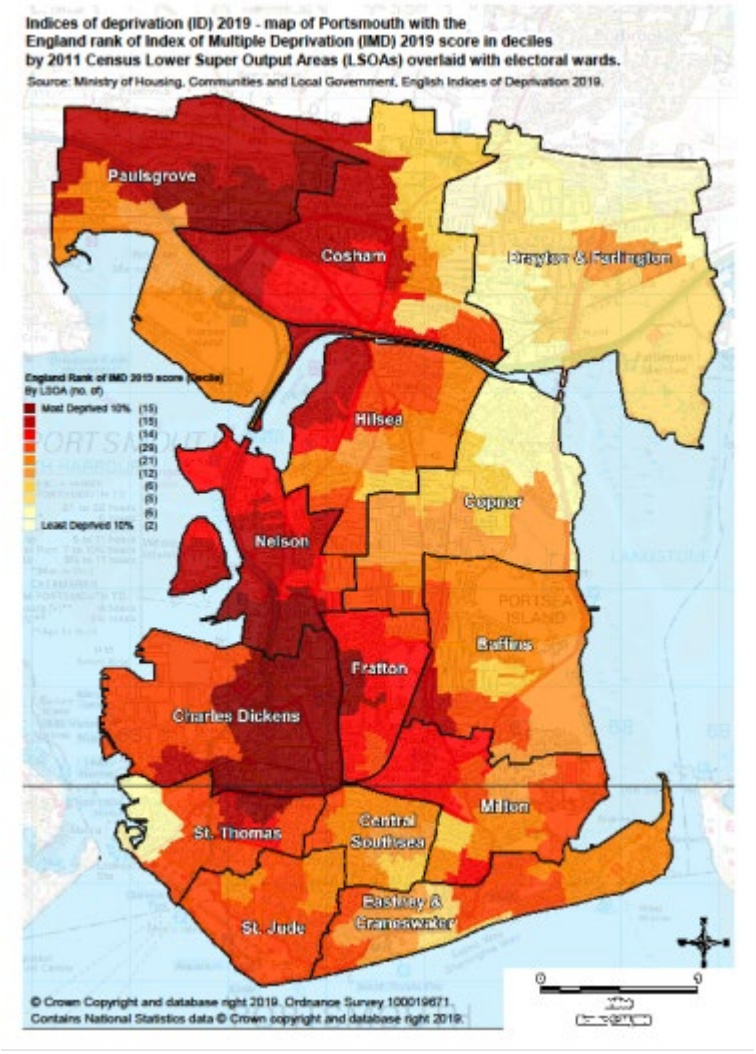


Figure 11. Map of Portsmouth with the England Rank of IMD 2019 score in deciles by 2011 Census LSOAs

[70] English Indices of Deprivation, 2019. Ministry of Housing, Communities & Local Government. https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019 [Accessed 26 September 2019]

5.2 Child poverty

The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy. There is also a wide variety of evidence to show that children who live in poverty are exposed to a range of risks that can have a serious impact on their mental health.

There are two indicators for measuring children in low-income families - an absolute and relative measure:

The children in absolute low-income families measure is useful for tracking changes over time in relation to a fixed reference point and is designed to assess how low incomes are faring with reference to inflation. So, the absolute low income takes the 60 per cent of median income threshold from 2010/11 and then fixes this in real terms (i.e. the line moves with inflation). It measures the number and proportion of individuals who have incomes below this threshold. The percentage of individuals in absolute low income will decrease if individuals with lower incomes see their incomes rise by more than inflation.

The children in relative low-income families measure is useful for comparing the situation in local areas and measuring the number and proportion of individuals who are currently in low income compared to the current median income. Relative low income sets a threshold as 60% of the UK average (median) income and moves each year as average income changes. It is used to measure the number and proportion of individuals who have income below this threshold. The percentage of individuals in relative low income will decrease if:

- Average (median) income stays the same or rises, and individuals with lower incomes see their incomes rise more than the average; or
- Average (median) incomes fall, and individuals with lower incomes see their incomes fall less than average incomes. [71]

In 2019/20, 16.5% of children aged under 16 years (6,528 children) in Portsmouth were in absolute low-income families (before housing costs). The gap between Portsmouth and England for children in absolute low-income families had previously been widening. In 2014/15, the Portsmouth percentage was similar to England, then from 2015/16 Portsmouth was significantly worse than England with the gap increasing in 2017/18. This gap between Portsmouth and England narrowed in 2019/20 and although Portsmouth remains significantly higher than the England average for this indicator, it has also reduced significantly compared to the previous year [72]. The percentage of children living in absolute low-income families (before housing costs) at smaller geographies in Portsmouth is contrasting. In 2019/20, the electoral ward with the highest number and percentage of children living in absolute low-income families remains Charles Dickens with 29% of children living in absolute low-income families; followed by St Thomas and Paulsgrove (both 21%), Fratton (19%) and Nelson (18%). Drayton and Farlington ward (7%) remains the ward with the lowest percentage of children living in absolute low-income families in the city. [73]

[71] Public Health Outcomes Framework. Public Health Profiles. Date accessed 29/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021'
[72] Public Health Outcomes Framework. Public Health Profiles. Date accessed 29/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021'
[73] Children in low-income families: local area statistics, United Kingdom: financial years ending (FYE) 2015 to 2020, Department for Work and Pensions. Accessed via Portsmouth JSNA: www.jsna.portsmouth.gov.uk

In 2019/20, 20.2% of children aged under 16 years (7,989 children) in Portsmouth were in relative low-income families (before housing costs); increasing (although not significantly) from 19.9% in 2018/19. The percentage of children aged under 16 years in Portsmouth in relative low-income families has been significantly worse (higher) than England between 2016/17 and 2019/20. Before this, the Portsmouth rate had been similar to England (since at least 2014/15) [74]. The percentage of children living in relative low-income families (before housing costs) at smaller geographies in Portsmouth also varies greatly. In 2019/20, the electoral ward with the highest number and percentage of children living in relative low-income families remains Charles Dickens with 35% of children living in relative low-income families; followed by Paulsgrove (26%), St Thomas (25%), Fratton (23%) and Nelson (22%). Drayton and Farlington ward (8%) remains the ward with the lowest percentage of children living in relative low-income families in the city. [75]

5.3 Older people

Based on data from 2015/16, the Income Deprivation Affecting Older People Index (IDAOPI) (a sub-domain of IMD 2019) estimate that 17% of Portsmouth residents (about 6,540 people) aged 60 years and over in the city lived in income-deprivation (12.7%, 24.8% and 15.8% in the North, Central and South localities respectively). Thirteen (out of 125) LSOAs in Portsmouth are within the most deprived 10% of LSOAs in England on the Income Deprivation Affecting Older People Index. Of these, only one is in the north of the city (in Paulsgrove) with the rest clustered in Charles Dickens and adjoining neighbourhoods.

5.4 Employment

The most recent Annual Population Survey, for the period April 2020 to March 2021, show that Portsmouth's percentage of people in employment aged 16-64 years at 76.4% was the highest since April 2011 to March 2012; however, this is not statistically significantly different to any of the previous periods. In 2020/21, Portsmouth's employment rate aged 16-64 years is higher but not significantly than England; and lower but not significantly than the South East region. However, in 2020/21, 66.1% of Portsmouth residents aged 50-64 years were in employment, which is lower but not significantly than England; and significantly lower than the South East region (74.7%).[76]

In 2020, the estimated unemployment rate (aged 16 years and over) for Portsmouth was 5.4% (roughly 6,200 residents), which was an increase on the previous year (4.0%). This remains higher, but not significantly than the England rate (4.7% in 2020 and 3.9% in 2019); and the Portsmouth rate is now significantly higher than the South East region (4.0% in 2020 and 3.0% in 2019).

The unemployed and the economically inactive represent two distinct categories. Groups comprising the economically inactive include: the long-term sick or disabled, the temporary sick (with no employment), people looking after family/home, students, and retired people. In 2020/21 (April to March), the Portsmouth economic inactivity rate[77] was estimated to be 19.3% of residents aged 16-64 years, which was the lower than in 2019/20 (23.3%). The Portsmouth economic inactivity rate was similar to England (20.9%) in 2020/21; but was significantly higher than England in 2019/20 (20.6%).[78]

[74] Public Health Outcomes Framework. Public Health Profiles. Date accessed 29/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021'

[75] Children in low-income families: local area statistics, United Kingdom: financial years ending (FYE) 2015 to 2020, Department for Work and Pensions. Accessed via Portsmouth JSNA: www.jsna.portsmouth.gov.uk

[76] Public Health Outcomes Framework (PHOF), Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 14/2/2022.

[77] defined as those not classed as employed or unemployed according to ILO definitions

[78] Wider Determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 14/2/2022.

In 2020/21, of the approximately 27,600 economically inactive residents in Portsmouth, roughly 7,300 (26.3%) wanted a job (roughly 20,400 or 73.7% did not want a job). [79]

As at March 2020, the unemployment Claimant Count rate for Portsmouth was 3.1% of residents aged 16-64 years (3.0% in England and 2.1% in the South East). However, the Claimant Count rate increased to 7.1% by March 2021, due to the impact of the Covid-19 pandemic (6.5% in England and 5.3% in the South East). As at December 2021, the Claimant count rate was 5.0% of residents aged 16-64 years (4.5% in England and 3.5% in the South East). Amongst electoral wards in Portsmouth, the Claimant Count rate per residents aged 16-64 years was above the Portsmouth rate in three of the electoral wards in the Central locality:

- Charles Dickens (5.1% of working age population in Mar 2020; 8.9% in Mar 2021; and 7.2% in Dec 2021);
- Nelson (4.4% in Mar 2020; 10.3% in Mar 2021; and 7.6% in Dec 2021);
- and Fratton (3.7% in Mar 2020; 8.9% in Mar 2021; and 6.4% in Dec 2021);
- Paulsgrove (3.9% in Mar 2020; 8.9% in Mar 2021; and 6.0% in Dec 2021) in the North locality;
- St. Jude (3.3% in Mar 2020; 7.1% in Mar 2021; and 5.3% in Dec 2021) in the South locality. [80]

As at March 2020, the unemployment Claimants as a proportion of economically active residents aged 16 years and over was 3.9% for Portsmouth (3.7% in England and 2.5% in the South East). However, the Claimant rate out of economically active increased to 8.9% by March 2021, due to the impact of the Covid-19 pandemic (8.0% in England and 6.3% in the South East). As at December 2021, the Claimant rate out of economically active was 6.3% of residents aged 16 years and over (5.5% in England and 4.1% in the South East). [81]

Job density (the number of filled jobs relative to the working age resident population - e.g. a job ratio of 1.0 is one job per person) provides further insight into the economic performance in an area when interpreted together with the unemployment rate. For example, an area with high unemployment combined with low job density is indicative of an underperforming economy, with too few jobs for the population. In contrast, high unemployment together with a high job density may indicate a skills mismatch between workers and jobs in the local economy. In 2019, the job density ratio in Portsmouth was 0.89, which was higher than in previous years (since 2013). The Portsmouth job density ratio was higher than the England average (0.88) but lower than the South East region (0.90)

5.5 Income

The link between income (in particular low income) and poor health is well established, and the relationship can operate in both directions: low income can lead to poor health and ill health can result in a lower earning capacity[82]. Earnings are the primary source of income; therefore, the Average Weekly Earnings indicator is designed to give insight into the variation of economic resources across areas and between subgroups (men and women, income decile). This measure of earnings includes full and part-time workers because the aim of the indicator is to provide insight into the economic resources available to people, not to compare wage rates per se (for which comparing full-time wages may be more appropriate). The measure excludes overtime payments because such earnings are potentially more erratic. In 2021, the median average weekly earnings in Portsmouth

[79] Data from ONS Claimant Counts via https://www.nomisweb.co.uk ONS © Crown copyright 2022. Date accessed 14/2/2022.
[80] Data from the Annual Population Survey via https://www.nomisweb.co.uk ONS © Crown copyright 2022. Date accessed 14/2/2022.
[81] Data from the Annual Population Survey via https://www.nomisweb.co.uk ONS © Crown copyright 2022. Date accessed 14/2/2022.
[82] Fair Society Healthy Lives (The Marmot Review): 'Fair Society Healthy Lives' 2010

was £468, which is higher, but not statistically significantly, than in 2020 (£407). Portsmouth's median average weekly earnings in 2021 was lower, but not significantly than the England average (£496) and Southampton (£521.40); and significantly lower than the South East (£530.40). [83]

The most commonly used threshold for income poverty is below 60% of median income. The latest data on households in poverty at sub regional geography is from the 2013/14 ONS estimates - at that time 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 is 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 is 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 is estimated that the Somerstown MSOA*[84] have roughly 44% of households below the after housing cost (AHC) threshold, compared to 17% of households in Prince Albert MSOA.[85]

5.6 Coastal Communities.

The Chief Medical Officer's 2021 Annual report focused on health inequalities in coastal areas, including Portsmouth communities. Coastal communities include a disproportionately high burden of ill health, particularly heart disease, diabetes, cancer, COPD and mental health. Life expectancy, healthy life expectancy and disability-free life expectancy are all lower in coastal areas for males and females. [86]

Portsmouth is defined as a 'coastal city' (along with Brighton and Hove, Kingston upon Hull, Liverpool, Plymouth and Southampton) using ONS methodology. Such cities experience greater exposure to risks and poorer health outcomes on a range measures, explored throughout this report, compared to none-coastal cities. This includes key wider determinants of health such as educational attainment where coastal cities perform significantly less well than non-coastal cities on progress between KS2 and KS4. The CMO report also highlights areas where coastal cities overall compare well to non-coastal cities, including KS2 attainment, % pupils eligible for Free School Meals, and employment rates.

Portsmouth's approach to addressing the 'causes of the causes' of poor health outcomes, which map closely against the issues identified by the CMO, is set out in the Health and Wellbeing Strategy 2022-2030[87]. This city-wide strategy is overseen by the Health and Wellbeing Board.

[83] Wider Determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 14/2/2022.
[84]*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.
[85] Households in Poverty estimates for middle layer super output areas, England & Wales, 2013/14. Office for National Statistics.
[86] Health in Coastal Communities, Chief Medical Officer's Annual Report 2021, 21/07/2021
[87] Health and Wellbeing Strategy 2022-2030, https://www.portsmouth.gov.uk/services/council-and-democracy/transparency/health-and-wellbeing-strategy/. Date accessed 16.06.2022

5.7 Left Behind Neighbourhoods

Left behind neighbourhoods (LBN's) feature in the most deprived 10% of areas in the Index of Multiple Deprivation, and the 10% of areas of greatest need in the Community Needs Index. Paulsgrove is identified as an LBN, and is also classified as coastal communities, highlighting its extremely high vulnerability to poor health outcomes.[88]

LBN's have a higher proportion of people who self-report their health to be 'bad' or 'very bad' than other deprived areas and England as a whole, and people in these neighbourhoods were 46% more likely to die of COVID-19 than the national average. These areas also have high rates of unemployment, high rates of obesity. People living in LBN's have lower life expectancy than the general population, living on average 7.5 fewer years in good health. Female life expectancy in LBN's is 3 years below the national average, and male life expectancy is 3.7 years below.

5.8 Health Inequalities in the ICS

NHS England published their approach to tackling health inequalities, 'Core20PLUS5', in November 2021. This approach seeks to support the reduction of health inequalities through defining a target population the 'Core20Plus' and identifies 5 focus clinical areas requiring accelerated improvement.

Core20:

- The Core20 population is defined as the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation

PLUS:

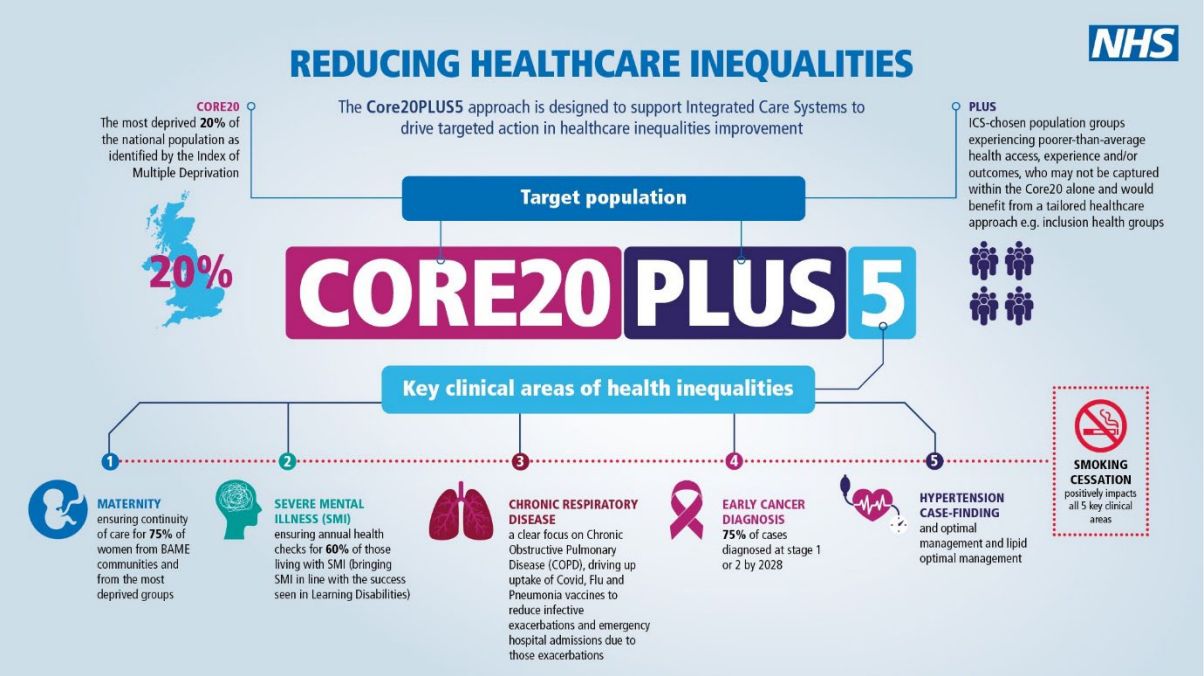
- The PLUS population groups include those groups that have poorer health outcomes for a variety of reasons, often relating to the way in which services are unable to meet their multiple and overlapping needs. Groups that ICSs are expected to identify include:
    - Ethnic minority communities
    - Inclusion health groups (people experiencing homelessness, people experiencing drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the criminal justice system, victims of modern slavery and other socially excluded / multiply disadvantaged groups)
    - People with learning disabilities and / or autism
    - Coastal communities with pockets of deprivation hidden amongst relative affluence
    - People with multi-morbidities
    - Protected characteristic groups (age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation)

5:

- Maternity - ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from deprived groups
- Severe Mental Illness (SMI) - ensuring annual health checks for 60% of those living with SMI
- Chronic respiratory disease - a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions as a result of these
- Early cancer diagnosis - 75% of cases diagnosed at stage 1 or 2 by 2028

[88] Left Behind? Understanding communities on the edge. Local Trust, 05/09/2019

- Hypertension case finding and optimal management and lipid optimal management - to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction (heart attack) and stroke



6. Long-term conditions

6.1 Prevalence and modelled prevalence of 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 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). [89]

[89] Ipsos MORI for Portsmouth City Council. Health and Lifestyle Survey, 2015 via Portsmouth JSNA.

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).

6.2 Hypertension

In 2020/21[90], hypertension is the most common condition on GP registers with 27,634 patients or 12.0% of registered patients of all ages, on hypertension registers. The range at practice level was from 15.9% at North Harbour Medical Group to 10.8% at Lake Road Practice (excluding Guildhall Walk and the University Practice prevalence rates). Portsmouth CCG recorded prevalence is lower than the prevalence figures for England (13.9%)[91]. However, Portsmouth's recorded prevalence 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 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) [92] - roughly 30,200 Portsmouth residents aged 16 years and over expected to be diagnosed with hypertension and there may be roughly, a further 19,100 residents aged 16+ years undiagnosed with hypertension (by applying the 2015 prevalence estimates to the ONS mid-2020 population aged 16+ years estimate).

6.3 Diabetes

In 2020/21, 12,851 people aged 17+ years (6.8% 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 (7.1%). Portsmouth's recorded prevalence of diabetes has increased annually from 4.9% in 2010/11. The range at practice level in 2020/21 was from 8.9% at Portsdown Group Practice to 5.7% at Trafalgar Medical Group Practice (excluding Guildhall Walk and the University Practice prevalence rates)[93]. However, due to the impact of Covid-19 pandemic on activity in general practice in 2020/21, the data may not be inaccurate and therefore comparisons with previous years may be misleading.[94]

It is unclear if the annual increasing recorded prevalence of diabetes on GP registers is due to increased diabetes prevalence in the Portsmouth population and/or due to improved identification of diabetic patients by GP practices leading to previously undiagnosed patients being recorded on registers. The gap between modelled prevalence estimates and recorded diabetes estimates has reduced. The modelled prevalence suggests that there may be roughly 1,200 Portsmouth CCG registered patients undiagnosed/ not on the diabetes register, compared to 3,000 in 2015.

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[90] Due to the impact of Covid-19 pandemic on activity in general practice in 2020/21, the data may not be inaccurate and therefore comparisons with previous years may be misleading. Quality and Outcomes Framework (QOF), NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2020-21 / Accessed 3 Mar 2022

[91] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 3/3/2022.

[92] 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]

[93] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 3/3/2022.

[94] Quality and Outcomes Framework (QOF), NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2020-21 / Accessed 3 Mar 2022

Modelled diabetes prevalence (based on 2012-14 national survey data) for Portsmouth residents aged 16 years and over was 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[95]. 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):

Scenario: the 2015 level of obesity *increases by 5%* every 5 years –it is estimated there would be 14,600 (8.0%) Portsmouth residents aged 16+ years with diabetes in 2025. This represents an additional 600 people with diabetes compared to if obesity levels remained at the same level as 2015. 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 (5% every 5 years). 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 13,400 (7.4%) Portsmouth residents aged 16+ years with diabetes in 2025. This represents 600 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. [96]

Non-diabetic hyperglycaemia (NDH), 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. [97] In 2020/21, 10,364 people aged 18+ years (5.6% of people aged 18+ years registered with Portsmouth City GP Practices) are on GP registers with NDH - higher than England (5.3%). The range at GP practice level in 2020/21 was from 9.4% at Portsdown Group Practice to 2.9% at The Drayton Surgery (excluding Guildhall Walk and the University Practice prevalence rates). However, due to the impact of Covid-19 pandemic on activity in general practice in 2020/21, the data may not be inaccurate as accuracy of the data depends on clinical case finding and coding by GP practices. [98]

Between 2011/12 and 2018/19, emergency hospital admissions for diabetes (where Insulin-dependent diabetes mellitus is the primary diagnosis) for Portsmouth children and young people aged under 19 years, had been a similar rate compared to England where nationally admissions had been decreasing each year. However, in 2019/20, emergency hospital admissions for diabetes for

[95] Diabetes prevalence model for local authorities and CCGs. PHE. https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations Accessed 03 March 2022

[96] Diabetes prevalence model for local authorities and CCGs. PHE. https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations Accessed 03 March 2022

[97] 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].

[98] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 4/3/2022.

Portsmouth aged under 19 years increased (as did England) but the Portsmouth rate was significantly worse than England for the first time since 2010/11.

6.4 Coronary heart disease

In 2020/21[99], there were 6,110 patients on the coronary heart disease (CHD) register (2.7% of registered patients of all ages compared with 3.0% in England). The range at GP practice level was from 3.5% of registered patients of all ages at The Drayton Surgery to 2.5% at the Derby Road practice (excluding Guildhall Walk Healthcare Centre and the University Practice). [100]

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[101] —roughly 3,400 people in 2015 (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 4,000 people aged 55-79 years by 2025 (applying the prevalence rate to the ONS 2018-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). [102]

In 2020, for Portsmouth males, the leading cause of death remained as coronary heart disease (also known as ischaemic heart disease) (101 deaths; 11% of all male deaths). For Portsmouth males aged 50-64 years, Ischaemic heart diseases was the leading cause of death each year from 2014 to 2020, except in 2015 where Malignant neoplasm of trachea, bronchus and lung was the leading cause. When looking at five-year age groups over six-year periods, the leading cause of death for Portsmouth males in each five-year age group from 45-49 years and over in 2002-07 and 2008-13 was Ischaemic heart diseases; in the most recent period in 2014-19, Ischaemic heart diseases remained a leading cause of death especially aged 50-84 years. [103]

For Portsmouth females, Ischaemic heart diseases was ranked third out of the leading causes of death in 2020, but was ranked second in the previous three years. [104]

In 2017-19, Portsmouth's female premature mortality (aged under 75 years) from coronary heart disease rate was significantly higher than England. In 2017/19, Portsmouth's male premature

[99] Due to the impact of Covid-19 pandemic on activity in general practice in 2020/21, the data may not be inaccurate and therefore comparisons with previous years may be misleading. Quality and Outcomes Framework (QOF), NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2020-21 / Accessed 3 Mar 2022

[100] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 4/3/2022.

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

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

[103] Civil Registration Data via Primary Care Mortality Database (PCMD), Copyright ©2021, re-used with the permission of HSCIC. All rights reserved. Accessed via JSNA Portsmouth www.jsna.portsmouth.gov.uk

[104] Civil Registration Data via Primary Care Mortality Database (PCMD), Copyright ©2021, re-used with the permission of HSCIC. All rights reserved. Accessed via JSNA Portsmouth www.jsna.portsmouth.gov.uk

mortality (aged under 75 years) from coronary heart disease rate was higher, but not significantly, than England males. [105]

6.5 Chronic obstructive pulmonary disease

In 2020/21, there were 4,490 registered patients of all ages recorded with COPD on GP practice registers (2.2% of all registered patients compared to 1.9% nationally). The range at GP practice level was from 3.3% of registered patients at North Harbour Medical Group to 1.8% at Trafalgar Medical Group Practice (excluding Guildhall Walk Healthcare Centre and University practice)[106]. Portsmouth's recorded prevalence of COPD is increasing (1.6% in 2010/11; 2.0% in 2015/16). However, due to the impact of Covid-19 pandemic on activity in general practice in 2020/21, the data may not be inaccurate and therefore comparisons with previous years may be misleading.[107]

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 Portsmouth residents of all ages[108] - 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. 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[109]. Portsmouth's modelled prevalence is 0.4 percentage points higher than the England estimate, which would give a rough estimate of 13,900 people (applying the prevalence rate to the ONS 2018-based subnational population estimates) estimated to have COPD. Estimating future prevalence might also be affected by an ageing population, smoking prevalence and deprivation.

Since 2015/16, emergency hospital admissions for COPD (where COPD is the primary diagnosis) for Portsmouth CCG registered patients of all ages has been significantly higher than England. In 2020/21, emergency admissions for COPD, all ages, decreased significantly for Portsmouth and England[110], which may be due to the impact of the Covid-19 pandemic.

In 2020, chronic lower respiratory disease (which includes COPD) was the third most frequent broad cause of death for Portsmouth males of all ages (72 deaths, 8% of all deaths) and fifth most frequent cause of death for Portsmouth females of all ages (45 deaths, 5% of all deaths). In 2020 (and 2016 and 2018), Chronic lower respiratory diseases was the leading cause of death for Portsmouth males aged 75-84 years. In 2017 and 2018, Chronic lower respiratory diseases was the leading cause of death for

[105] Public Health England. Public Health Profiles. Date accessed 4/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021' via JSNA Portsmouth www.jsna.portsmouth.gov.uk
[106] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 4/3/2022.
[107] Quality and Outcomes Framework (QOF), NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2020-21 / Accessed 3 Mar 2022
[108] Disease and risk factor prevalence, Public Health England https://fingertips.phe.org.uk/profile/prevalence [Accessed 04 August 2017]
[109] 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]
[110] Inhale - INteractive Health Atlas of Lung conditions in England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 4/3/2022.

Portsmouth females aged 65-74 years (15% of all female deaths aged 65-74 years in 2017 and 13% in 2018). [111]

In 2017-19, the Portsmouth mortality rate from chronic obstructive pulmonary disease (COPD) remained similar to the previous period and was significantly higher than England and the South East, but similar to Southampton.[112] The mortality rate from COPD for Portsmouth males, in particular, is amongst the highest in the country although the Portsmouth female rate is also significantly higher than England.[113]

6.6 Asthma

In 2020/21, there were 14,621 registered patients of aged 6 years and over (6.8% of all registered patients aged 6 years and over) on GP Practice asthma registers. The national prevalence was 6.4% aged 6 years and over. Previously, Asthma recorded prevalence on GP registers included all ages so are not comparable. The range at GP practice level in 2020/21 was from 9.5% of registered patients aged 6 years and over at Sunnyside Medical Centre to 6.1% at Craneswater Group Practice (excluding Guildhall Walk Healthcare Centre and University practice) [114]

The 2010 Health Survey for England indicated 9.5% of adults and children reported having asthma. Most of the care for people with asthma is provided in primary care. NICE guidelines for the management of asthma state that people with asthma should not need emergency treatment if appropriate routine care is given. Between 2017/18 and 2019/20, emergency hospital admissions for asthma (where asthma is the primary diagnosis) for Portsmouth CCG registered patients, aged 19 years and over, was significantly lower than England. In 2020/21, emergency admissions for asthma in adults decreased significantly for Portsmouth and England[115], which may be due to the impact of the Covid-19 pandemic.

Since 2015/16, hospital admissions for asthma (where asthma is the primary diagnosis) for Portsmouth residents, aged under 19 years, was lower than England and significantly lower than England in 2016/17. In 2019/20 hospital admissions for asthma or Portsmouth residents, aged under 19 years was significantly lower than England. However, 2019/20 and especially 2020/21, emergency admissions for asthma, aged under 19 years, decreased significantly for Portsmouth and England[116], which may be due to the impact of the Covid-19 pandemic.

6.7 Stroke

In 2020/21, there were 3,583 patients on the Stroke or Transient Ischaemic Attacks registers in primary care (1.6% of registered patients of all ages compared with 1.8% in England). The range at GP

[111] Civil Registration Data via Primary Care Mortality Database (PCMD), Copyright ©2021, re-used with the permission of HSCIC. All rights reserved. Accessed via JSNA Portsmouth www.jsna.portsmouth.gov.uk
[112] Local Tobacco Control Profiles. Public Health Profiles. Date accessed 8/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021' via JSNA Portsmouth www.jsna.portsmouth.gov.uk
[113] Mortality Profiles. Public Health Profiles. Date accessed 9/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021' via JSNA Portsmouth www.jsna.portsmouth.gov.uk
[114] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 4/3/2022.
[115] Inhale - INteractive Health Atlas of Lung conditions in England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 4/3/2022.
[116] Inhale - INteractive Health Atlas of Lung conditions in England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 4/3/2022.

practice level was from 2.1% at Craneswater Group Practice to 1.4% at North Harbour Medical Group and Derby Road Practice (excluding Guildhall Walk and the University Practice prevalence rates). [117]

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[118] — roughly 1,600 people aged 55-79 years in 2015 (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 2018-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).[119]

Atrial fibrillation (AF) is a heart condition and is the most common form of cardiac arrhythmia. AF is associated with increased risk of stroke as well as reduced cardiac performance and early mortality. Stroke patients with uncontrolled AF are more likely to be diagnosed with severe stroke which can lead to poorer outcomes. AF is often asymptomatic, frequently unrecognised and consequently it is difficult to quantify the true prevalence in the general population. In 2020/21, there were 4,206 patients on the atrial fibrillation registers in primary care (1.8% of registered patients of all ages compared with 2.0 % in England). The range at GP practice level was from 2.6% at Craneswater Group Practice to 1.7% at Sunnyside Medical Centre, Lake Road Practice and Derby Road Practice (excluding Guildhall Walk and the University Practice prevalence rates). In 2019, the estimated prevalence of AF was 2.1% for Portsmouth, which suggests that, given a recorded prevalence of AF on GP registers of 1.7% in 2018/19, there could have been roughly 800 undiagnosed patients at that time. Assuming that the estimated prevalence of AF remains at the same rate as in 2019 at 2.1%, then there could be a further 600 undiagnosed patients in 2020/21. [120]

In 2020/21, hospital admissions for stroke (where stroke is the primary diagnosis) for Portsmouth residents of all ages was higher, but not significantly, than England. The Portsmouth rate has remained similar since 2015/16 [121]. Behavioural risk factors play a large part in the prevention of stroke with smoking, excessive alcohol use and an unhealthy diet being major risk factors. Emergency admissions are used as a proxy for the incidence of stroke and an indication of where public health interventions may be targeted for prevention of the condition - in 2015/16-2019/20 (5 years pooled), the emergency hospital admissions for stroke rate for Portsmouth persons of all ages was significantly higher than England. [122]

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[117] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 7/3/2022.
[118] Disease and risk factor prevalence, Public Health England https://fingertips.phe.org.uk/profile/prevalence [Accessed 04 August 2017]
[119] Stroke prevalence model technical document, Disease and risk factor prevalence, Public Health England https://fingertips.phe.org.uk/profile/prevalence [Accessed 04 August 2017]
[120] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 7/3/2022.
[121] Cardiovascular disease, Diabetes and Kidney Disease profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 7/3/2022.
[122] Local health profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 7/3/2022.

In 2020, Cerebrovascular diseases (which includes stroke) was the sixth most frequent broad cause of death for Portsmouth males of all ages (40 deaths, 4% of all deaths) and fourth most frequent cause of death for Portsmouth females of all ages (46 deaths, 6% of all deaths). In 2017-19, cerebrovascular diseases was third leading cause of death for Portsmouth males aged 50-64 years and fourth leading cause of death for Portsmouth males aged 65-74 years. In 2016, cerebrovascular diseases was the leading cause of death for Portsmouth females aged 75-84 years (12% of all female deaths aged 75-84 years). [123]

In 2017-19, the premature mortality (aged under 75 years) rate from stroke for Portsmouth males was significantly higher than England and the South East region; and higher, but not significantly than Southampton. The premature mortality rate from stroke for Portsmouth females remained similar compared to England, the South East and Southampton.[124]

6.8 Skin cancer

In 2017-19, Portsmouth's incidence of malignant melanoma of skin was 38.1 registrations per 100,000 persons of all ages (age-standardised rate) (n=196 registered tumours); and there was no significant difference between males and females for Portsmouth CCG. The 2017-19 Portsmouth incidence rate was significantly higher than the rate for England. [125]

6.9 Dementia

In May 2021, in Portsmouth there were 1,370 patients aged 65 and over, on the dementia register (4.1% of registered patients aged 65 years and over compared with 3.9% in England). The range at Practice level was from 4.8% of patients registered with Craneswater Group practice to 2.8% at North Harbour Medical Group (excluding Guildhall Walk Healthcare Centre and the University Practice)[126]. 97% of all dementia registrations are people aged 65 and over. In December 2020, there were 46 Portsmouth patients aged under 65 years on the dementia register (2.33 per 10,000 compared to 3.05 per 10,000 in England). [127]

Portsmouth's prevalence of dementia aged 65 years and over has not changed significantly between years (4.7% in May 2017; 4.6% in May 2018; 4.5% in May 2019 and 4.2% in May 2020). However, NHS Digital has noted that from 2020 data onwards COVID-19 has led to unprecedented changes in the work and behaviour of General Practices and as a result this data will be impacted.

In 2018/19, Portsmouth's crude rate of newly diagnosed dementia registrations is 10.4 per 1,000 patients registered aged 65+ years (342 patients newly diagnosed with dementia), similar to the England rate (11.4 per 1,000 patients registered aged 65+ years). [128]

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[123] Civil Registration Data via Primary Care Mortality Database (PCMD), Copyright ©2021, re-used with the permission of HSCIC. All rights reserved. Accessed via JSNA Portsmouth www.jsna.portsmouth.gov.uk
[124] Mortality Profiles. Public Health Profiles. Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 7/3/2022.
[125] CancerData, National Cancer Registration and Analysis Service (NCRAS) and NHS England. https://www.cancerdata.nhs.uk [accessed 2 Mar 2022].
[126] Recorded dementia diagnosis summaries https://digital.nhs.uk/data-and-information/publications/statistical/recorded-dementia-diagnoses Accessed June 2021.
[127] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.
[128] Dementia Profile, Public Health England. https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia Accessed 1 June 2021 via Portsmouth JSNA

Modelled prevalence suggests that in 2022, it is estimated that approximately 2,260 people[129] aged 65+ years have dementia in Portsmouth. With an ageing population, by 2025 and 2035 the number of people aged 65+ years with dementia is predicted to increase by 7% (about an additional 150 people (2,390 in total)) and 32% (approximately an additional 720 people (2,960 in total)), respectively.[130]

There are about 770 fewer people on GP dementia registers than is predicted by 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. The Portsmouth estimated diagnosis rate[131] in 2020 was 68.0%, which is similar to the national benchmark (66.7%) and similar to the England and Southampton rates (67.4% and 66.8% respectively).[132] However, comparing the May 2021 recorded prevalence to the dementia prevalence estimates[133] used by the Projecting Older People Population Information System (POPPI) indicates there are about 980 fewer people on GP dementia registers. [134]

The leading cause death[135] for Portsmouth residents in 2020 (and since 2015 (Figure 10) for persons of all ages was Dementia and Alzheimer's disease (213 deaths; 12% of all deaths). For Portsmouth females, the leading cause of death in 2020 remained as Dementia and Alzheimer's disease (142 deaths; 17% of all female deaths). For Portsmouth males, Dementia and Alzheimer's disease was the fourth leading cause of death (71 deaths; 8% of all male deaths). The leading cause of death is usually age and gender dependent; for both males and females in Portsmouth, Dementia and Alzheimer's disease was the leading cause of death in aged 85 and over each year from 2014 to 2020. Dementia and Alzheimer's disease was also the leading cause of death for females aged 75-84 years, each year from 2014 to 2020, except in 2016 where Cerebrovascular diseases (stroke) was the leading cause of death. For females in 2014-19 (6 years pooled), in each five-year age group from 80-84 to 85-89 years as well as those aged 90 years and over, Dementia and Alzheimer's disease was the leading cause of death - for males in 2014-19, Dementia and Alzheimer's disease was also the leading cause of death in aged 85-89 years as well as those aged 90 years and over. [136]

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[129] 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.

[130] Projecting Older People Population Information System. www.POPPI.org.uk accessed June 2021 via Portsmouth JSNA

[131] The rate of persons aged 65 and over with a recorded diagnosis of dementia per person estimated to have dementia given the characteristics of the population and the age and sex specific prevalence rates of the Cognitive Function and Ageing Study II, expressed as a percentage with 95% confidence intervals. Significance is determined by the non-overlapping of confidence intervals with the 66.7% benchmark.

[132] Dementia Profile, Public Health England. https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia Accessed June 2021 via Portsmouth JSNA

[133] Recorded dementia diagnosis summaries https://digital.nhs.uk/data-and-information/publications/statistical/recorded-dementia-diagnoses Accessed June 2021. via Portsmouth JSNA

[134] Projecting Older People Population Information System. www.POPPI.org.uk accessed June 2021

[135] The cause of death groups used are based on a list developed by the World Health Organization (WHO), modified for use in England and Wales by ONS - the list used is based on ONS revised 2016 list. It was modified in 2016 for use on 2015 mortality data. Minor changes were made in 2017 to ensure mutual exclusivity between groupings. This involved the removal of meningitis and meningococcal diseases (A39), sepsis due to haemophilus influenzae (A41.3), rabies (A82), certain mosquito-borne diseases (A83) and yellow fever (A95) from the vaccine preventable diseases grouping.

COVID-19 is a new novel disease since March 2020, therefore has been added as an addition to the 2016 list.

[136] Civil Registration Data via Primary Care Mortality Database (PCMD), Copyright ©2021, re-used with the permission of HSCIC. All rights reserved. Accessed via JSNA Portsmouth www.jsna.portsmouth.gov.uk

In 2019, the dementia (directly age-standardised) mortality rate aged 65 and over in Portsmouth was 1,026 per 100,000 population, which was significantly higher than England and similar to Southampton (849 and 927 per 100,000 population, respectively). [137]

6.10 Mental health

6.10.1 Common mental health disorders

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. [138]

The APMS 2014 found prevalence of common mental health disorders is higher in females compared to males aged 16 years and over nationally - 20.7% of females compared to 13.2% of males. [139] Using the national prevalence rates identified in the APMS 2014 and apply to Portsmouth's population aged 16-64 years, then about 27,600 Portsmouth residents aged 16-64 years are predicted to be affected by common mental disorders in 2022; increasing to 27,700 by 2025 (assuming the prevalence rate remains the same)[140] [141]. However, Public Health England provided modelled estimates for CMD (based on APMS 2014) taking into account of local population differences in age structure, sex and deprivation to allow for comparisons with statistical neighbours: in 2017, the estimated prevalence of CMD aged 16 years and over for Portsmouth was 18.5% (approximately 32,330 people), which is higher than England (16.9%) and similar to Southampton (18.7%). Also, the estimated prevalence of CMD aged 65 years and over for Portsmouth was 11.4% (approximately 3,410 people), which is higher than England (10.2%) and similar to Southampton (11.5%).[142]

In 2020/21 22,829 people aged 18+ years (12.3%) were recorded by Portsmouth CCG GPs as having depression which is similar to the prevalence for England (12.3%). The range at GP practice level in Portsmouth was from 18.6% (Portsdown Group Practice) to 5.3% (University Surgery). There were 1,944 new cases of depression in 2020/21— 1.0% of the GP practice register aged 18+ years in

[137] Dementia profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 22/2/2022.
[138] 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.
[139] NHS Digital. Adult Psychiatric Morbidity Survey, 2014 (Table 2)
[140] NHS Digital. Adult Psychiatric Morbidity Survey, 2014 (Table 2) and ONS 2018 sub-national populations projections
[141] 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.
[142] Public Health England. Common Mental Health Disorders profile. Common Mental Health Disorders - PHE Accessed 25 June 2021

Portsmouth and this is significantly lower than the England incidence rate (1.4%)[143]. However, due to the impact of Covid-19 pandemic on activity in general practice in 2020/21, the data may not be inaccurate and therefore comparisons with previous years may be misleading.[144]

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)[145]. This also correlates closely to the 2015/16 estimated prevalence of depression and anxiety from the self-reported GP patient survey (GPPS) (15.3% of NHS Portsmouth patients aged 18+ years), although this increased to 16.3% of NHS Portsmouth patients aged 18+ years in 2016/17 (the latest year the question was included)[146] - using the 16.3% estimated prevalence from GPPS, then approximately 28,250 residents aged 18 years and over would be expected to have depression in 2022 (applying the prevalence rate to the ONS 2018-based subnational population estimates). Assuming the depression prevalence remains the same in future years, then roughly 28,600 people by 2025 (again, applying the prevalence rate to the ONS 2018-based subnational population estimates). However, depression prevalence is also can be impacted on from 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. [147]

In 2021, 12.9% of Portsmouth CCG registered patients aged 16+ years reported having a long-term mental health problem (from the self-reported GP patient survey (GPPS)) which is higher than the prevalence in England (11%)[148]. Using the 12.9% estimated prevalence from GPPS, then approximately 23,000 Portsmouth residents aged 16 years and over would be expected to have a long-term mental health problem in 2022 (applying the prevalence rate to the ONS 2018-based subnational population estimates).

6.10.2 Serious Mental Illness

In 2020/21 2,142 people of all ages (0.93%) were recorded by Portsmouth CCG GPs as having schizophrenia, bipolar affective disorder and other psychoses which is similar to the prevalence for England (0.95%). The range at GP practice level in Portsmouth was from 1.41% (Trafalgar Medical Group Practice) to 0.27% (University Surgery)[149]. Using the national prevalence from the Adult Psychiatric Morbidity Survey (APMS) 2014 (by assuming no change in prevalence and applying it to the projected Portsmouth population), it is estimated that in 2022, 880 adults aged 16-64 years had a psychotic disorder in the past year (unless prevalence was to change then this estimate is expected to

[143] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.
[144] Quality and Outcomes Framework (QOF), NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2020-21 / Accessed 3 Mar 2022
[145] 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]
[146] Mental Health and Wellbeing JSNA, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022 . Date accessed 8/3/2022.
[147] 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]
[148] Mental Health and Wellbeing JSNA, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.
[149] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.

be similar up to 2030). However, psychotic disorders in the past year are expected to be an underestimate, so using the APMS 2014 probable psychotic disorders national prevalence, then there could be a further 300 (up to 1200) Portsmouth adults aged 16-64 years with a psychotic disorder.[150] [151]

Self-harm is an expression of personal distress and there are varied reasons for a person to harm themselves irrespective of the purpose of the act. There is a significant and persistent risk of future suicide following an episode of self-harm. Hospital admissions can be used as a proxy of self-harm incidence, but hospital admissions are a very small proportion of incidents of self-harm and the identification and coding of intent may be subject to recording bias. In 2020/21, the emergency hospital admissions rate for intentional self-harm for Portsmouth residents of all ages was significantly higher than England and the South East region. The 2020/21 intentional self-harm emergency admission rate for Portsmouth was significantly lower than the previous two years (2019/20 and 2018/19).[152]

Suicide is a significant cause of death in young adults, and is seen as an indicator of underlying rates of mental ill-health. Suicide is a major issue for society and a leading cause of years of life lost. Suicide is often the end point of a complex history of risk factors and distressing events, but there are many ways in which services, communities, individuals and society as a whole can help to prevent suicides. In 2018-20, Portsmouth's suicide and mortality from injury of undetermined intent directly age standardised rate (DSR) aged 10 years and over (10.3 per 100,000 population) was similar to England (10.4 per 100,000 persons aged 10+ years) and the South East region (10.1 per 100,000 persons aged 10+ years). [153]

6.10.3 Children's Mental Health

Between 2017 and 2021, nationally, the percentage of children aged 6-16 year-olds with a probable mental health disorder increased from 11.6% to 17.4%; and a similar increase was seen in young adults aged 17-19 years (10.1% with a probable mental health disorder in 2017 to 17.4% in 2021. The prevalence for both age groups was similar between 2020 and 2021. The 2020 and 2021 surveys were follow-up surveys to the Mental Health of Children and Young People (MHCYP) in 2017 to assess the impact of the COVID-19 pandemic, although comparisons between years may have been affected by the survey design (face-to-face in 2017 to online surveys for the follow-ups[154]. Applying these national prevalence rates to Portsmouth's population (using ONS mid-year estimates[155]) then it is estimated that in 2017 there were roughly 3,050 children aged 6-16 years with a probable mental disorder, rising to 4,500 in 2021. In 2017, there was an estimated 1,000 young people aged 17-19 years in Portsmouth with a probable mental disorder increasing to 1,700 in 2021.

[150] NHS Digital. Adult Psychiatric Morbidity Survey, 2014 (Table 5) ONS 2018 sub-national populations projections

[151] 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.

[152] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.

[153] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.

[154] Mental Health of Children and Young People in England 2021 - wave 2 follow up to the 2017 survey https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2021-follow-up-to-the-2017-survey Accessed 14 Mar 2022

[155] 2017 estimate using ONS mid-2017 estimated Portsmouth population aged 6-16 years and 17-19 years. The 2021 estimate using ONS mid-2020 estimated Portsmouth population aged 6-16 years and 17-19 years

6.10.4 Student Mental health

Nationally, 2% of first year undergraduate students disclosed a mental health condition to their educational institution in 2015/16. In a local survey of Portsmouth University students in 2018, 72% of respondents reported mental ill-health (which included depression, worry, anxiety or stress in the measure) in the past year but this was from a small sample (47 out of 65 respondents)). Of these 47, 16 (34%) respondents also reported that they had not accessed any support. It is not known what type of mental health and wellbeing problem was being experienced by these individuals. [156]

7 Risk factors and behaviours

7.10 Smoking

Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix. Smoking is a modifiable behavioural risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population. [157]

In 2020, based on the national Annual Population Survey (APS)[158] (which is designated as a National statistic), it is estimated that 14.3% of Portsmouth adults (aged 18+ years) are current smokers - higher, but not significantly than the estimated prevalence for England and the South East region[159]. The 2020 prevalence estimate is based on a new telephone survey design, whereas previously was conducted as a face-to-face interview; this means that the 2020 prevalence estimate cannot be compared to the previous years because ONS found that selection bias would have impacted the final prevalence estimates. [160]

The smoking prevalence (from APS) in Portsmouth had estimated to have generally decreased from 2011-2019 and each of the 2017-2019 single year estimates were significantly lower than each of the 2011-2013 single year estimates. The Portsmouth smoking prevalence estimate was 16.4% of adults in 2019 compared to 22.0% in 2013 (Figure 12). [161]

[156] Portsmouth JSNA: https://www.portsmouth.gov.uk/wp-content/uploads/2020/04/portsmouth-student-health-needs-assessment-2018.pdf Date accessed 18/2/2022.
[157] Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.
[158] From 2016, the APS survey question was 1) Have you ever smoked cigarettes regularly? (yes/no) 2) And do you smoke cigarettes at all nowadays? (yes/no)
[159] Data for 2020 is based on Q2-Q4 survey collection only due to the impact of the COVID-19 pandemic. As such, the confidence limits are wider than observed for a typical year of the APS which has resulted in fewer local areas being statistically significantly higher or lower than the England average. (Source: Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.)
[160] C18 - Smoking Prevalence in adults (18+) - current smokers (APS) (2020 definition), Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.
[161] C18 - Smoking Prevalence in adults (18+) - current smokers (APS), Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.

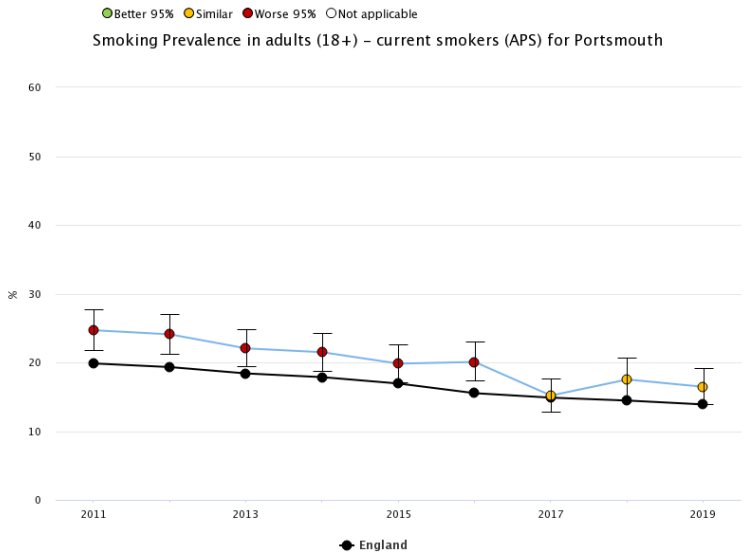

Figure 12. Smoking prevalence in adults (aged 18+ years) - current smokers (APS survey), Portsmouth and England, 2011-2019

An alternative smoking prevalence estimate for Portsmouth is from the GP patient survey (GPPS), which is an online or paper questionnaire and therefore a different research methodology; the smoking questions[162] are also different to the APS, therefore the GPPS estimate offer an alternative view. The latest 2019/20 GPPS estimate 18.1% of Portsmouth adults aged 18 years and over are current smokers, which is significantly higher than the England average (14.3%). The 2019/20 Portsmouth GPPS smoking prevalence estimate is also higher, but not significantly, than the previous two years (16.4% in 2018/19 and 17.5% in 2017/18). [163]

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).[164]

Smoking prevalence also has a strong association nationally with deprivation, socio-economic classification, age, gender, sexuality, housing tenure, health status, ethnic groups, country of birth, religion and mental health. In 2020, the APS smoking prevalence estimate amongst Portsmouth adults (aged 18-64 years) in 'routine and manual occupations' (a national statistics socio-economic classification) was 27.2%, which is higher, but not significantly, than the prevalence in this group in England (21.4%), the South East (20.1%) and Southampton (22.2%). In 2019/20, the GPPS smoking prevalence estimate amongst Portsmouth adults (aged 18+ years) with a long term mental health condition was 36.8%, which is significantly higher, than adults with a long term mental health condition in England (25.8%), the South East region (24.9%) and Southampton (21.0%). In 2019/20,

[162] The number of people who responded either "regular smoker" or "occasional smoker" to the question "Which of the following best describes your smoking habits?"
[163] Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.
[164] Ipsos MORI for Portsmouth City Council. Health and Lifestyle Survey, 2015.

the GPPS smoking prevalence estimate amongst Portsmouth adults (aged 18+ years) with a long-term mental health condition was 36.8%, which is significantly higher than adults with a long term mental health condition in England (25.8%), the South East region (24.9%) and Southampton (21.0%).[165]

Smoking during pregnancy causes premature births, miscarriage and perinatal deaths. It also increases the risk of stillbirth, complications in pregnancy, low birthweight, and of the child developing other conditions in later life. In 2018/19, the percentage of Portsmouth women smoking at time of booking an appointment with a midwife was 13.5% - similar to Southampton (13.8%) but significantly higher than the South East region (11.3%) and higher, but not significantly than England (12.8%). In the same year, the percentage of Portsmouth women smoking at time of delivery (SATOD) was 13.0% (albeit a different data source to the smoking at booking estimate in 2018/19). In 2020/21, the percentage of Portsmouth women smoking at time of delivery (SATOD) was 12.1%, which was a decrease on the previous two years - the 2020/21, Portsmouth's percentage SATOD of 12.1% remained significantly higher than England (9.6%) and the South East region; and higher, but not significantly than Southampton (10.7%).[166]

Admissions to hospital due to smoking related conditions not only represent a large demand on NHS resources, but can also be used as a proxy for variations in smoking related ill health in the general population across England. High smoking attributable admission rates are indicative of poor population health and high smoking prevalence; however, smoking attributable admissions are based on the primary diagnosis of the admission episode and subsequent episodes which relate to smoking but where the admission episode is not related to smoking are not included, therefore this is likely to be an underestimate of smoking related admissions. In 2019/20, the rate of smoking attributable hospital admissions for Portsmouth residents (aged 35+ years) remained similar since 2016/17. The Portsmouth smoking attributable admission rate in 2019/20 was higher (but not significantly) than England and significantly higher than the South East region; but the Portsmouth rate was significantly lower than Southampton. COPD is a serious lung disease for which smoking is the biggest preventable risk factor - the rate of emergency hospital admissions for COPD for Portsmouth residents aged 35 years and over has remained similar since 2014/15 (up to 2019/20). The Portsmouth COPD emergency hospital admission rate (aged 35+ years) in 2019/20 was significantly higher than England and the South East region; but the Portsmouth rate was significantly lower than Southampton. [167]

Lung cancer registration and oral cancer registration are both a direct measure of smoking-related harm. Given the high proportion of lung cancer registrations and oral cancer registrations are due to smoking, a reduction in the prevalence of smoking would reduce the incidence of both lung cancer and oral cancer. The lung cancer registration rate for Portsmouth residents (all ages) has remained similar since 2007/09 (up to 2016-18). The Portsmouth lung cancer registration rate in 2016/18 was significantly higher than England and the South East region; but the Portsmouth rate was lower, but not significantly, than Southampton. The oral cancer registration rate for Portsmouth residents (all ages) has remained statistically similar since 2007/09 (up to 2016-18); but in 2016-18, the rate was the highest since 2007/09 and was for the first time significantly higher than the England rate. The

[165] Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.
[166] Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.
[167] Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.

Portsmouth oral cancer registration rate in 2016/18 was also significantly higher than the South East region; but the Portsmouth rate was higher, but not significantly, than Southampton.[168]

Smoking remains the biggest single cause of preventable mortality and morbidity in the world[169]. It still accounts for 1 in 6 of all deaths in England, and there exist huge inequalities in smoking related deaths: areas with the highest death rates from smoking are about three times as high than areas with the lowest death rates attributable to smoking. In 2017-19, Portsmouth had a significantly higher rate of smoking-attributable deaths in persons aged 35+ years compared to England and the South East region; but a similar rate to Southampton. The Portsmouth rate has remained similar since 2014-16. Also, compared to England, Portsmouth had significantly higher rates of deaths from lung cancer (2017-19) and deaths from chronic obstructive pulmonary disease (2017-19). [170]

7.11 Alcohol

Alcohol-related harm is determined by the volume of alcohol consumed and the frequency of drinking occasions. As such, the risk of harm is directly related to levels and patterns of consumption. Drinking very large amounts of alcohol on a single occasion increases the likelihood of experiencing acute alcohol-related harms. [171]

Alcohol use is the biggest risk factor in Portsmouth adults aged 15-49 years from 2017-2019, in terms of Years Lived with Disability (YLD) per 100,000 (695 YLD per 100,000 in 2019). In 2009, Drug use was the biggest risk factor, with Alcohol use (610 YLD per 100,000 in 2009) ranked second in Portsmouth. Alcohol use is the second biggest risk factor in 2019 in England (646 YLD per 100,000). [172]

The local Health and Lifestyle Survey from 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

[168] Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.
[169] World Health Organization Report on the Global Tobacco Epidemic 2009 http://www.who.int/tobacco/mpower/2009/en/index.html via Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.
[170] Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.
[171] Local Alcohol Profiles for England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 22/2/2022.
[172] GBD compare, Global Burden of Disease: https://vizhub.healthdata.org/gbd-compare/ . Date accessed 22/2/2022.

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. [173]

Data from the Health Survey for England allows for comparisons to be made with statistical neighbours and in 2015-2018, Portsmouth had a higher percentage of adults (aged 18 years and over) binge drinking on the heaviest day in the last week (16.7%) compared to England (15.4%), the South East (14.9%) and Southampton (14.5%), 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 2015-2018, Portsmouth had a lower (but not significantly) percentage drinking more than 14 units of alcohol a week (19.3%) than England (22.8%), the South East region (22.9%) and Southampton (20.6%).[174]

Alcohol-related hospital admissions are used as a way of understanding the impact of alcohol on the health of a population. There are two measures used to assess this burden: the Broad and the Narrow measure. 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 2019/20 and 2020/21 (both years included due to the impact of Covid-19 on hospital activity in 2020/21, in particular) for Portsmouth males and females were significantly higher than the rate for England. The narrow measure (better than the broad measure for measuring alcohol harm that is less sensitive to the changes that have occurred in coding over the years) of the directly aged-standardised rate (DSR) of alcohol-related hospital admissions of all ages in 2020/21 for Portsmouth males was significantly higher than the rate for England, but the Portsmouth rate decreased compared to 2019/20 (although the rate of decrease was not as great as England) - however, the 2020/21 rate may have been impacted on due to the impact of Covid-19 on hospital activity in 2020/21. Both the Portsmouth and England rates for males had been increasing up to 2019/20 (Figure 13). A similar trend can be seen for Portsmouth females for the narrow alcohol-related hospital admissions, where the Portsmouth rate was slowly increasing (although the rate was highest in 2018/19) then decreased in 2020/21; but unlike Portsmouth males, the female rate remained similar to the England rate (Figure 14) .

When it comes to hospital admissions wholly attributable to alcohol, the alcohol-specific admission rate for Portsmouth males and females had been increasing since 2018/19 and in both 2019/20 and 2020/21 the alcohol-specific admission rate for both Portsmouth males and females remained significantly higher than the England rate. [175]

[173] Ipsos MORI for Portsmouth City Council. Health and Lifestyle Survey, 2015.
[174] Local Alcohol Profiles for England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 22/2/2022.
[175] Local Alcohol Profiles for England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 22/2/2022.

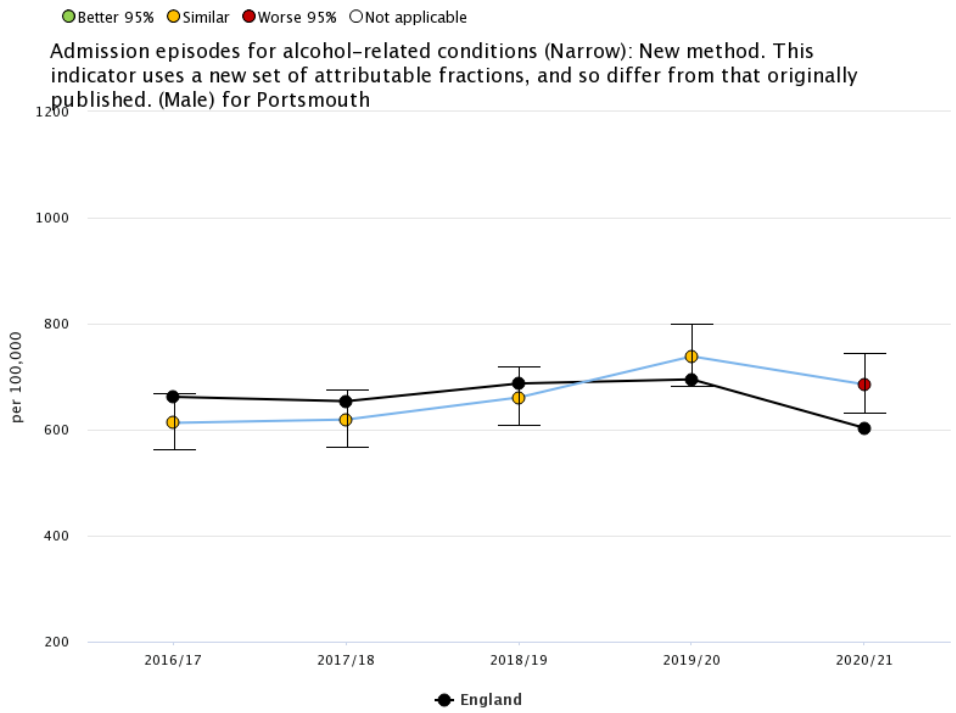

Figure 13. Alcohol-related admission rate for males (Narrow definition), Portsmouth and England, 2016/17 to 2020/21

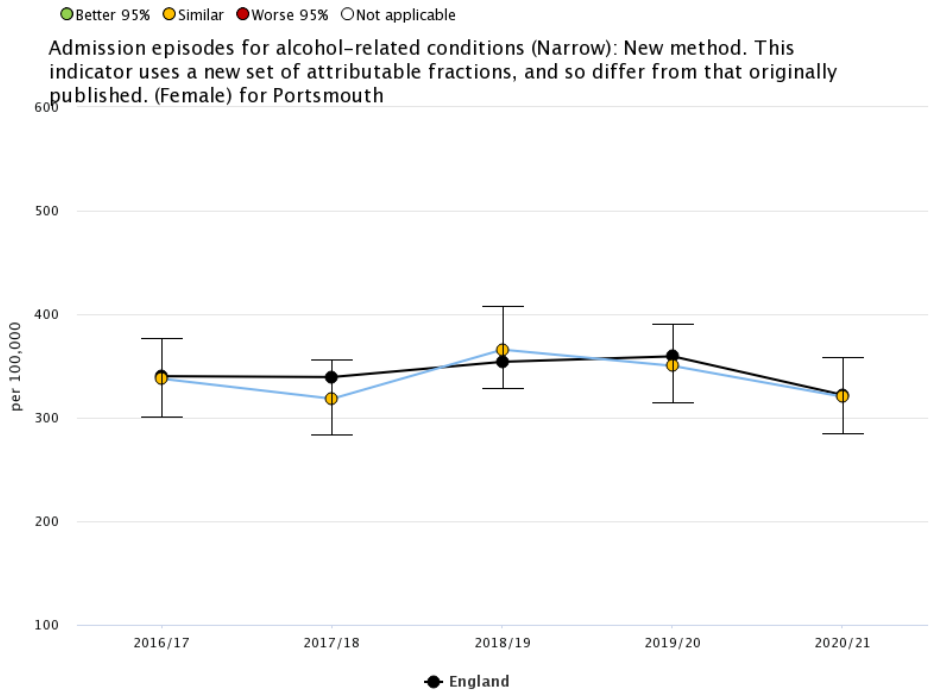

Figure 14. Alcohol-related admission rate for females (Narrow definition), Portsmouth and England, 2016/17 to 2020/21

In 2018/19 (the most recent estimate), it was estimated that between 2,600 and 4,400 adults were alcohol dependent and potentially in need of specialist treatment - at 1.90 adults per 100 adults, this is a higher, but statistically different, rate to the England average (1.37 per 100 adults). [176]

In 2020/21, there were 336 adults in treatment for alcohol dependency only at a specialist alcohol service in Portsmouth plus an additional 146 adults in treatment for alcohol and a non-opiate substance - an increase from 303 alcohol only receiving treatment (plus 109 alcohol and a non-opiate substance) in 2019/20. Of the 336 people in treatment for alcohol dependency only, 208 of these were new presentations in 2020/21. In 2019/20, it is estimated that, of the estimated number of alcohol dependent Portsmouth adults in need of treatment, 12% received treatment, leaving potentially an estimated 88% of unmet need. [177] However, demand for treatment in 2020/21 was 100% met within three weeks of waiting for treatment i.e. out of first alcohol treatment interventions starting in 2020/21, no one in Portsmouth waited over three weeks to commence treatment. In 2020, there were 104 Portsmouth adults successfully completing treatment (free of alcohol dependence and who do not re-present within 6 months), which was 30.7% of all adults receiving structured treatment - this percentage is lower, but not statistically significantly, than the England average (35.3%). In 2018/19-2020/21 (three-years pooled), there were 10 deaths amongst adults in alcohol treatment which is a mortality ratio of 1.08 out of expected deaths (if Portsmouth experienced the same the same age-specific mortality rates as in the whole alcohol treatment population in England) - therefore, Portsmouth's mortality ratio is higher, but not significantly, than England (mortality ratio of 1.00) [178]

Portsmouth's alcohol-related mortality rate for males and females has remained broadly similar from 2016 to 2020. In 2020, the alcohol-related mortality rate for males and females was higher, but not significantly, than England.

Portsmouth's alcohol-specific mortality rate for males has generally decreased since 2009-11, but the 2017-19 rate is not significantly different between periods since then. The Portsmouth alcohol-specific mortality rate for males in 2017-19 was higher, but not significantly, than England. Portsmouth's alcohol-specific mortality rate for females increased in 2009-11 and has remained broadly similar since. The Portsmouth alcohol-specific mortality rate for females in 2017-19 was significantly higher than England. The Portsmouth premature (under 75 years) mortality rate from alcoholic liver disease for females in 2017-19 was significantly higher than England. [179]

7.12 High body-mass index, physical inactivity and poor diet

There is national ambition to "significantly reduce childhood obesity" as set out in "Child Obesity - A Plan for Action". There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older. [180]

[176] Alcohol dependence prevalence in England, Public Health England https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england © Crown copyright 2022. Date accessed 22/2/2022.
[177] National Drug Treatment Monitoring System (NDTMS). Office for Health Improvement and Disparities. https://www.ndtms.net/ Date accessed 22/2/2022.
[178] Local Alcohol Profiles for England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 22/2/2022.
[179] Local Alcohol Profiles for England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 22/2/2022.
[180] Obesity Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 23/2/2022.

In 2019/20, 23.8% of Year R pupils (aged 4-5 years) and 38.1% of Year 6 pupils (aged 10-11 years) residing in Portsmouth were overweight, including obesity (i.e. "excess weight"). The proportion overweight, including obesity, for Year R pupils residing in Portsmouth is statistically significantly similar to Southampton and England (24.1% and 23.0% respectively). The proportion overweight, including obesity, for Year 6 pupils residing in Portsmouth is similar to Southampton, and statistically significantly higher than England (37.6% and 35.2% respectively). 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. [181]

In 2019/20, 11.0% of Year R pupils (aged 4-5 years) and 22.1% of Year 6 pupils (aged 10-11 years) residing in Portsmouth were obese, including severe obesity - the former having reduced since 2018/19 (previously 12.5%). The proportion obese, including severe obesity, for Year R pupils residing in Portsmouth is similar to Southampton, and statistically similar to than England (9.9% and 9.9% respectively). The proportion of obese, including severe obesity, for Year 6 pupils residing in Portsmouth is similar to Southampton and England (23.8% and 21.0% respectively).[182]

Due to the data collection limitations arising from the Covid-19 pandemic, the National Childhood Measurement Programme data from the 2020/21 has not been provided at local authority level. National data for 2020/21 has, however, been published by NHS digital. In 2020/21, 14.4% of Year R pupils (aged 4-5 years) and 25.5% of Year 6 pupils (aged 10-11 years) residing in England were obese, including severe obesity. This represents a significant increase for both Year R and Year 6 when compared to 2019/20 when 9.9% of Year R pupils and 21.0% of Year 6 pupils were considered obese (including severe obesity).[183]

Good physical activity habits established in childhood and adolescence are also likely to be carried through into adulthood. If we can help children and young people to establish and maintain high volumes of physical activity into adulthood, we will reduce the risk of morbidity and mortality from chronic non-communicable diseases later in their lives. In 2020/21, Sport England's Active Lives Children and Young People Survey found 55.7% of Portsmouth children (aged 5-16 years) were 'physically active'[184] - significantly higher than in 2018/19 (38.1%); however, in 2018/19 and 2019/20 no data was collected in Years 1 and 2[185], which may have impacted on the response profile between survey years. In 2020/21, Portsmouth's percentage of physically active children was significantly higher than England (44.9%). [186]

Obesity is a priority area for Government. The Government's "Call to Action" on obesity (published Oct 2011) included national ambitions relating to excess weight in adults, which is recognised as a

[181] NCMP profile, PHE. https://fingertips.phe.org.uk/profile/national-child-measurement-programme Accessed 21 April 2021
[182] NCMP profile, PHE. https://fingertips.phe.org.uk/profile/national-child-measurement-programme Accessed 21 April 2021
[183] NHS Digital, National Child Measurement Programme, England 2020/21, National Child Measurement Programme, England 2020/21 School Year - NHS Digital Accessed 03 February 2022
[184] Defined as children meeting the UK Chief Medical Officers' recommendation of an average of at least 60 minutes moderate-vigorous intensity activity per day across the week
[185] Sport and Physical Activity Levels amongst children and young people in school years 1-11 (aged 5-16), Active Lives Survey, Sport England https://sportengland-production-files.s3.eu-west-2.amazonaws.com/s3fs-public/2021-12/ALS%20CYP%2020-21%20Tables%201-4%20Levels%20of%20activity..xlsx?VersionId=2cULHc35FT.GDerJFPNayav.RB9XbiQa Date accessed 23/2/2022.
[186] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 23/2/2022.

major determinant of premature mortality and avoidable ill health[187]. In 2017/18, Sport England's Active Lives Survey found 28.6% of Portsmouth adults (aged 18 years and over) were obese, which is significantly worse than England (23.4%) and the South East (21.4%) and worse (but not significantly) than Southampton (24.3%).[188]

The same survey in 2019/20 found that 67.4% of Portsmouth adults (aged 18 years and over) were overweight or obese (66.5% in 2018/19). This is significantly worse than the South East which found that 61.5% of adults were overweight or obese in 2019/20 (60.9% in 2018/19 and 59.7% in 2017/18). This is also higher than Portsmouth's JSNA Unitary Authority comparator group average in 2019/20 (61.8%) and significantly worse than England where 62.8% of adults were classed as overweight or obese in 2019/20 (62.3% in 2018/19 and 62.0% in 2017/18) [189].

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 costs of diet related chronic diseases to the NHS and more broadly to society are considerable. Average intakes of saturated fat, sugar, and salt are above recommendations while intakes of fruit and vegetables, oily fish, fibre and some vitamins and minerals in some groups are below recommendations. In 2019/20, the Active Lives Survey found that 49.7% of Portsmouth adults met the '5-a-day on a usual day' recommendation - this was lower than in 2018/19 when 51.9% of adults met this recommendation. The 2019/20 percentage of Portsmouth adults meeting the recommended '5-a-day' on a 'usual day' was significantly lower than England (55.4%), lower than Portsmouth's JSNA Unitary Authority comparator group average (54.1%) and was significantly lower than the South East region (58.3%). [190]

The H&LS 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). [191]

People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health. In older adults physical activity is associated with increased functional capacities. The estimated direct cost of physical inactivity to the NHS across the UK is over £0.9 billion per year. In 2019/20, Sport England's Active Lives Survey found 69.7% of Portsmouth adults

[187] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 23/2/2022.
[188] Adjusted BMI from the Active Lives Survey, Public Health England.
[189] Public Health Outcomes Framework, indictor 2.12 (current method), Public Health England. https://fingertips.phe.org.uk Accessed 3rd June 2021
[190] Public Health Outcomes Framework, Public Health England. Public Health Profiles. 2021 https://fingertips.phe.org.uk © Crown copyright 2021, Accessed 03/06/2021
[191] 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

(aged 19 years and over) were physically active[192] which is higher (but not significantly) than England (66.4%) and the South East Region (69.5%). The percentage of adults in Portsmouth who were physically active was also higher than Portsmouth's JSNA Unitary Authority comparator group average (66.9%). The same survey found that 17.3% of Portsmouth adults (aged 19 years and over) were physically inactive[193] which is significantly lower than England (22.9%) and lower (but not significantly) than the South East Region (20.1%). It was also lower than Portsmouth's JSNA Unitary Authority comparator group average which was 22.0%. [194]

The 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 localities (and the Portsmouth average) - 66% in the South compared to 55% and 54% in North and Central.[195]

7.13 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 2018 (2014 was part of a wider 'measuring wellbeing survey'). Key findings from the 2018 survey include:

- Using cannabis use as an approximation for overall drug use, over 90% of pupils have never tried drugs
- Cannabis is the most frequently tried drug—9% of pupils have tried it at least once (2% in Year 8, but 18% 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 (5%) since 2012, including significantly lower than 2014 survey (15%).

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

- Have ever tried, or be a regular user of cannabis, ecstasy, ketamine, cocaine and speed. They were more likely to have tried all other substances included in the survey with the exception of solvents (glue, gas or aerosols) where the proportions were very similar;
- Think that about half, most, or all of people their age takes drugs;
- Have received advice at school on drugs and alcohol

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

- Think that none or a few people their age take drugs. [196]

[192] 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.
[193] 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.
[194] Public Health Outcomes Framework, Public Health England. Public Health Profiles. 2021 https://fingertips.phe.org.uk © Crown copyright 2020, Accessed 03/06/2021
[195] Ipsos MORI for Portsmouth City Council. Health and Lifestyle Survey, 2015.
[196] Portsmouth City Council, 2018. 'You Say' Survey Secondary Schools.

The latest estimate from 2016/17 for the number of opiate and/or crack cocaine users (OCUs) aged 15-64 years in Portsmouth is 1,541 (or between 1,329 and 1,838 users) - as a crude rate this is 10.6 per 1,000 population aged 15-64 years, which is estimated to be higher, but not significantly, than England and Southampton; but significantly higher than the South East region. The 2016/17 estimates that OCUs in Portsmouth are more likely to be aged 25-34 or 35-64 (12.4 and 12.9 per 1,000 respectively), compared to the aged 15-24 age group (4.5 per 1,000), but the difference is not statistically different - as estimated numbers this is 949 users aged 35-64 years, 419 users aged 25-34 years and 173 users aged 15-24 years.[197] In 2019/20, it is estimated that, of the estimated number of OCU Portsmouth adults in need of treatment, 49% received treatment, leaving potentially an estimated 51% of unmet need. [198] In 2020/21, there were 1,056 adults aged 18 years and over in treatment at specialist drug misuse services in Portsmouth.

Mental health problems are common amongst those needing and/or in treatment for drug use. In 2016/17, there were 82 adults in Portsmouth entering into a specialist drug misuse service who were in concurrent contact with a mental health service - 27.8% of all adults entering into a specialist drug misuse service. The 2016/17 Portsmouth proportion in concurrent contact with mental health services was higher, but not significantly, than England. [199]

Persons who inject drugs are at increased risk of contracting hepatitis B and C infections. In 2016/17, of Portsmouth residents entering substance misuse treatment and eligible for a Hep B vaccination, 3.2% (n=6) of these completed a course of Hep B vaccination, which is significantly lower than the England average (8.1%). However, in 2017/18, of Portsmouth residents entering substance misuse treatment who inject drugs, 487 received a Hep C test (90.9%) - significantly higher than the England average (84.2%).[200]

In 2020, there were 766 clients aged 18 years and over resident to Portsmouth in treatment for opiate use [201]. Portsmouth's percentage of successful completion of drug treatment for opiate users (ie the percentage who do not re-present within 6 months) was 4.8% (n=37) - similar compared to England (4.7%); and lower but not significantly than the South East Region (5.7%) and higher, but not significantly than Southampton (3.9%). In the same year (2020), 27.1% (n=79) of Portsmouth residents receiving treatment for non-opiate drug use was successful, which was significantly lower than England (33.0%); and lower, but not significantly, than the rate for the South East region (33.3%) and Southampton (28.9%).[202]

In 2020/21, 24.6% (n=32) of Portsmouth adults with substance misuse treatment need successfully engaged in community-based structured treatment following release from prison. This was

[197] Opiate and crack cocaine use: prevalence estimates by local area, Public Health England. https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations [Accessed 24 February 2022]
[198] National Drug Treatment Monitoring System (NDTMS). Office for Health Improvement and Disparities. https://www.ndtms.net/ Date accessed 23/2/2022.
[199] Co-occurring substance misuse and mental health issues, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 23/2/2022.
[200] Health Protection Profile, Office for Health Improvement and Disparities. https://fingertips.phe.org.uk © Crown copyright 2022. [Accessed 25 February 2022]
[201] National Drug Treatment Monitoring System (NDTMS). Office for Health Improvement and Disparities. https://www.ndtms.net/ Date accessed 23/2/2022.
[202] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 28/2/2022.

significantly lower than England (38.1%) and the South East region (37.5%); but similar compared to Southampton (22.2%).[203]

In 2018-20, the death rate from drug abuse for Portsmouth males was significantly higher than England, the South East; higher, but not significantly than Southampton; and lower but not significantly compared to Brighton and Hove and Plymouth (Figure 15). The Portsmouth male drug abuse death rate was also higher, but not significantly, than 2017-19 (Figure 16). Deaths from drug abuse for Portsmouth females was rising since 2013-15 and the rate was significantly higher than England until 2017-19. In 2018-20, the death rate from drug abuse for Portsmouth females was not significantly different to England, but remained significantly higher than the South East. The Portsmouth female drug abuse death rate was also lower, but not significantly, than 2017-19. [204]

Deaths from drug misuse (Male) 2018 - 20

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	5,912	7.3	7.1	7.5
JSNA UA	–	-	-	-	-
Newcastle upon Tyne	–	73	17.5	13.5	22.1
Liverpool	–	112	17.1	13.8	20.3
Brighton and Hove	–	65	14.3	10.9	18.3
Plymouth	–	50	13.8	10.2	18.2
Bristol	–	88	13.2	10.5	16.4
Portsmouth	–	35	11.2	7.7	15.6
Sheffield	–	82	10.4	8.2	12.9
Southampton	–	30	8.3	5.4	12.1
Nottingham	–	33	7.8	5.4	11.1
Coventry	–	35	6.7	4.6	9.4
Bournemouth	–	-	-	-	-

Figure 15. Chart to compare Portsmouth males deaths from drug abuse to England and comparator areas, 2018-20

[203] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 28/2/2022.
[204] Mortality Profiles. Public Health Profiles. Date accessed 9/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021'

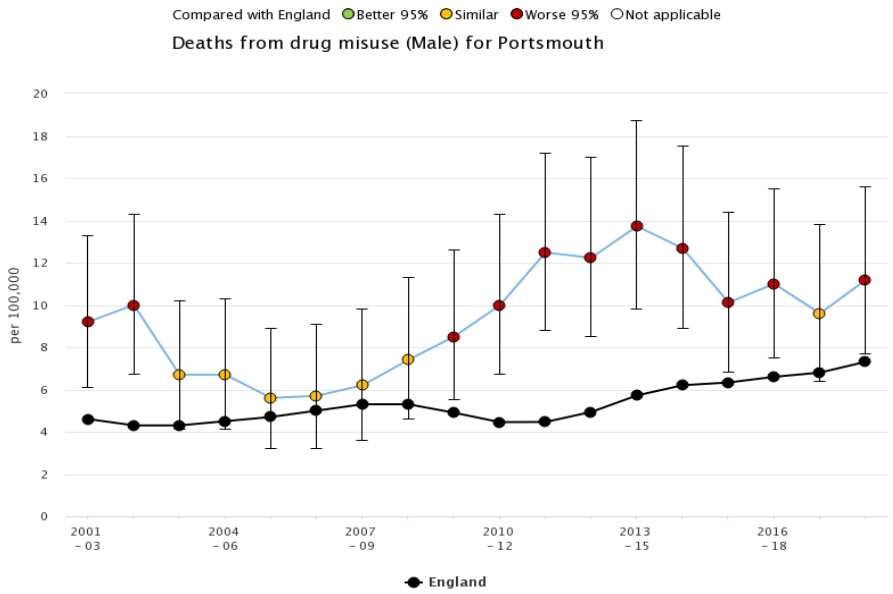

Figure 16. Line chart to show trend in Portsmouth male deaths from drug abuse and compared to England rate, 2001-03 to 2018-20

7.14 Sexual health

In 2020, there were 2,038 new STIs diagnosed Portsmouth residents as a rate Portsmouth had a significantly higher rate of all new STIs compared to England (949 per 100,000 population, all ages compared to 562 per 100,000 population, all ages). In 2020, the Portsmouth rate for new STI diagnoses excluding Chlamydia aged under 25 years was also significantly higher than England (770 per 100,000 population, aged 15-64 years compared to 619 per 100,000 population, aged 15-64 years). Perhaps unsurprisingly, Figure 17 shows the new STI diagnoses rate is strongly correlated with the STI testing rate (i.e. the more people tested often leads to higher diagnosis rates) - in 2020, Portsmouth had a significantly higher STI testing rate (excluding Chlamydia aged under 25 years) than England; but has a similar testing rate compared to the following comparator local authorities: Southampton, Nottingham and Derby. Of these local authorities, in 2020, Portsmouth had a significantly higher new STI diagnosis rate (excluding Chlamydia aged under 25 years) than Derby; but a similar rate compared to Southampton and Nottingham. Portsmouth's positivity rate has been increasing and in 2020 the positivity rate in Portsmouth was 7.6% which is similar to 7.3% in England. In 2020, Portsmouth also had a similar STI testing positivity rate to Nottingham and Southampton. Portsmouth's STI diagnosis rate (excluding chlamydia in under 25 year-olds) remains higher than England from 2017 to 2020, which given an increasing positivity rate and a higher testing rate, it may be indicative of a high burden of infection in Portsmouth relative to England.

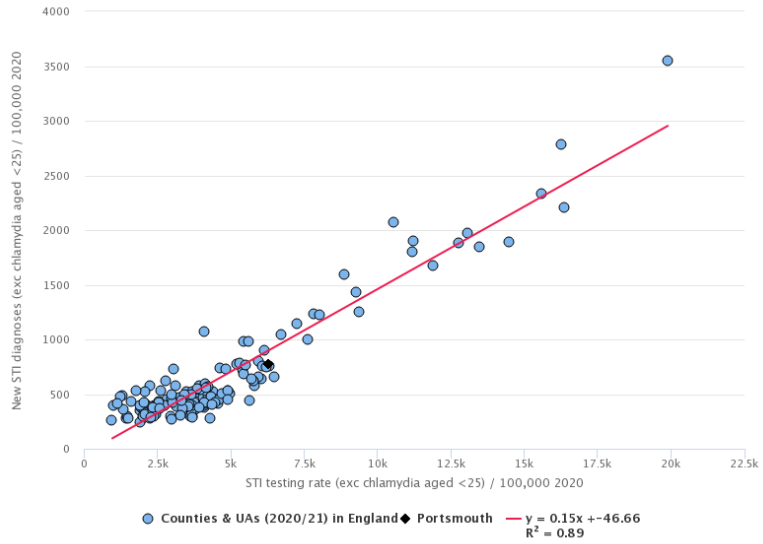

Figure 17. New STI diagnoses (exc chlamydia aged <25) per 100,000 aged 15-64 years, 2020 compared to STI testing rate (exc chlamydia aged <25) aged 15-64 years, 2020; by Unitary Authorities. Source: Sexual and Reproductive Health Profiles, Office for Health Improvement & Disparities

Chlamydia is more common in younger people aged 15-24 years and in Portsmouth, in 2020, over half (63%) of all the diagnoses are from this age group (891 diagnoses). Chlamydia is most often asymptomatic, a high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. A higher diagnosis rate is usually associated with a higher chlamydia proportion of the population tested (screened), especially in the 15-24 years age group. It is recommended that local authorities achieve a detection rate (diagnosis rate) of a least 2,300 per 100,000 residents aged 15 to 24 years and Portsmouth's detection rate in 2020 was 2,323 per 100,000 population (891 positives out of 5,871 screened), higher than the 2,300 target. In 2020, in Portsmouth, 15.3% of 15-24 year-olds were screened for chlamydia, compared to 14.3% in England. Figure 18 shows a close relationship nationally between the proportion screened for Chlamydia and the Chlamydia detection rate, aged 15-24 years, but also shows that Portsmouth has an above average diagnosis (detection) rate aged 15-24 years compared to comparator unitary authorities with a similar proportion of the population screened - a higher detection rate than Bristol (15.8% screened), Plymouth (14.8% screened), Newcastle-upon-Tyne (15.4% screened) and Southampton (14.4% screened), although the Southampton detection rate is also above average compared to Bristol, Plymouth and Newcastle-upon-Tyne. [205] Variation in rates of chlamydia detection may represent differences in prevalence, but are influenced by screening coverage and whether most at risk populations are being reached (i.e. the proportion testing positive). [206]

In June 2021, the National Chlamydia Screening Programme (NCSP) changed to focus on reducing the harms from untreated chlamydia infection. These harms occur predominantly in young women and other people with a womb or ovaries - this includes transgender men, non-binary people assigned

[205] Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 28/2/2022.
[206] Summary profile of local authority sexual health (SPLASH) report, Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.

female at birth, and intersex people with a womb or ovaries. Therefore, opportunistic screening should focus on these groups, combined with reducing time to test results and treatment, strengthening partner notification and re-testing after treatment. In practice this means that chlamydia screening in community settings (e.g. GP and Community Pharmacy) will only be proactively offered to young women and other people with a womb or ovaries. Services provided by sexual health services remain unchanged and everyone can still get tested if needed. [207]

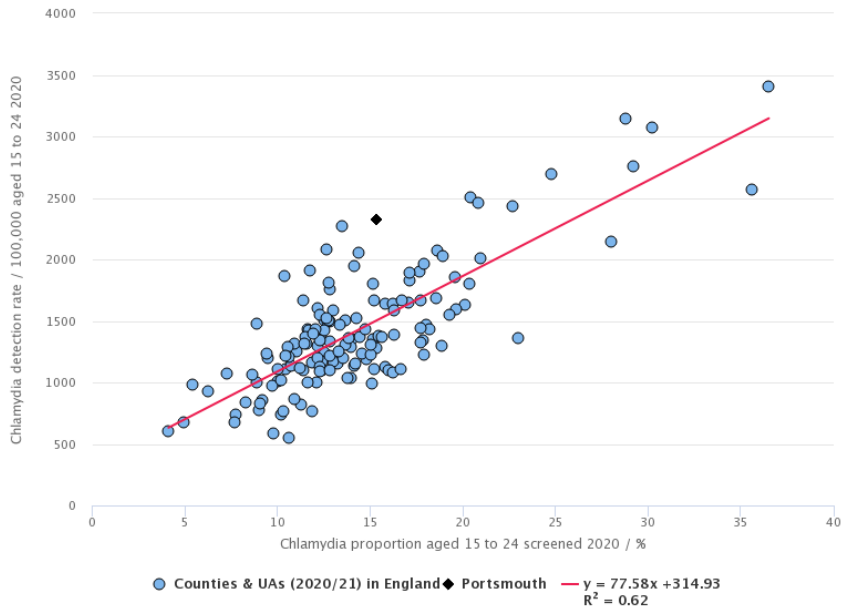

Figure 18. Proportion of aged 15-24 population screened for Chlamydia, 2020 compared to Chlamydia detection rate per 100,000 young people aged 15-24, 2020, by Unitary Authorities. Source: Sexual and Reproductive Health Profiles, Public Health England

Common STIs in Portsmouth are genital warts (161 diagnoses or 75.0 diagnoses per 100,000 persons of all ages, in 2020); herpes (113 diagnoses or 52.6 diagnoses per 100,000 persons of all ages, in 2020); gonorrhoea (206 diagnoses or 96.0 diagnoses per 100,000 persons of all ages, in 2020) and syphilis (31 diagnoses or 14.4 diagnoses per 100,000 persons of all ages, in 2020). [208] It should be noted that if high rates of gonorrhoea and syphilis are observed in a population, this reflects high levels of risky sexual behaviour. [209]

In 2020, Portsmouth had higher rates of genital 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 and Southampton; and significantly higher than the South East region.

[207] Summary profile of local authority sexual health (SPLASH) report, Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[208] Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.u k © Crown copyright 2022. Date accessed 28/2/2022.
[209] Summary profile of local authority sexual health (SPLASH) report, Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.

Between 2013 and 2020, the rate of genital warts diagnoses had decreased in Portsmouth (following national and regional trends) which can largely be attributed to the protective effect of HPV vaccination and are particularly evident in the younger age groups (aged 25 years and younger) who have been offered the vaccine since the national programme began[210]. Between 2013 and 2020, herpes diagnoses generally decreased in Portsmouth; but remained higher than England and SE region. Between 2013 and 2019, the rate of gonorrhoea diagnoses had increased nationally, regionally and in Portsmouth; and in 2019 the Portsmouth rate was significantly higher than England - the data reported in 2020 may have been impacted by the reconfiguration of sexual health services during the national response to COVID-19. Syphilis numbers and rates have increased in Portsmouth, regionally and nationally; however, the number of Portsmouth diagnoses in 2020 remain similar to previous years despite the data reported potentially impacted by reconfiguration of sexual health services during the national response to COVID-19 or theoretically reduced sexual behaviours due to national and regional lockdowns in 2020.[211]

Cervical screening checks a sample of cells from the cervix for certain types of human papillomavirus (HPV). HPV infections can come from any kind of skin-to-skin contact of the genital area, not just from penetrative sex. Nearly all cervical cancers are caused by an infection with certain types of human papillomavirus (HPV). Cervical screening and the HPV vaccination are the best way to prevent cervical cancer. 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 2021, Portsmouth's cervical screening coverage for women aged 25-49 years was 64.3% and coverage for women aged 50-64 years was 71.5% - both remained significantly lower than both the national and regional rates; however, screening coverage in 2020/21, in particular, decreased and may have been affected by the Covid-19 pandemic locally and nationally.[212]

Free and effective antiretroviral therapy (ART) in the UK has transformed HIV from a fatal infection into a chronic but manageable condition. People living with HIV in the UK can now expect to have a near normal life expectancy if diagnosed promptly and they adhere to treatment. In addition, those on treatment are unable to pass on HIV, even if having unprotected sex (undetectable=untransmissible [U=U]). The number of new HIV diagnoses among people aged 15 years and above in Portsmouth was 16 in 2020. In 2020, there were 321 Portsmouth residents aged 15 to 59 years and 36 residents aged 60 years and over who were seen at HIV services (the prevalence of diagnosed HIV). The diagnosed prevalence per 1,000 residents aged 15 to 59 years was 2.35, which is similar to 2.31 per 1,000 in England. The rank of Portsmouth was 52nd highest (out of 148 UTLAs/UAs) - since 2019, the increase in Portsmouth was 5%; in the 5 years since 2015, the increase was 25%.

Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality - in Portsmouth, in the three-year period between 2018-20, the percentage of HIV diagnoses made at a late stage of infection (all individuals with CD4 count ≤350 cells/mm3 within 3 months of diagnosis) was 47.4% (n=27 late stage diagnoses) - similar to 42.4% in England.

[210] Summary profile of local authority sexual health (SPLASH) report, Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[211] Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[212] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.

HIV testing is integral to the treatment and management of HIV infection. In 2020, amongst Portsmouth residents, the percentage of eligible Sexual Health Service attendees who received an HIV test was 37.4%, worse than 46.0% for England - this was a significant decrease in HIV testing coverage compared to 2019 both locally and nationally (in 2019, Portsmouth's HIV testing coverage was 58.1% and in England was 64.9%). For 2020, the percentage of men who have sex with men (MSM) in Portsmouth who had tested more than once in the previous year was 47.3%, similar to 52.0% in England. [213]

8 Wider determinants of health

8.10 Education

Children from poorer backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early in life. Children are defined as having reached a good level of development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy. In 2018/19, 69.4% of Portsmouth children achieved a good level of development at the end of Reception, which was significantly lower than the England average (71.8%) and the South East region (74.6%).

There is some evidence to suggest that the highest level of educational qualifications is a significant predictor of wellbeing in adult life; educational qualifications are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources. Educational attainment is influenced by both the quality of education children receive and their family socio-economic circumstances. In 2019/20, the Average Attainment 8 score of Portsmouth's 15-16 year-olds was 45.7, which was significantly lower than the England average (50.2) and the South East region (51.3). [214]

Parents of children of compulsory school age (aged 5 to 15 at the start of the school year) are required to ensure that they receive a suitable education by regular attendance at school or otherwise. In 2018/19, Portsmouth pupils aged 5-15 years missed 5.41% of school sessions due to overall absence - Portsmouth's pupil absence rate was significantly higher than England (4.73%) and the South East region (4.71%).[215]

Young people who are not in education, employment or training are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood. In 2020, the percentage of Portsmouth young people aged 16-17 years not in education, employment or training (NEET) or whose activity is not known was 5.6%, which is higher, but not significantly, than the previous four years. Portsmouth's 2020 NEET rate was higher, but not significantly than England (5.5%); and lower, but not significantly, than the South East region (6.4%). [216]

[213] Summary profile of local authority sexual health (SPLASH) report, Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[214] Wider Determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 14/2/2022.
[215] Wider Determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 14/2/2022.
[216] Wider Determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 14/2/2022.

8.11 Teenage conception and abortions

Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS. While for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty.

In 2019, the teenage conception rate, aged under 18 years, in Portsmouth increased to 20.5 per 1,000 females aged 15-17 years (n=65) - the Portsmouth rate was significantly higher than England (15.7 per 1,000 females aged 15-17 years) and the South East (12.7 per 1,000 females aged 15-17 years); and higher, but not significantly, than Southampton (18.5 per 1,000 females aged 15-17 years). [217]

The three-year pooled trend in the under 16 years conception rate for Portsmouth continues to decrease (2.6 per 1,000 females aged 13-15 years in 2017-19, compared to 3.8 in 2016-18) and is similar to Southampton (2.5 per 1,000 females aged 13-15), and England (2.5 per 1,000 females aged 13-15). [218]

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, Fratton and Baffins in the Central locality; and St. Thomas ward in the South locality, all have higher rates than England, in 2017-19 (Figure 19).

[217] Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[218] Table 7, VSOB, Office for National Statistics © Crown Copyright via Portsmouth JSNA: www.jsna.portsmouth.gov.uk

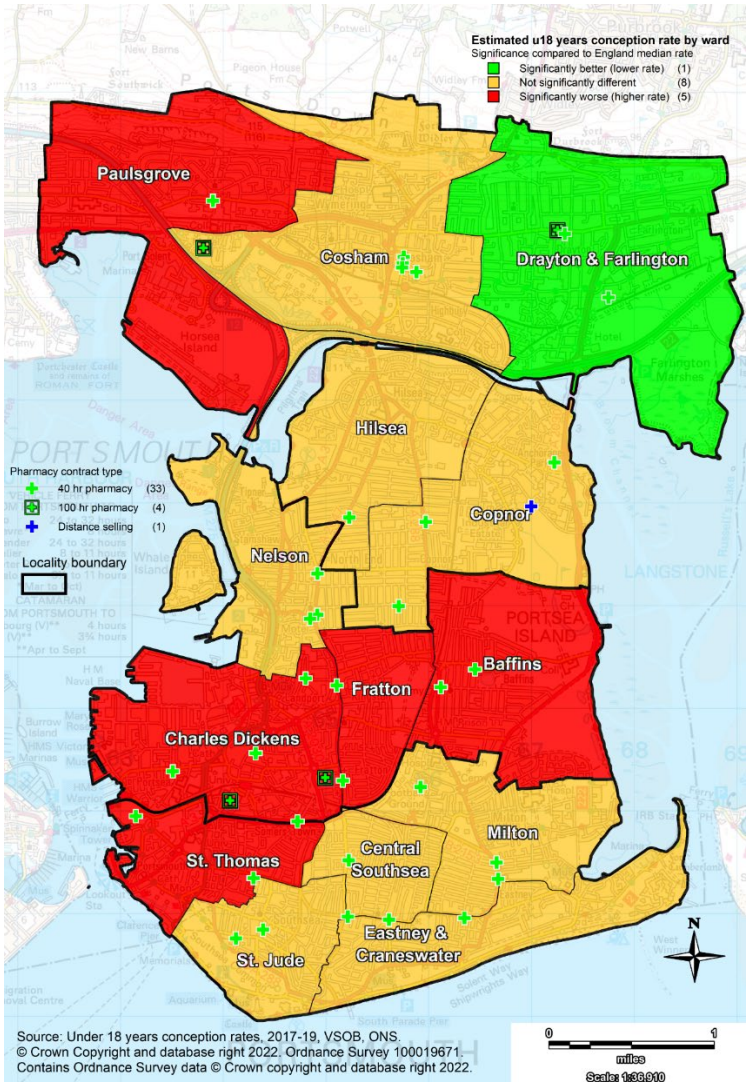

Figure 19. Map of Portsmouth comparing the estimated electoral ward under 18 years conception rate to the England median, 2017-19, overlaid by localities and pharmacies

Teenagers are more likely to present late for abortion and to book late for antenatal care. The higher risk of unplanned pregnancy, late confirmation of pregnancy and fear of disclosure, all contribute to delays in accessing abortion and maternity services. Early pregnancy diagnosis, unbiased advice on pregnancy options and swift referral to maternity or abortion services are required to minimise delays. Young people who have experienced pregnancy are also at higher risk of subsequent unplanned conceptions [219]. In 2017-19, 69.2% of conceptions to under 16 year-olds in Portsmouth led to abortion—a higher (but not significantly) percentage than England, the South East region and Southampton. The percentage of under 16 years conceptions leading to abortion in Portsmouth in 2017-19 was the highest since 2008/10 [220]. In 2019, 56.9% of conceptions to Portsmouth women aged under 18 year-olds led to abortion - higher (but not significantly) than England and Southampton, but lower (but not significantly) than the South East region. [221]

[219] Summary profile of local authority sexual health (SPLASH) report, Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[220] Table 7, VSOB, Office for National Statistics © Crown Copyright via Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[221] Table 6, VSOB, Office for National Statistics © Crown Copyright via Portsmouth JSNA: www.jsna.portsmouth.gov.uk

In 2020, Portsmouth's abortion rate[222] in females aged under 18 years is 10.7 per 1,000 females aged 15-17 years. The Portsmouth abortion rate for females aged under 18 years was significantly higher than England and the South East region; and higher, but not significantly, than Southampton. The 2020 Portsmouth under 18 years abortion rate is higher, but not significantly than in 2018 and 2019. [223]

The total abortion rate, under 25 years repeat abortion rate, under 25 years abortions after a birth, and over 25 years abortion rates may be indicators of lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method. [224]

In 2020, there were 950 abortions for Portsmouth females of all ages. The age-standardised total abortion rate in Portsmouth was 18.7 abortions per 1,000 women aged 15-44 years - higher, but not significantly, than England and Southampton. In 2020, the over 25 years abortion rate per 1,000 women aged 25-44 years in Portsmouth was 19.5 (n=556), which is significantly higher than England (17.6 per 1,000) and the South East region (16.4 per 1,000); and similar to Southampton (19.4 per 1,000 women). Abortions are safer when carried out in early pregnancy—before 10 weeks[225]. The proportion of NHS-funded abortions carried out before 10 weeks has continued to increase in Portsmouth and nationally. In 2020, 91.3% of abortions were performed under 10 weeks – higher than the percentage for England, the South East region and Southampton. [226]

In 2020, of the Portsmouth women aged under 25 years having an abortion, 31% had a previous abortion which is the highest percentage since 2012 (in 2019, 22.8% had a previous abortion). The Portsmouth percentage having a previous abortion aged under 25 years, in 2020, was higher than England (29.2%) and the South East (28.7%). In 2020, of the Portsmouth women aged under 25 years having an abortion, 22.3% had previously given birth - this was significantly lower than England (27.1%).[227]

In 2020, of the Portsmouth women aged 25 years and over having an abortion, 49.6% had undergone a previous abortion, this was higher than England (48.9%) and represents a decrease from the previous year for Portsmouth (51.8% in 2019). [228]

8.11.4.1 Student Sexual health

Nationally and regionally, STIs disproportionately affect young people. South East residents aged between 15 and 24 years accounted for 50% of all new STI diagnoses in 2018.[229] Sexual health clinic activity for 18-22 year-olds peak and trough in line with University of Portsmouth term times. During the 2016/17 academic year, accessing sexual health support online (the first year of the online access)

[222] Defined as abortions in the calendar year from DHSC, whereas an alternative source would be via ONS, which provides abortion rate but based on the year of conception, so may differ.
[223] Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[224] Summary profile of local authority sexual health (SPLASH) report, Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[225] DH Abortion Statistics © Crown Copyright. Table 10d via Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[226] DH Abortion Statistics © Crown Copyright. Table 11a via Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[227] Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[228] DH Abortion Statistics © Crown Copyright. Table 11d via Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[229] Public Health England. Spotlight on sexually transmitted infections in the South East: 2018 data https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/827649/2019_08_SE_STISpot2018.pdf Date accessed 18/2/2022.

accounted for 4.9% of all initial contacts into the service. Booked and wait to be seen appointments accounted for over three-quarters of initial contacts in the service for this age group. Community pharmacy provision of EHC was the most frequently used route to access EHC accounting for 90% of EHC provided in the 6 months September 17 to February 18 inclusive (10% through the sexual health service). 41% of EHC accessed through pharmacies between September 2017 to February 2018 (inclusive) were for individuals recorded to be a student. A local survey carried out in 2018 of University students found the majority of who had used the sexual health service or via the Let's Talk About It website, reporting that it was quite or extremely easy to use, with the vast majority of students reporting that local provision of sexual health services met their needs. In 2018, the findings of the Student Health Needs Assessment found that the service provision at the time appeared to meet the needs of students in Portsmouth in regards to ease of use and access.[230]

8.12 Crime and disorder

The police recorded 22,882 crimes in Portsmouth during 2020/21, which is 11% (n2,832) fewer than last year. The reduction in crimes were largely due to reduction in violence with injury and many types of theft offences, particularly vehicle related thefts. However, increases were seen in other offences including: stalking and harassment, shoplifting, crimes flagged as domestic abuse, drug offences, sexual offences, robbery and possession of a weapon. The 2020/21 crime rate of 106.5 per 1,000 residents in Portsmouth is higher than the average for other similar local authority areas (96.5 per 1,000). The overall level of crime in Portsmouth was generally lower in 2020/21 than the previous three years, apart from July to September, when there were fewer restrictions on socialising during the Covid-19 pandemic. [231]

9 Covid-19 impacts and ongoing response

9.10 Impacts of Covid-19 in Portsmouth

Cases

Up to 31st March 2022, Portsmouth has now had 68,201 people with at least one positive Covid-19 test result (either lab-confirmed or lateral flow device) since the first confirmed city case on 9th March 2020. Cases in the third wave peaked on 1st January 2022 at an average of 599 cases each day over the previous 7 days, driven by the more transmissible Omicron variant. This was nearly three times the height of the second wave which peaked on 11th January 2021 with an average of 210 cases each day over the previous 7 days. Rates fell during February before rising again with the emergence of Omicron BA.2. While recorded rates peaked on 19th March at just over half the rates recorded earlier in the year, ONS Infection Survey data estimated that prevalence of Covid was at the highest levels seen throughout the pandemic. Since then recorded rates have fallen steadily though changes in testing policy have made it harder to maintain a consistent picture.

Comparisons between waves remain difficult due to the significant changes in testing regimes. The roll-out of the vaccination programme, targeted initially at older and more vulnerable cohorts, significantly changed the age profile of cases in wave 3 and reduced the link between cases and severe outcomes, while testing rates increased in wave 3 meaning more asymptomatic cases were identified. The levels of Covid seen during the Omicron wave have led to significant pressure on healthcare systems despite the lower severity with the current variant and levels of antibodies in the population.

[230] Portsmouth JSNA: https://www.portsmouth.gov.uk/wp-content/uploads/2020/04/portsmouth-student-health-needs-assessment-2018.pdf Date accessed 18/2/2022.
[231] ONS data via the Portsmouth Strategic Assessment 2020-21: https://www.saferportsmouth.org.uk/strategic-assessments Date accessed 17/2/2022.

Covid related admissions to Portsmouth Hospitals NHS Trust peaked in early April 2022 at around 75% of the levels seen in January 2021.

Severe health outcomes

Demographic factors such as age and gender correlated with higher rates severe health outcomes - hospitalisation and death due to COVID-19. Older people and males were disproportionately affected by these severe COVID-19 outcomes. Higher numbers of cases were reported in females when compared to males, which may be linked to occupation. Local analysis suggesting that the burden of Long COVID may disproportionately fall on the female working age population.

Care homes were disproportionately affected by the COVID-19 outbreak as residents and those working in care homes were more vulnerable to the virus.

People from ethnic minority groups were more likely to be diagnosed with COVID-19 and were disproportionately affected by severe health outcomes - hospitalisation and death due to COVID-19.

National data reported a link between occupation and severe outcomes from contracting COVID-19. Local analysis found that for two occupational groups the relative increase in deaths was far higher than the average. These were caring, leisure and other service occupations and elementary occupations. These types of occupation suggest employees with increased socio economic vulnerabilities and working conditions such as unable to work from home, working in multiple settings (such as carers) and being lower paid.

Deaths

Portsmouth Hospitals NHS Trust recorded its first Covid-19 death on 14th March. Since then, up to the 31st March 2022, there have been a total of 455 Covid-19 related deaths in Portsmouth within 28 days of positive test. Nearly two thirds (63%) of these occurred during the second wave (between October 2020 and March 2021), with 80 deaths (22%) in wave 1 and 88 deaths (19%) since 1st July 2021. Significantly lower mortality in the third wave demonstrates the success of the vaccination programme as well as the lower severity of Delta and Omicron variants to those that preceded them.

The total number of deaths each week in Portsmouth was significantly higher than in an average week during the peaks of wave 1 and wave 2. These excess deaths were mostly Covid-19 related. Despite the very high prevalence of Covid-19, deaths in most weeks in 2022 have so far been below the weekly average in previous years before the pandemic.

Wave 1 deaths analysis

Analysis of deaths in Portsmouth between 1st March and 31st August 2020 in which Covid-19 was mentioned on the death certificate ('Wave 1 Covid-19 deaths') shows the following:

- Portsmouth had a relatively lower rate of Covid-19 mentioned deaths compared to England and other local authorities
- 99% deaths were in hospital or care homes
- Covid-19 was the underlying cause in 92% of deaths in which Covid-19 was mentioned
- Portsmouth **males had a statistically significantly higher Covid-19 mortality rate than females** both aged 75+ and under 75 years during March to August 2020 (see fig1 below)
- Covid-19 was the leading cause of death for males of all ages, while dementia remained the leading cause of death for females

Indirect impacts of Covid-19

The whole population has been impacted by national policy responses to Covid; however, particular groups have been impacted in different ways and experienced varying levels of hardship over the course of the pandemic. National evidence, summarised below, highlights some of the ways in which people's socio-economic situation has impacted on their experience during the pandemic.

Children: The number of children living in relative poverty has been steadily increasing prior to COVID and the economic impact of COVID has disproportionately impacted low-income families, potentially further driving and widening the inequalities for these children. Children saw decrease in overall activity, reduced access to healthy food, and increases in obesity, particularly for children from more disadvantaged backgrounds. Education has been significantly impacted on due to school closures and the time spent learning declined during lockdown. Schools in higher areas of deprivation had greater months of learning lost when compared to schools in lower deprivation areas

Young people: Adolescence is a key period for social cognitive development - young people saw increased feelings of loneliness and isolation, concerns about school, college or university work, trouble sleeping, anxiety about catching and spreading COVID-19 and a breakdown in routine. The young working age population had the highest rates of furlough as they were less likely to be able to work from home. Young people also have characteristics which make them particularly vulnerable to experiencing a decline in their mental wellbeing related to COVID-19 restrictions. They have characteristics which compound their vulnerability; being in education or insecure employment, having less financial security and having high scores for loneliness and mental health conditions.

Working age population: Those with low income or loss of income associated with increasing levels of loneliness during lockdown and higher levels of anxiety and mental distress. They were more likely to experience financial strain, longer working hours, poorer work life balance or increased fear of potential exposure to COVID-19. Women in lower socio-economic jobs were more likely to be furloughed than any other positions. Lockdown policy meant that those working in food service, accommodation, arts and entertainment were the workforce most affected. People living in smaller, more crowded homes with less access to private garden space would have experienced greater stress during social distancing restrictions than those with garden and additional living space. One in five adults have experienced some form of depression, double that observed before the pandemic. People who have never experienced adverse mental health in the past may be experiencing mental health conditions for the first time during and after COVID-19. Similarly, those who have past or ongoing experiences with their mental health may have also felt a decline in their mental wellbeing related to COVID-19.

Carers and social care: Nationally, there has been an increase in unpaid carers during the pandemic as people provide informal help for family members. Carers have reported a decline in mental health and increased isolation.

Older people: Decreased social connectiveness led to increasing feelings of loneliness and isolation and growing concern of cognitive decline due to lack of mental stimulation and socialising. Anxiety and depression also increased.

9.11 Living with Covid

In March 2022, the Government published its latest COVID-19 response guidance 'Living with Covid-19 '. The Government's objective in the next phase of the COVID-19 response is to enable the country to manage COVID-19 like other respiratory illnesses, while minimising mortality and retaining the ability to respond if a new variant emerges which may be more severe or more transmissible than the Omicron variant putting the NHS under unsustainable pressure.

The Government will structure its ongoing response around four principles:

1. **Living with COVID-19:** removing domestic restrictions while encouraging safer behaviours through public health advice, in common with longstanding ways of managing most other respiratory illnesses;
2. **Protecting people most vulnerable to COVID-19**: through vaccination guided by Joint Committee on Vaccination and Immunisation (JCVI) advice, the best available treatments and deploying targeted testing;
3. **Maintaining resilience**: ongoing surveillance, contingency planning and the ability to reintroduce key capabilities such as mass vaccination and testing in an emergency;
4. **Securing innovations and opportunities from the COVID-19 response,** including investment in life sciences.

In Portsmouth, we are aiming to ensure a smooth transition from acute phase of response to 'Living safely with Covid' and support the government measures outlined above.

We need to ensure that the most vulnerable in our community continue to be supported and will build on the innovation and partnership work with organisations and residents developed through the pandemic to do this.

We continue to promote safer behaviours to limit the likelihood of transmission in the community. This includes the promotion of vaccination, good hygiene practices such as handwashing, good ventilation, wearing face coverings in crowded spaces, testing if symptomatic and staying at home if positive.

A follow up Contingency Framework is awaited from the UK Health Security Agency. This will clarify plans for maintaining resilience, including Local Authority roles in managing the consequences of infection. In order to prepare, we are developing local escalation frameworks and delivery plans to reactivate mass testing and tracing should it become necessary. We aim to remain agile as we continue to monitor and adapt to any new challenges that the virus presents in the future.

10 Conclusion

Portsmouth is a unique city and a fantastic place to live, work and visit. It faces many of the challenges common to coastal cities identified in the 2021 CMO report, as well as local issues such as poor equality that are linked to its geography. Life chances and health outcomes are too low for too many of our residents and the inequalities, both within the city and between Portsmouth and the rest of the country are stark. The Covid-19 pandemic has highlighted the impact that people's circumstances and background has on their health outcomes but many of these problems were evidence prior to that, as this report sets out.

As a city we have identified our priorities through the Health and Wellbeing Strategy to address these long-standing issues. As a health and care system we have an opportunity through the new

Integrated Care System to focus on how we work together in Portsmouth to address the areas of poor outcomes and the place-based factors that influence those outcomes and the behaviours that drive them. As Director of Public Health I look forward to continuing to work with you all to make Portsmouth a healthy and happy city.

Helen Atkinson, Director of Public Health

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Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Date of meeting:	21st September 2022
Subject:	Pharmaceutical Needs Assessment 2022
Report by:	Matt Gummerson, Head of Strategic Intelligence and Research
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). The current PNA was approved by the HWB in 2018. The statutory requirement to publish a new PNA was delayed in response to the Covid-19 pandemic. The new PNA must be approved by the HWB and published by 1st October 2022.

1.2 In line with the recommendations agreed by the HWB on 9th February 2022, a draft PNA was published for consultation in March 2022. The consultation closed on 6th June 2022, and the responses to the consultation are summarised in section 4.3 below. The consultation findings have not changed the conclusion of the PNA. This report seeks HWB approval to publish the statutory PNA attached as Appendix A by 1st October 2022 in line with the regulations.

2. Recommendations

2.1 The HWB is asked to:

1. Approve the final Pharmaceutical Needs Assessment 2022 as set out at Appendix A.

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. This requirement was delayed in 2021 by the Department of Health and Social Care in light of the pressures on the health and social care system brought about by the Covid-19 pandemic. The refreshed Portsmouth PNA must now be published on 1st October 2022.

3.2 The draft Portsmouth PNA 2022 which underwent consultation concludes that in Portsmouth there are 37 community pharmacies, one distance selling pharmacy and one dispensing appliance contractor. The Health and Wellbeing Board (HWB) consider the location, number, distribution and choice of pharmaceutical services serving the Portsmouth residents to meet the needs of the population. The HWB also consider that there is currently no identified need for improvements and better access to pharmaceutical services in Portsmouth.

4. Reasons for recommendations

4.1 PNAs are relevant when deciding if new pharmacies are needed, in response to applications by businesses, including independent owners and large pharmacy companies. Applications are contested by applicants and existing NHS contractors and can be open to legal challenge if not handled properly. They also inform commissioning decisions by local commissioning bodies.

4.2 The content of PNAs is set out in Schedule 1 to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. They must include:

- A statement of the pharmaceutical services provided that are necessary to meet needs in the area;
- A statement of the pharmaceutical services that have been identified by the HWB that are needed in the area, and are not provided (gaps in provision);
- A statement of the other services which are provided, which are not needed, but which have secured improvements or better access to pharmaceutical services in the area;
- A statement of the services that the HWB has identified as not being provided, but which would, if they were to be provided, secure improvements or better access to pharmaceutical services in the area;
- A statement of other NHS services provided by a local authority, the NHS Commissioning Board (NHS England), a Clinical Commissioning Group (CCG) or an NHS Trust, which affect the needs for pharmaceutical services;
- An explanation of how the assessment has been carried out (including how the consultation was carried out); and
- A map of providers of pharmaceutical services.

4.3 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. As part of the Portsmouth PNA refresh, the consultation ran from Friday 1st April to Monday 6th June 2022. 10 responses were received: 4 representing the views of an organisation such as a Health and Wellbeing Board, Local Pharmaceutical Committee, Local Medical Committee or CCG; 2 personal views as a pharmaceutical professional working in a community

pharmacy; 1 personal view as a member of the public; and 3 others. The responses to the consultation were positive, with 100% of responses agreeing or strongly agreeing with the conclusions of the PNA.

4.3.1 100% of respondents also agreed or strongly agreed with the following statements:

- The purpose of the pharmaceutical needs assessment has been explained within the draft document
- The draft PNA reflects the current provision of pharmaceutical services in your area
- The draft PNA identifies gaps in service provision i.e. when, where and which services are available that have not been identified in the PNA
- The draft PNA reflects the needs of your area's population
- The draft PNA provides information to inform market entry decisions i.e. decisions on applications for new pharmacies and dispensing appliance contractor premises
- The draft PNA provides information to inform how pharmaceutical services may be commissioned in the future
- The draft PNA provides enough information to inform future pharmaceutical services provision and plans for pharmacies and dispensing appliance contractors.

4.3.2 One respondent (25% of the 4 respondents to answer this question) agreed with the statement "There are gaps in pharmaceutical services that could be provided in a community pharmacy setting in the future that have not been highlighted". However, no further information was provided as to what these gaps might be.

4.3.3 One specific comment about recent changes to opening hours was provided. This has been addressed through the changes set out in section 4.4 below.

4.4 The PNA sets out the position at a particular point in time, with the majority of the document using analysis carried out prior to the publication of the draft PNA in March 2022. There is a process for updating the PNA through supplementary statements when required in response to major changes in pharmacy provision. Some minor changes to the draft PNA have been made however between the draft and final versions.

4.4.1 NHSE have provided an updated list of pharmacy opening times as at 1st August 2022. This has been used to update section 6.1, and additional maps showing this information has been included as an appendix to the main report. These changes have been analysed and they do not change the PNA's assessment of accessibility to pharmacy services.

4.4.2 From 1st July 2022, the Hampshire and Isle of Wight Integrated Care Board assumed delegated responsibility for commissioning of pharmaceutical services in the area that were previously delegated to the CCG. This change has been reflected in the final PNA.

5. Integrated impact assessment

5.1 An Integrated Impact Assessment has been completed.

Portsmouth CITY COUNCIL

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.

7. Director of Finance's comments

7.1 There are no direct financial implications arising from the recommendations within this report.

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Signed by:

Helen Atkinson, Director of Public Health

Appendices:

Appendix A - Portsmouth Pharmaceutical Needs Assessment 2022
Appendix B - Integrated 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
Draft Pharmaceutical Needs Assessment 2022	https://www.portsmouth.gov.uk/wp-content/uploads/2022/03/portsmouth-pharmaceutical-draft-needs-assessment-2022-accessible.pdf

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

……
Signed by:

Portsmouth Pharmaceutical Needs Assessment 2022

Table of Contents

1 Executive Summary

1.1 Purpose and structure of the Pharmaceutical Needs Assessment

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

This document describes the purpose of the PNA (section 2), the process by which it has been developed (section 3) and the local context (section 4). It then provides details of the pharmaceutical services available in the city (section 5) and analyses how accessible they are (section 6).

Section 8 provides detailed analysis of the key demographic and health needs in the city that services respond to. The PNA then identifies any potential future needs that may emerge from planned developments in the city (section 9) and GP extended opening (section 10).

Section 11 explores any gaps in provision before section 12 sets out the HWB's conclusions.

1.2 Key points

In Portsmouth there are 37 community pharmacies, one distance selling pharmacy and one dispensing appliance contractor. The Health and Wellbeing Board (HWB) consider the location, number, distribution and choice of pharmaceutical services serving the Portsmouth residents to meet the needs of the population.

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

This conclusion is based on the following key points:

- The total Portsmouth population is within a 1.6km straight line distance of a community pharmacy (section 6.1.6.1).
- There is a good geographical spread of community pharmacies across all three localities in the city (section 6.7) and within communities experiencing greatest deprivation.
- There are 17.2 community pharmacies per 100,000 Portsmouth population, which is slightly higher than the average for Hampshire and the Isle of Wight (HIOW) ICS and is broadly in line with national averages (section 6.2.1).
- Over 99% of the Portsmouth population are within a 20-minute walk of a community pharmacy (section 6.1.6.5).
- Good access demonstrated by opening hours from early morning, through lunchtimes and late into the evening as well as weekend opening (section 6.1.3 and 6.1.4).
- A distance selling pharmacy, four 100-hour pharmacies, supplementary hours in other Portsmouth community pharmacies as well as provision in a neighbouring HWB area provide improvements which meets the needs of Portsmouth residents (section 5.2).
- All pharmacies provide the full range of essential pharmaceutical services (section 6.2).
- Good provision of advanced services across the city (section 6.3).
- A range of enhanced and locally commissioned services delivered in the city (section 6.4). 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 6.1.7).
- There will not be substantial changes in population areas, nor major development, which can be anticipated during the three-year lifespan of this PNA and which would warrant the need for additional pharmaceutical services. Smaller changes would be managed by existing providers. (Section 8.1 and 10).

1.3 Conclusion

The Health and Wellbeing Board has considered the city's demography and health needs, and pharmaceutical provision 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.
- There is good coverage across the city of Advanced, Enhanced and locally commissioned services in place.
- Despite consolidations and changes in provision and extended hours in the last three years which have reduced the availability of pharmaceutical services, we still believe that there is a good range of pharmaceutical services provided in the city. However, further reductions in provision of services could require an updated assessment of the needs of the local population.
- There are no identified specific improvements or better access that could be met by an additional pharmaceutical services provider at this time. Future improvements could be met by the current pharmaceutical service providers.

2 Introduction

2.1 Definition and purpose of the PNA

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

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 wants to provide pharmaceutical services, they are required to apply to NHS England 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 Wellbeing Board (HWB) area. This includes decisions 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.

The PNA can also inform the commissioning of additional pharmaceutical services by Portsmouth City Council (PCC) and NHS Hampshire and Isle of Wight Integrated Care Board (ICB) as locally commissioned services.

2.2 Historical and Legal Background

The Health Act 2009 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.

The Health and Social Care Act 2012 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 HWBs. In addition, this Act also transferred 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 set out the legislative basis for developing and updating PNAs. The NHS (Pharmaceutical and Local Pharmaceutical Services (Amendment and Transitional Provision) Regulations 2014 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 HWB was published on 1st April 2015 to comply with these regulations. The regulations state that each HWB must publish a revised statement within three years of its previous publications and this document has been produced to satisfy this requirement.

3 Process for producing the PNA

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 HIOW PNA Steering Group.

The Portsmouth PNA published in 2018 has been used as the basis for the Portsmouth PNA 2022 and the work from its authors is gratefully acknowledged. The Portsmouth PNA 2022 has been in development since winter 2021 and work on it has continued up to the completion of this final version in September 2022 in preparation for its official publication on the 1st October 2022. The key stages in the process 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, Southampton, Hampshire and the Isle of Wight. The group has representation from Public Health teams, NHS England (South East) and Community Pharmacy South Central (Local Pharmaceutical Committee) and reports to the Directors of Public Health in each upper tier local authority. 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 HWBs.

Stage 2: Collation of information and data

The Joint Strategic Needs Assessment data 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 short questionnaire about their services to inform the development of the PNA. This survey was open from December 2021, originally until January 2022, but was then extended, with messages sent via PharmOutcomes and an additional prompt to all HIOW pharmacies on 7th February before being closed on 1st March 2022. 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.

Stage 3: Analysis

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

Stage 4: Draft PNA

The draft PNA was shared with the joint chairs of the HWB in March 2022 prior to consultation. This is in line with the process agreed by the HWB in February 2022.

Stage 5: Consultation

A stakeholder consultation to meet the statutory requirements was held from 1st April to 6th June 2022. Members of the public were also able to respond to the survey via the council's website.

Stage 6: Review of consultation responses

10 responses were received: 4 representing the views of an organisation such as a Health and Wellbeing Board, Local Pharmaceutical Committee, Local Medical Committee or CCG; 2 personal

views as a pharmaceutical professional working in a community pharmacy; 1 personal view as a member of the public; and 3 others. All responses to the consultation have been considered and have informed the development of the final PNA.

The responses to the consultation were positive, with 100% of responses agreeing or strongly agreeing with the conclusions of the PNA. 100% of respondents also agreed or strongly agreed with the following statements:

- The purpose of the pharmaceutical needs assessment has been explained within the draft document
- The draft PNA reflects the current provision of pharmaceutical services in your area
- The draft PNA identifies gaps in service provision i.e. when, where and which services are available that have not been identified in the PNA
- The draft PNA reflects the needs of your area's population
- The draft PNA provides information to inform market entry decisions i.e. decisions on applications for new pharmacies and dispensing appliance contractor premises
- The draft PNA provides information to inform how pharmaceutical services may be commissioned in the future
- The draft PNA provides enough information to inform future pharmaceutical services provision and plans for pharmacies and dispensing appliance contractors.

One respondent (25% of the 4 respondents to answer this question) agreed with the statement "There are gaps in pharmaceutical services that could be provided in a community pharmacy setting in the future that have not been highlighted". However, no further information was provided that could inform the identification of any gaps.

One specific comment about recent changes to opening hours was provided. This has been addressed with updates to section 6.1 reflecting the position as at 1st August 2022 and the addition of maps at appendix A.

Stage 7: Publication

The final PNA will be published on 1st October 2022.

4 Introduction to Portsmouth

Portsmouth is located on the south coast of England. In 2021, it is estimated that approximately 213,000 people are resident in Portsmouth.

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 (5,315 people per square kilometre in Portsmouth).

4.1 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. 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.

4.2 North Locality Profile

The North locality comprises 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 2021, it is estimated that 68,948 people live in the North locality but is estimated to increase slightly to 68,978 residents by 2025 (Hampshire County Environment Department's 2011 Census, 2021-based Small Area Population Forecasts (SAPF)). See demography and needs section for more information on the population.

Employment

The large employers in this area include Portsmouth Hospitals University NHS Trust (Queen Alexandra Hospital), Highbury College (part of City of Portsmouth 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 Morrisons.

NHS services

The ICB 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 Copnor Road Surgery which is part of the Derby Road Group Practice. Queen Alexandra Hospital, provided by Portsmouth Hospitals University 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 six opticians located in the North locality. There are 14 community pharmacies in the area (including one distance selling pharmacy) - three 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 two 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 June 2022

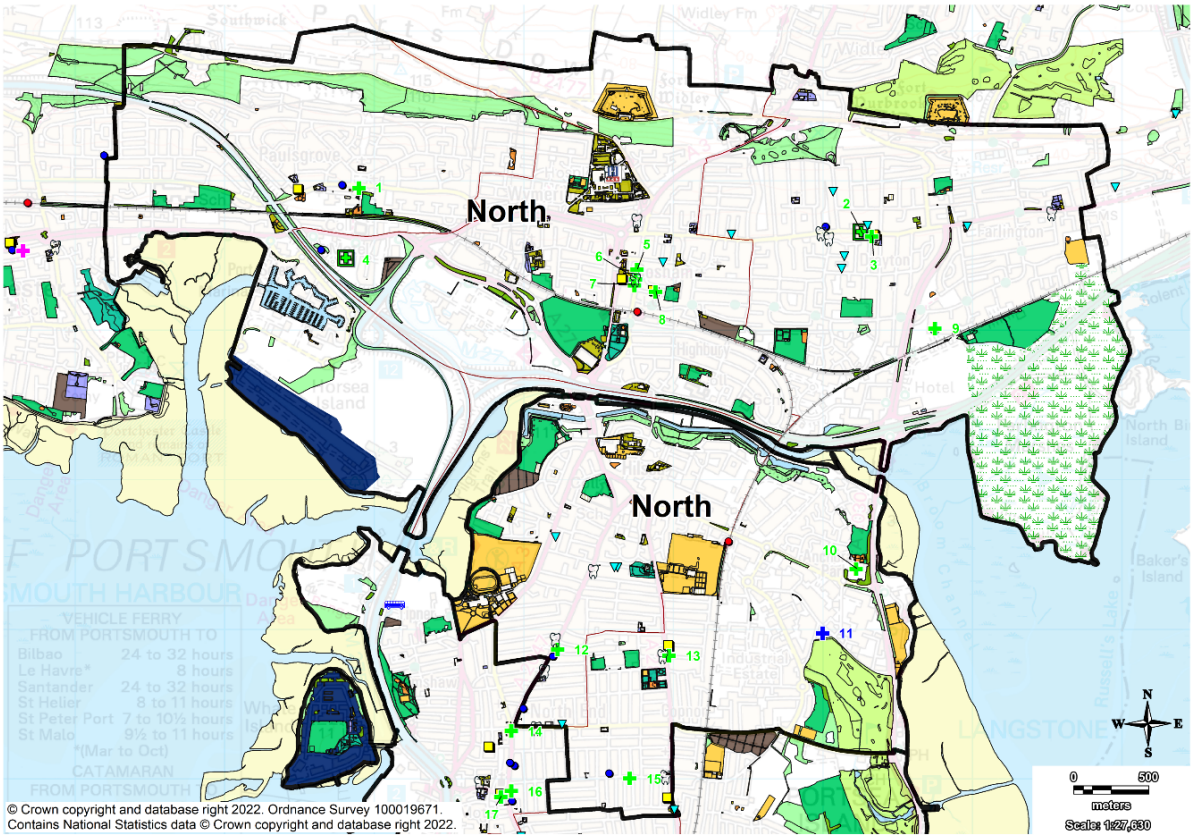

Figure 2. Map of the North locality of Portsmouth showing the location of pharmacies and other key sites, as at June 2022.

4.3 Central Locality Profile

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

Population

In 2021, it is estimated that 67,780 people live in the Central locality but is estimated to increase to 69,292 residents by 2025 (Hampshire County Environment Department's 2011 Census, 2021-based SAPF). 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 ICB member practices are Lake 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 the University Surgery. There are six dental practices providing NHS dental services and there are eight opticians located in the Central locality. There are thirteen community pharmacies in the area. Two of these pharmacies are '100' hour pharmacies providing evening and weekend services. A further three pharmacies routinely open on Sunday.

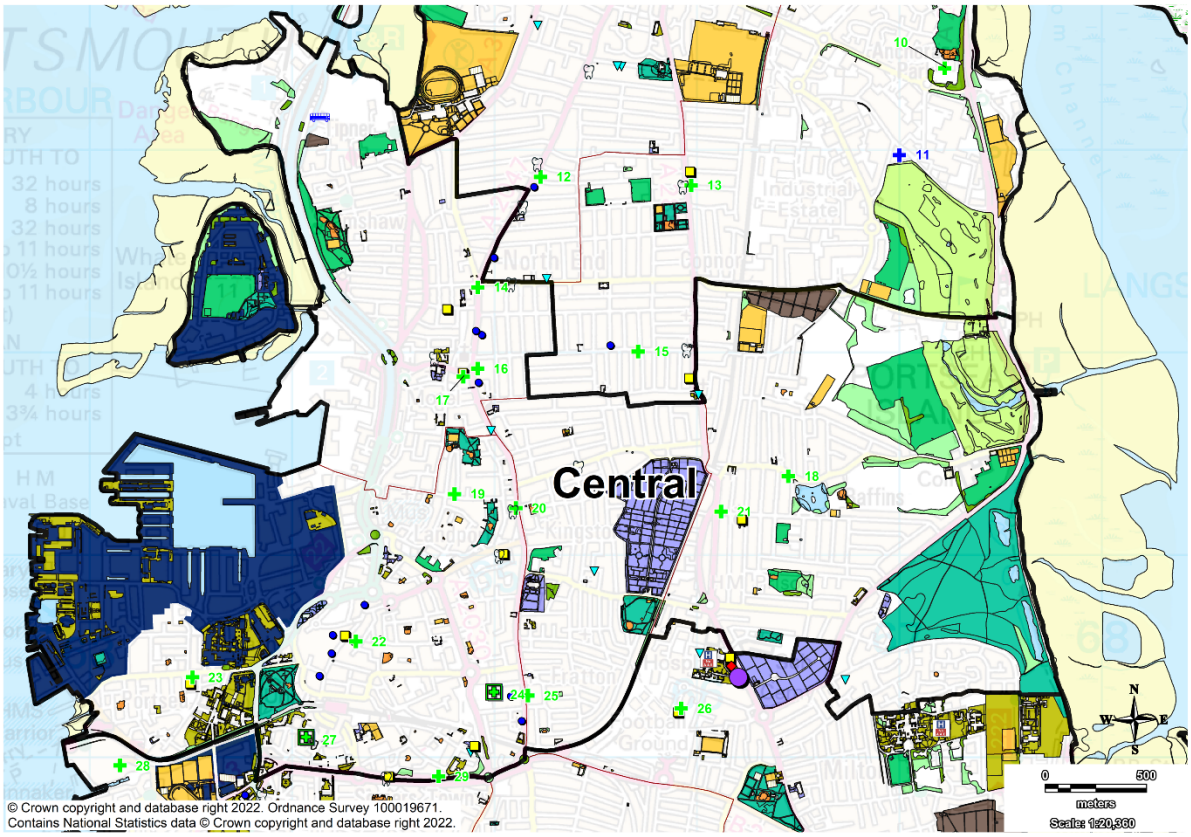

Figure 3. Map of the Central locality of Portsmouth showing the location of pharmacies and other key sites, as at June 2022. *Note: the only change following the draft PNA consultation is that the University Surgery has relocated to Commercial Road*.

4.4 South 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 2021, it is estimated that 76,361 people live in the South locality but is estimated to increase to 78,037 residents by 2025 (Hampshire County Environment Department's 2011 Census, 2021-based SAPF). See demography and needs section for more information on the population.

Employment

The larger employers in this area are in retail, leisure and the 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 and the Pompey Centre.

NHS services

The ICB member practices are Sunnyside Surgery, Portsdown Practice (Heyward Surgery), Trafalgar Medical Group (3 sites), Craneswater Group Practice (2 sites), Devonshire Practice which is part of the Lighthouse Group Practice, and East Shore Partnership (Milton Park Practice). There are twelve 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 four opticians in the South locality. The NHS St Mary's 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 Mary's 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 eleven 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.

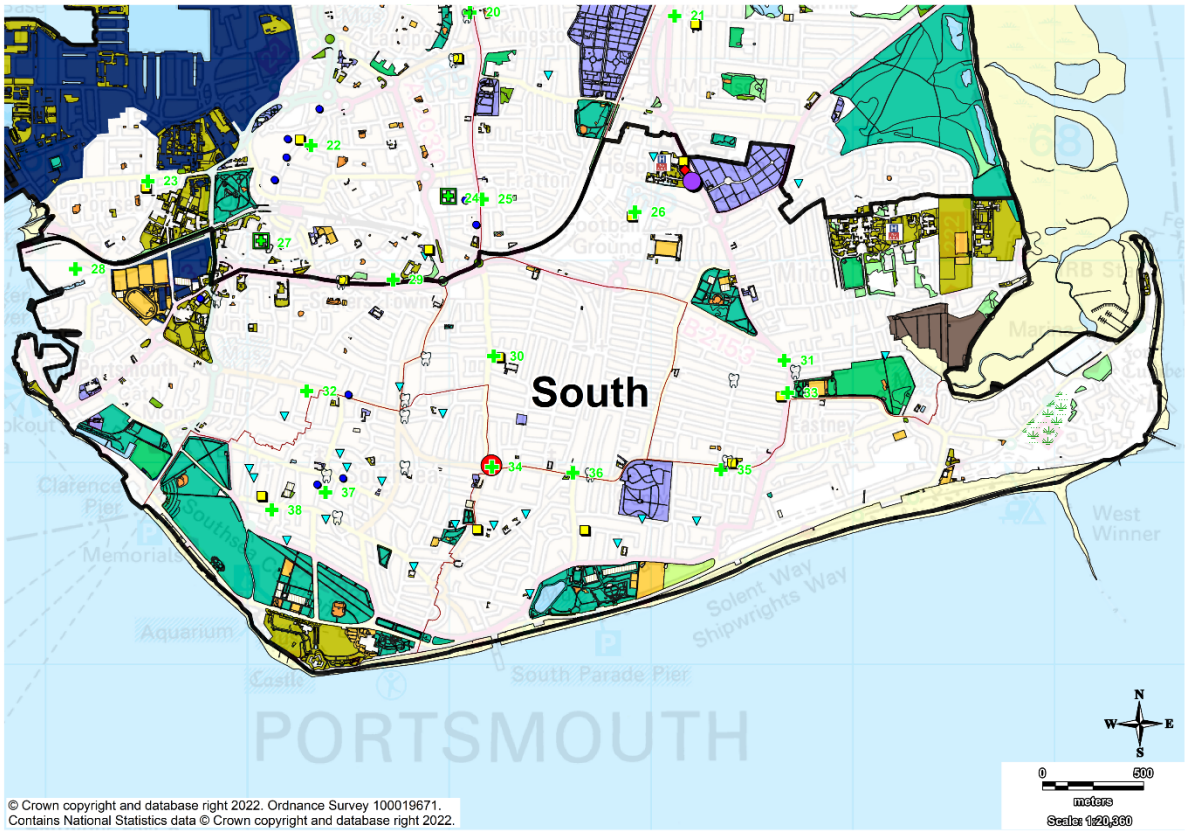

Figure 4. Map of the South locality of Portsmouth showing the location of pharmacies and other key sites, as at June 2022. *Note: the only change following the draft PNA consultation is that the University Surgery has relocated to Commercial Road*

5. Current Pharmaceutical Services

The NHS Act 2006 sets out the definition for pharmaceutical services.

5.1 Community Pharmacies

Portsmouth has 37 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 33 pharmacies providing '40 core hours' of service and 4 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.

5.2 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.

5.3 Dispensing Doctor

None of the GP practices in Portsmouth are on a dispensing doctor list. GP practices can only apply for approval to dispense to patients on their list if they meet a set of eligibility criteria, and the area has been designated a controlled locality. This usually applies to rural areas. Portsmouth is a totally urban area and the conditions for such an application would not arise.

5.4 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.

5.5 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 providing delivery services. All pharmacies within the city are also able to dispense appliances.

5.6 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.

5.7 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 to reflect changes in pharmaceutical services in the form of a supplementary statement if required, for example, when pharmacy premises open, close or relocate. This map shows the locations of the 38 community pharmacies, one distance selling pharmacy and one dispensing appliance contractor.

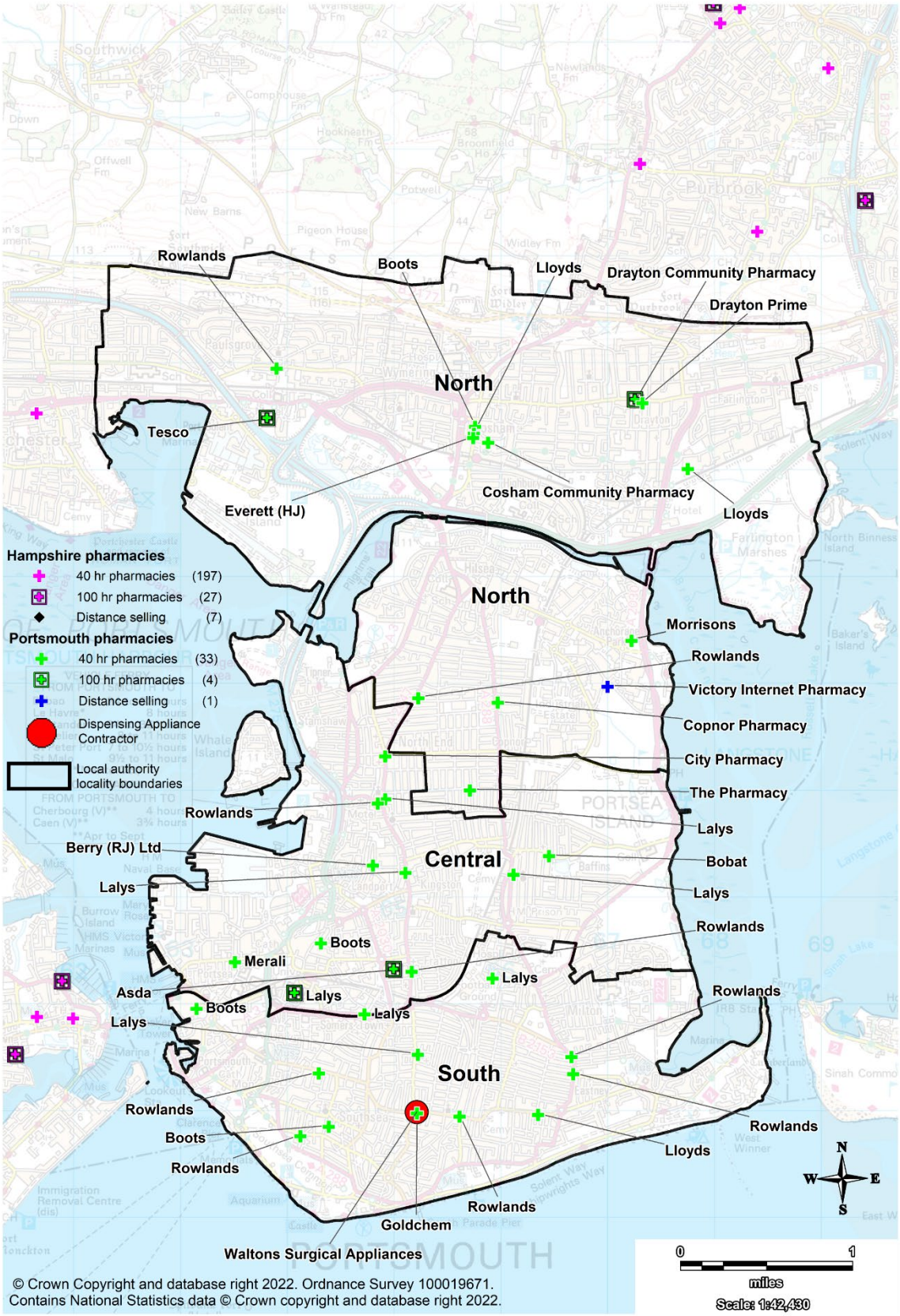

Figure 5. The map detailing the location of Pharmaceutical Service providers in Portsmouth; and the nearest providers outside the city. Source: SHAPE Place Atlas

6. 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.

6.1 Access to Pharmaceutical Services

6.1.1 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 as at 1st August 2022. Details of individual pharmacy opening times can be found on the NHS website *(*www.nhs.uk) using the "find a pharmacy" tool. 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 using supplementary hours. This gives a broad range of opening hours for the pharmacies located across the city. The maps in Appendix A and the following text relating to weekdays have been drawn based on Monday opening hours. This, in general, is the same opening hours for all weekdays.

6.1.2 100-hour core hour of service pharmacies

There are four '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.

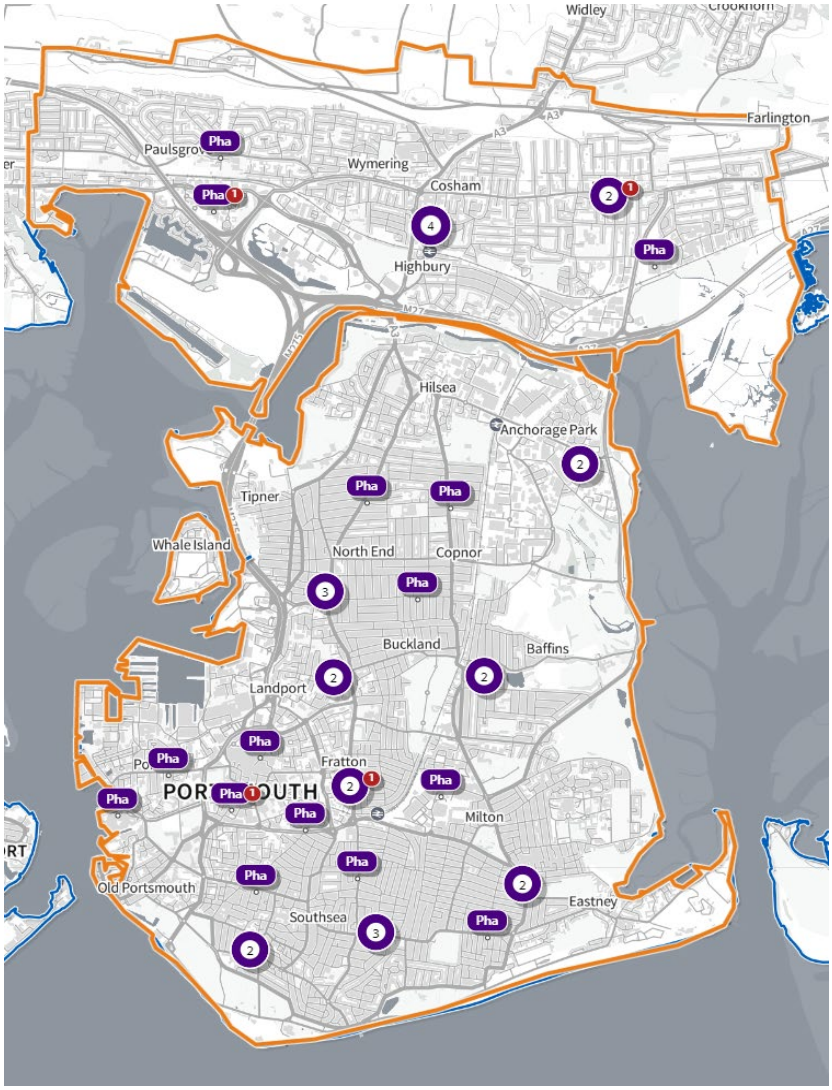

Figure 6 showing the location of 100-hour pharmacies in Portsmouth. Source: SHAPE Place Atlas

6.1.3 Opening hours during the week

For early morning access eleven pharmacies open before 9am on weekday. There is also access to NHS pharmaceutical services during the lunch period (12pm to 3pm) in all of the thirty-eight Portsmouth pharmacies. Nineteen pharmacies are continuously open during lunch time without closure. One pharmacy is closed for more than an hour. Thirteen pharmacies are closed for one hour during lunch. The remaining five pharmacies are closed for 30 minutes or less. In the evening, the four 100-hour pharmacies are open late in the evening between 8pm and 11pm. Another five pharmacies are open between 6.30pm and 8pm. The remaining twenty-nine are closed by 6.30pm.

6.1.4 Opening hours on the weekend

The majority of pharmacies are open for at least part of the day on a Saturday with only six pharmacies closed all day. Nineteen pharmacies close at 2pm or earlier, eight are also open between hours of 2pm to 6.30pm and the remaining five are open after 6.30pm as well as the majority of the day.

Thirty pharmacies are closed all day on Sunday. Eight pharmacies are open regularly on a Sunday. For four 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 two 100-hour pharmacies are open before 10am to after 5pm; and the other two pharmacies are open for 5 hrs and 5 and half hours up to 4.30pm.

6.1.5 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 holidays 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 usually available on the NHS website www.nhs.uk.

6.1.6 Access distance

6.1.6.1 Pharmacies with Buffer Zone of 1.6km

Figure 7 shows all pharmacy locations in Portsmouth with a buffer zone of 1.6km (approximately 1 mile) Euclidean distance (straight line). This demonstrates that the majority of Portsmouth's population are within 1.6km of a pharmacy. There is a small area in the north-west that is outside the merged buffer zone. However, people who live or work in this area are sufficiently covered by pharmaceutical provision in Portchester. Another area outside the 1.6km buffer zone is on the western edge of Tipner. This area corresponds to the western edge of the defence training estate and does not have a significant level of resident population. This area is an identified strategic site for housing, but there are currently no housing plans that would lead to a new residential population to emerge within the PNA timeframe. The small areas on the eastern edges of the city do not contain significant numbers of residential dwellings.

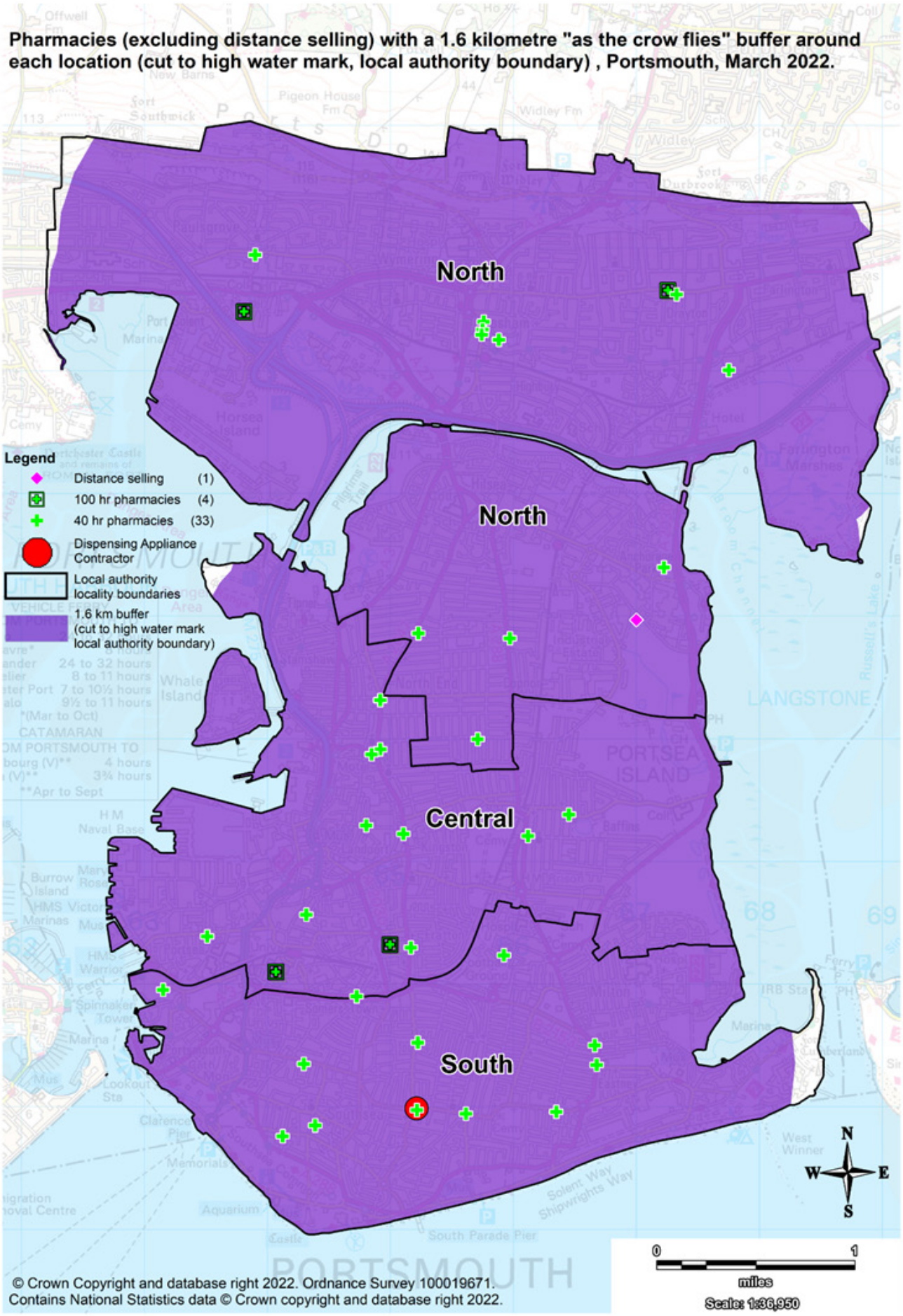

Figure 7: Map showing distance zone of 1.6km from a pharmacy inside Portsmouth.

6.1.6.2 Driving

As per table 1, a community pharmacy in Portsmouth should still be accessible within a five-minute drive for the entire population in Portsmouth. The areas shown in figure 8 which are not covered by the 5-30 minute drive times are areas with low residential density.

In terms of accessibility to New Medicine Service, Medicines Utilisation Review, Covid-19 vaccination, flu vaccination and stoma appliance customisation, the entire population of Portsmouth are within a 15-minute drive travel time. All of the mentioned services, except for Covid-19 vaccination sites, are also within a 10-minute drive-time to all residents in Portsmouth.

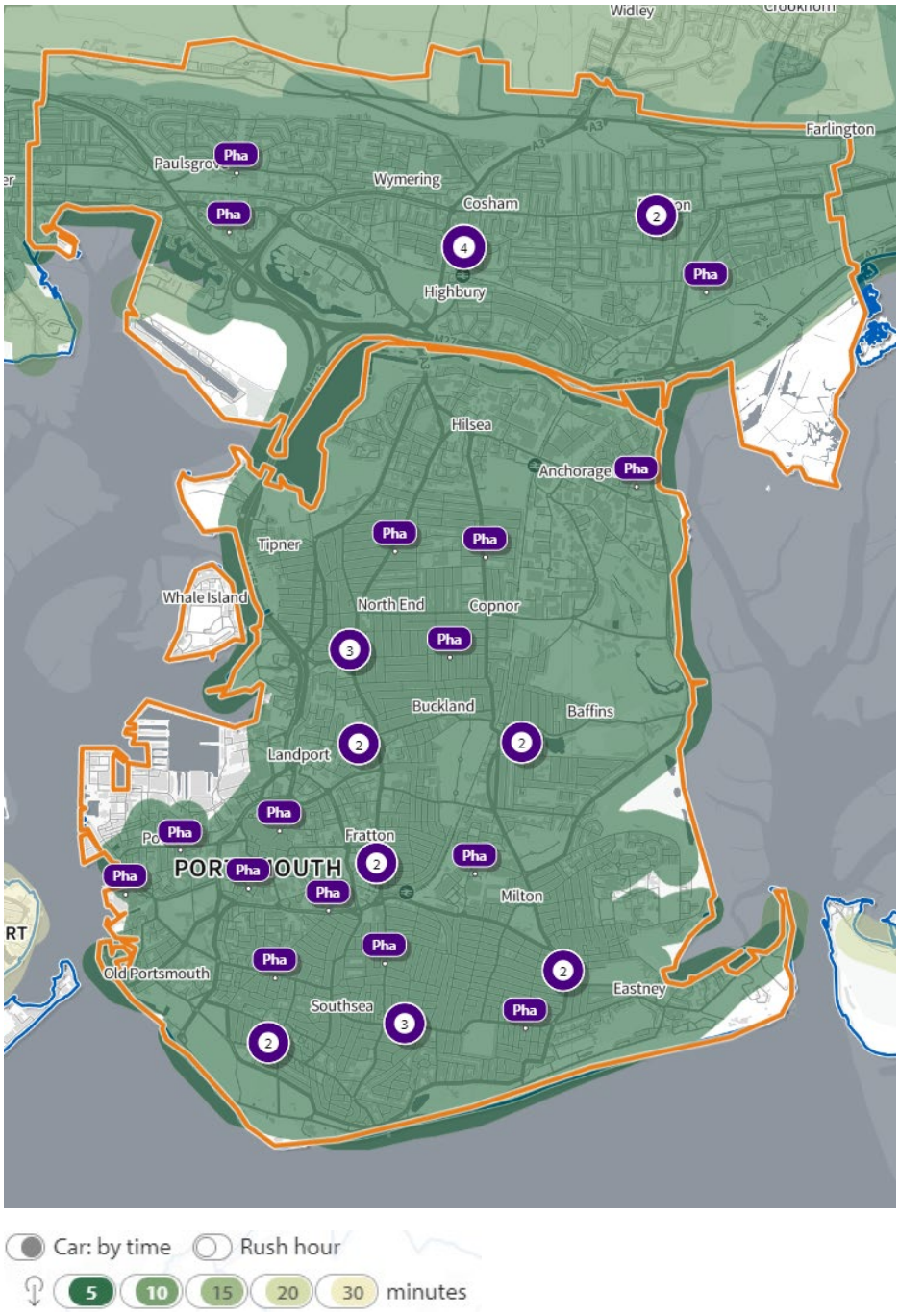

Figure 8 shows the drive times (5 to 30 minutes) to the nearest community pharmacies (excluding Victory Internet Pharmacy). Source: SHAPE Place Atlas

Access	Travel time (minutes)	Included population: Portsmouth CCG pharmacies as at February 2022	Excluded population: Portsmouth CCG pharmacies as at February 2022	% of population excluded from Portsmouth CCG pharmacies as at February 2022
	12	192,344	22,348	10.4%
	15	206,353	8,339	3.9%
Car: by time	5	214,692	0	0.0%
	10	214,692	0	0.0%
	15	214,692	0	0.0%
	20	214,692	0	0.0%
	30	214,692	0	0.0%
Public transport	5	167,888	46,804	21.8%
	10	210,815	3,877	1.8%
	15	214,692	0	0.0%
	20	214,692	0	0.0%
	30	214,692	0	0.0%
Cycle	4	183,254	31438	14.6%
	8	214,692	0	0.0%
	12	214,692	0	0.0%
	16	214,692	0	0.0%
	20	214,692	0	0.0%
Car: by time	5	213,299	1393	0.6%
	10	214,692	0	0.0%
	15	214,692	0	0.0%
	20	214,692	0	0.0%
	30	214,692	0	0.0%

Table 1 shows the travel time it takes to reach the nearest community pharmacy by walking, car, cycling and using public transport in minutes and the percentage of population included and excluded in the travel time by using each mode of transport. Source: SHAPE Place Atlas

	Services / Commissioned services	Included population: Portsmouth CCG pharmacies as at February 2022	Excluded population: Portsmouth CCG pharmacies as at February 2022	% of population excluded from Portsmouth CCG pharmacies as at February 2022
Drive time: 5 minutes	New Medcine Service	214,692	0	0.0%
	Covid	92,023	122,669	57.1%
	Flu vaccination	214,692	0	0.0%
	Stoma appliance customisation	206,369	8,323	3.9%
Drive time: 10 minutes	New Medcine Service	214,692	0	0.0%
	Covid	164,019	50,673	23.6%
	Flu vaccination	214,692	0	0.0%
	Stoma appliance customisation	214,692	0	0.0%
Drive time: 15 minutes	New Medcine Service	214,692	0	0.0%
	Covid	214,692	0	0.0%
	Flu vaccination	214,692	0	0.0%
	Stoma appliance customisation	214,692	0	0.0%
Drive time: 20 minutes	New Medcine Service	214,692	0	0.0%
	Covid	214,692	0	0.0%
	Flu vaccination	214,692	0	0.0%
	Stoma appliance customisation	214,692	0	0.0%
Drive time: 30 minutes	New Medcine Service	214,692	0	0.0%
	Covid	214,692	0	0.0%
	Flu vaccination	214,692	0	0.0%
	Stoma appliance customisation	214,692	0	0.0%

Table 2 shows drive times to essential services including New Medicine Service, Covid vaccination, flu vaccination and stoma appliance customisation in Portsmouth. Source: SHAPE Place Atlas

6.1.6.3 Cycling

85.4% of the Portsmouth population are within a four minute cycle ride of a pharmacy (excluding distance selling); and the entire 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 indicates that cycling to a pharmacy is a reasonable option.

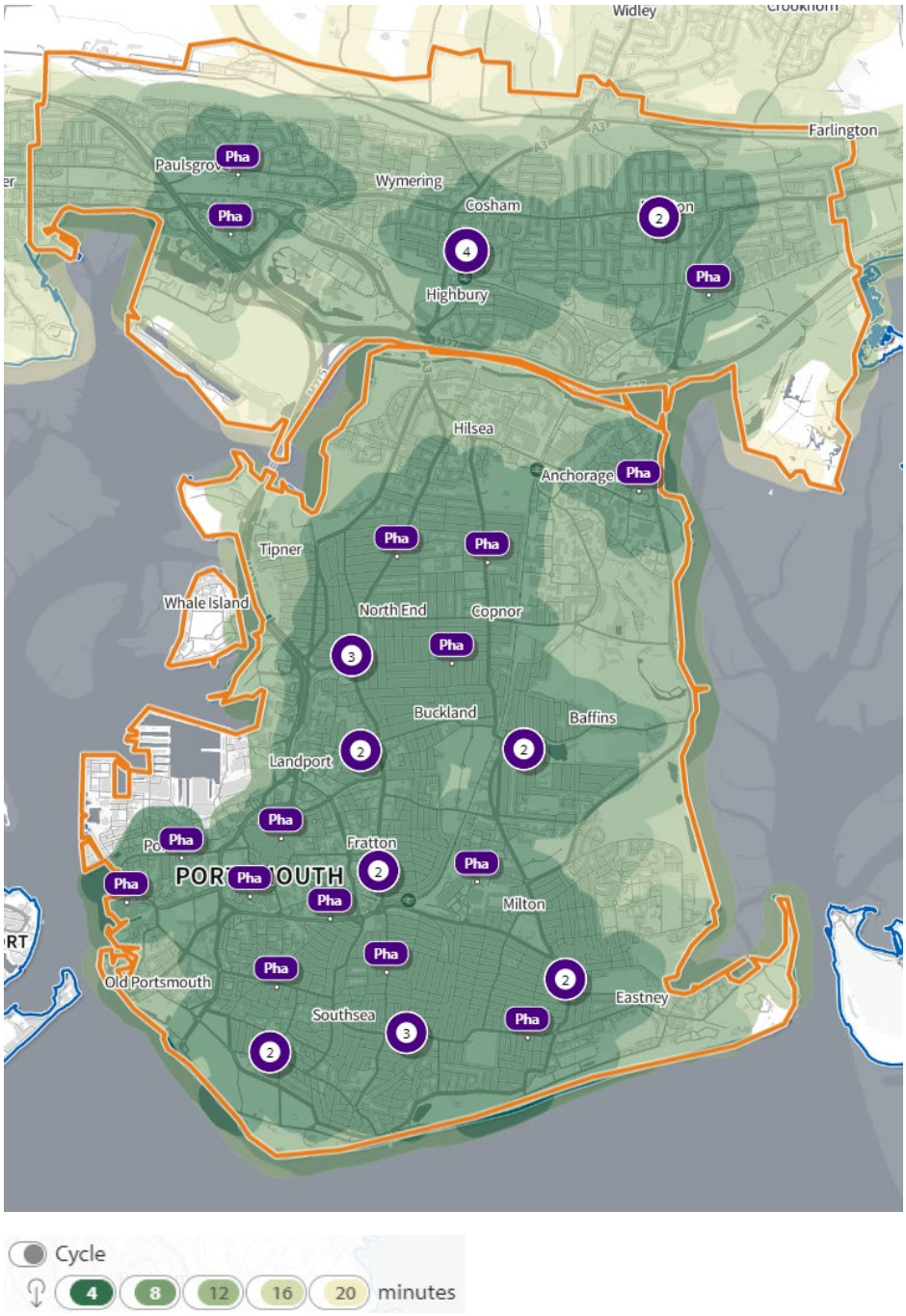

Figure 9 shows the travel times by cycling (5 to 30 minutes) to the nearest community pharmacies (excluding Victory Internet Pharmacy). Source: SHAPE Place Atlas

6.1.6.4 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.

Figure 10 shows the number of pharmacies and travel times to those sites by using public transport services.

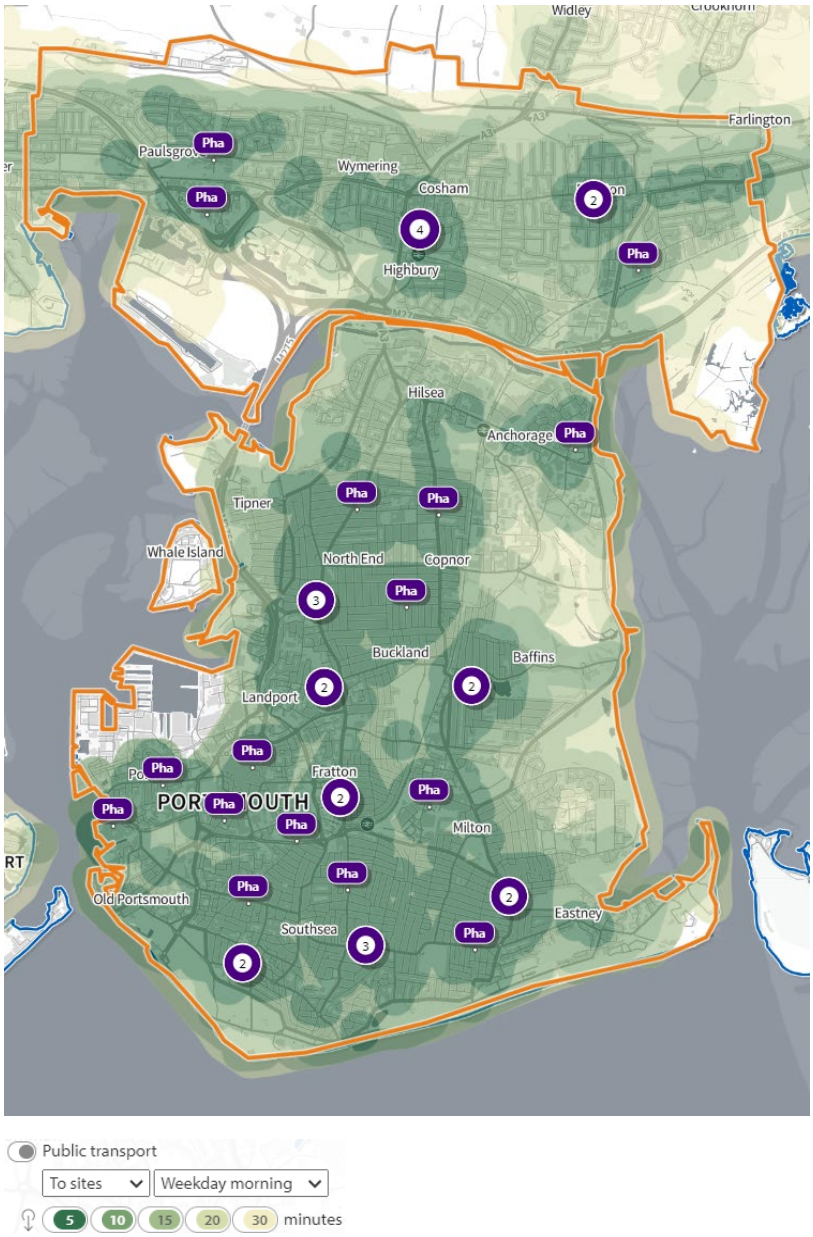

Figure 10 shows the number of pharmacies and travel times to those sites by using public transport services. Source: SHAPE Place Atlas

6.1.6.5 Walking

Over 96% of the population can reach a pharmacy in Portsmouth (excluding distance selling) within a 15-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 70% of the Portsmouth population is within a six-minute walk of a pharmacy (Figure 11). This proportion is higher in the South and Central localities of the city. Portsea Island is relatively flat with few hills/inclines which might make walking a realistic alternative for many to public transport or car use. The total Portsmouth population is within a 25-minute walk of a pharmacy.

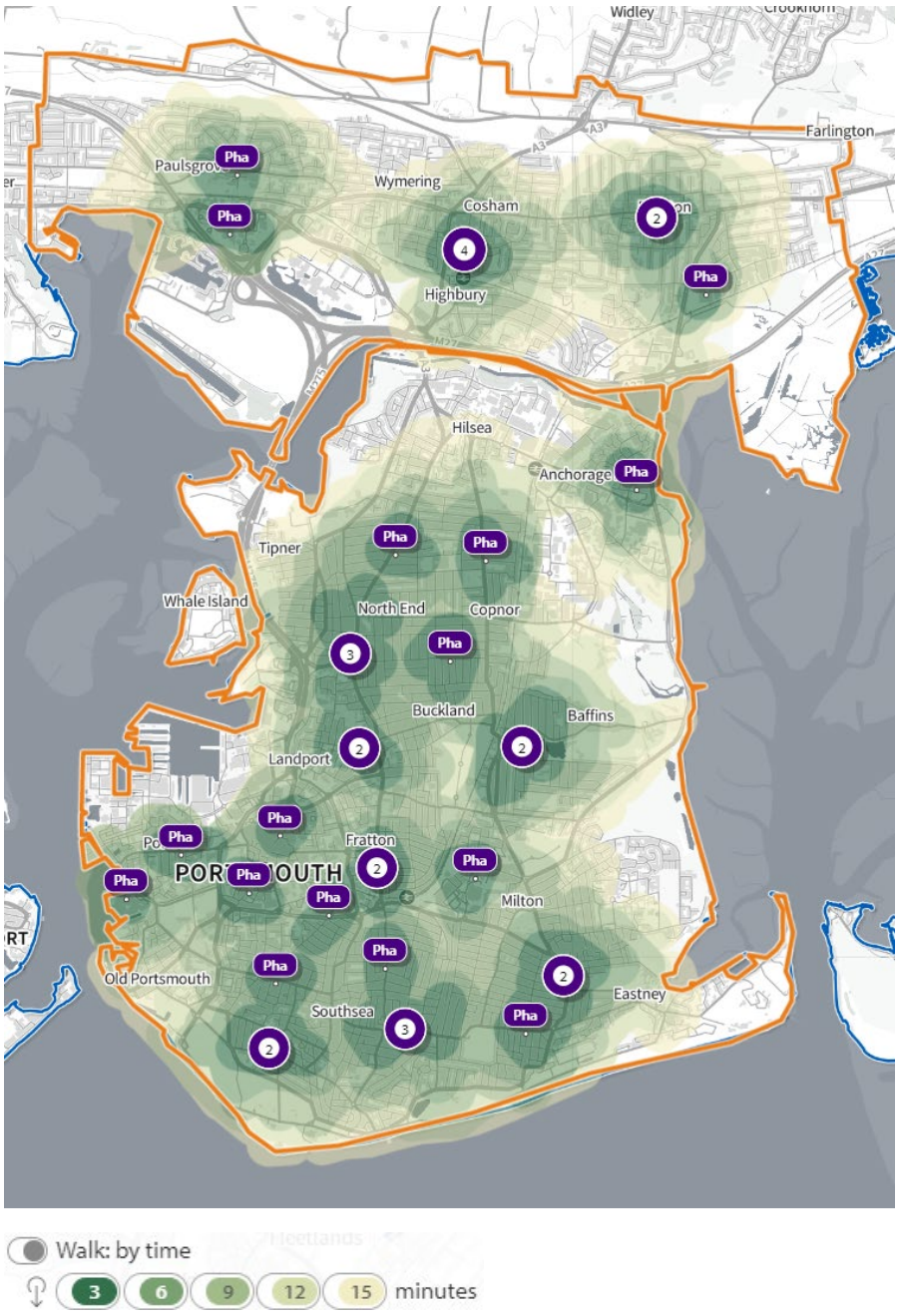

Figure 11: Map of walking times (3-15 minutes) from pharmacies in Portsmouth (excluding distance selling). Source: SHAPE Place Atlas

6.1.6.6 Proximity to GP Practices

The location of GP surgeries along with the shortest straight-line distance to a community pharmacy is given in Figure 12. Locations of GP surgeries are all within 500m straight line distance of a community pharmacy.

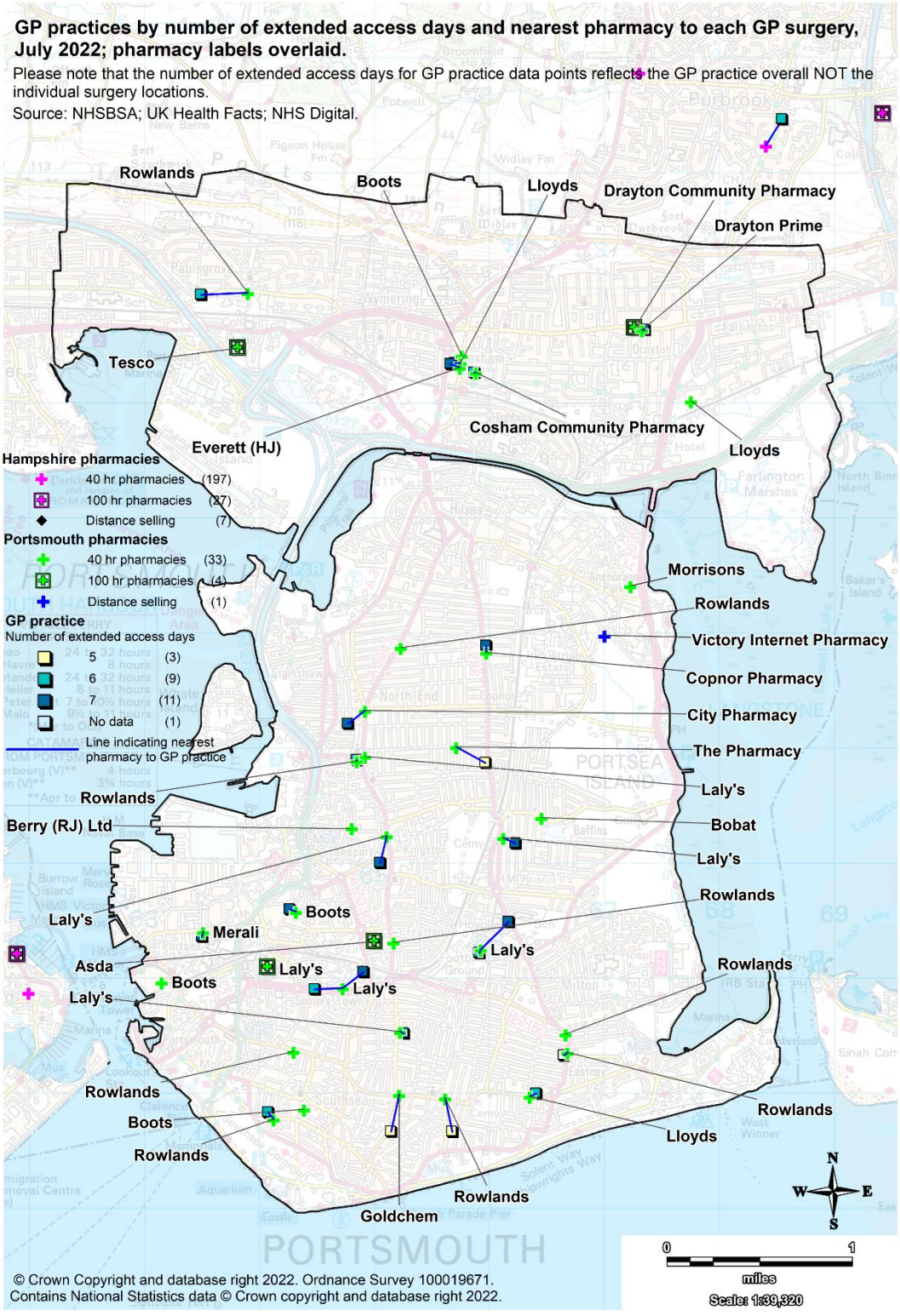

Figure 12: Map of GP surgeries proximity to pharmacies in Portsmouth. *Note: the only change following the draft PNA consultation is that the University Surgery has relocated to Commercial Road*.

6.1.7 Access for residents with additional needs

The contractor questionnaire was issued to all 38 community pharmacies and one DAC in Portsmouth. This resulted in 12 responses.

Housebound

The survey of pharmacies indicated that 9 out of 12 pharmacies who responded will collect prescriptions from GP practices across the city. 7 of these pharmacies stated they provide a delivery service free of charge to residents, including housebound patients, which is not an NHS service. Two of these pharmacies stated that they provide a delivery service with charge. One of the pharmacies stated that they provide a delivery service only to housebound patients who are unable to collect dispensed medications themselves and who have no friends and family that can help them to collect. 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 wheelchairs, 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 18 different languages were spoken from amongst Portsmouth staff in the 12 pharmacies that completed the survey. 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 in addition to English: Arabic, Bengali, Cantonese, Estonian, Farsi, French, German, Greek, Gujarati, Hindi, Hungarian, Italian, Polish, Punjabi, Russian, Swahili and Urdu.

6.2 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
- repeat dispensing and electronic prescribing services
- disposal of unwanted medicines
- providing support for self-care
- promoting healthy lifestyles
- signposting
- discharge medicine service
- clinical governance.

6.2.1 Dispensing NHS prescriptions

A range of nationally and locally available statistics has been researched to determine whether there is sufficient capacity within Portsmouth pharmacies to dispense prescriptions generated within the city. In 2020-2021 there were 3,328,922 items prescribed by Portsmouth GPs dispensed across the country (an increase of 7.2% from the 3,105,241 items dispensed in 2019-2020). More than 99% of these prescription items are dispensed through less than 100 sites. Further analysis of these 100 sites shows that 95.8% of these prescriptions are dispensed within Portsmouth community pharmacies.

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.

Table 3a shows that Portsmouth has slightly more community pharmacies per 100,000 population (17.2 per 100,000 population) compared to Hampshire and Isle of Wight Integrated Care System (ICS) (16.5 per 100,000); and fewer than the rest of England (19.2 per 100,000).

Table 3a. Number of community pharmacies (excluding distance selling pharmacies) per 100,000 population by dispensing location England, HIOW ICS and Portsmouth, as at 27th February 2022.

Dispensing location	ONS Mid-2020 Population	Number of pharmacies	Pharmacies per 100,000 population
*England	56,550,138	10,855	19.2
Portsmouth	214,692	37	17.2
Hampshire and Isle of Wight ICS	1,999,066	330	16.5

Source: NHS England

*as at January 2022

Table 3b shows that in 2020/21 Portsmouth has a slightly lower number of prescription items dispensed at Portsmouth community pharmacies per 100,000 population (1,462,520 per 100,000 population) compared to Hampshire and Isle of Wight Integrated Care System (ICS) (1,490,968 per 100,000 population); and lower than the rest of England (1,700,736 per 100,000). Overall, the number of pharmacies and their dispensing workload is broadly in line with national averages.

Table 3b. Prescription items dispensed at community pharmacies (excluding distance selling pharmacies) per 100,000 population by dispensing location England, HIOW ICS and Portsmouth, 2020/21

Dispensing location	Population Mid 2020	Number of prescription items dispensed		Prescription items dispensed (rate per 100,000 population)	
		*In-area	Total	In-area	Total
England	56,550,138	961,205,851	961,768,502	1,699,741	1,700,736
Portsmouth	214,692	3,006,425	3,139,914	1,400,343	1,462,520
Hampshire and Isle of Wight ICS	1,999,066	28,487,814	29,805,426	1,425,056	1,490,968

Source: Practice prescribing dispensing data (NHSBSA) via NHS England.
*where the number of in-area prescription items dispensed is the number of items both prescribed and dispensed in a given location.
Note that the prescription UTLA name field contained blanks meaning some in-area prescription items dispensed may have been excluded.

6.2.2 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 (now part of the ICB) 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 4).

% of EPS items out of all items for Portsmouth CCG compared to England, December 2018 to December 2021

Area	Dec-18	Dec-19	Dec-20	Dec-21
Portsmouth CCG	72.98	96.61	97.37	97.71
England	66.88	73.46	88.91	89.29

Source: EPS and eRD Utilisation Dashboard, percentage of all items prescribed as EPS comparing all CCGs (GP Practices only) in England via NHSBSA.

Table 4 shows the percentage of all items prescribed using electronic prescribing system as a proportion of all prescription items in Portsmouth and England from December 2018 to December 2021

As can be seen in Table 4, in December 2021, 97.71% of all prescription items in Portsmouth have been dispensed using electronic prescription service, which showed a significant increase from 72.98% in December 2018. The percentage of items prescribed using electronic prescription service has been higher in Portsmouth as compared to England in each year.

% of eRD items out of all EPS items for Portsmouth CCG compared to England, December 2018 to December 2021

Area	Dec-18	Dec-19	Dec-20	Dec-21
Portsmouth CCG	28.24	23.21	22.34	19.33
England	14.65	14.57	14.69	14.69

Source: EPS and eRD Utilisation Dashboard, percentage of all items prescribed as EPS comparing all CCGs (GP Practices only) in England via NHSBSA.

Table 5 shows the percentage of all items prescribed using electronic repeat dispensing system (eRD) as a proportion of all prescription items in Portsmouth and England from December 2018 to December 2021

Electronic repeat dispensing is a process that allows a patient to obtain repeated supplies of their medication or appliances without the need for the prescriber to hand sign authorised repeat prescriptions each time. This allows the prescriber to authorise and issue a batch of repeat prescriptions until the patient needs to be reviewed. The prescriptions are then available for dispensing at the specified interval by the patient's nominated dispenser. As seen on table 5, 19.33% of all items were dispensed using eRD in December 2021 in Portsmouth, which is slightly a higher figure than 14.69% in England.

6.3 Advanced Services

- There are eight 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:
- New Medicine Service (NMS)
- Appliance Use Reviews (AUR)
- Stoma Appliance Customisation
- Flu Vaccination Service
- Community Pharmacist Consultation Service (CPCS)
- Hypertension Case Finding Service
- Smoking Cessation Advanced Service
- Hepatitis C Testing Service

6.3.1 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 service 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 shows that all 38 pharmacies were accredited to deliver the New Medicine Service for 2020-21 for these patient groups, providing 4,154 provisions of service. The average for the city was 109 per pharmacy.

6.3.2 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 38 community pharmacies and one DAC in Portsmouth had 12 responses. None of the pharmacies reported 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 patient's home. Patients have good access to these services.

6.3.3 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 15 of 38 pharmacies (39%) were accredited to provide stoma customisation services for 2020-21.

6.3.4 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 38 pharmacies (95%) were accredited to deliver flu vaccinations for 2020- 2021 giving a total of 10,464 vaccinations during the flu season between September 2020 and March 2021. The average number of flu vaccinations for the city was 268 per pharmacy.

6.3.5 Community Pharmacist Consultation Service (CPCS)

This service was launched across England in October 2019. The CPCS manages a referral from NHS 111 to a community pharmacy where a patient has contacted NHS 111 for low acuity conditions / minor illness or for urgent medicine supply. The service enables appropriate access to medicines or appliances including Out-of-Hours (OOH) via community pharmacy, relieving pressure on urgent and emergency care services by shifting demand from GP out-of-hours providers to community pharmacy. All of the 38 Portsmouth pharmacies are signed up to CPCS. Since November 2021 GPs are able to refer to the CPCS.

6.3.6 Hypertension Case-Finding Service

The Hypertension Case-Finding Service (HCFS) was commissioned as an Advanced Service from 1st October 2021. The service has two stages. The first is identifying people at risk of hypertension and offering them blood pressure measurement. The second stage, where clinically indicated, is offering 24-hour ambulatory blood pressure monitoring (ABPM). The blood pressure test results will then be shared with the patient's GP to inform a potential diagnosis of hypertension.

The service received a soft launch and uptake has been relatively slow due to pressures related to the Covid-19 pandemic. It is anticipated that more local pharmacies will sign up to provide this advanced service over the lifetime of this pharmaceutical needs assessment. 15 out of 38 pharmacies in Portsmouth are signed up to HCFS.

6.3.7 Smoking Cessation Service Advanced (SCS)

The Smoking Cessation Service Advanced (SCS) was commissioned as an Advanced Service from 10th March 2022 and will be introduced for patients who started their stop-smoking journey in hospital. This service will allow NHS trusts to refer patients to a pharmacy of their choice so they can continue receiving treatment, advice, and support with their attempt to quit smoking when they are

discharged. It is expected that this service will continue to develop over the lifetime of this PNA. 7 out of 38 community pharmacies are signed up to SCS.

6.3.8 Hepatitis C Testing Service

The Community Pharmacy Hepatitis C Antibody Testing Service was added to the Community Pharmacy Contractual Framework (CPCF) in 2020, commencing on 1st September 2020. The introduction of this new Advanced Service was originally trailed in the 5-year CPCF agreement, but its planned introduction in April 2020 was delayed by five months because of the Covid-19 pandemic.

The service is focused on provision of point of care testing (POCT) for Hepatitis C (Hep C) antibodies to people who inject drugs (PWIDs), i.e. individuals who inject illicit drugs e.g. steroids or heroin but who have not yet moved to the point of accepting treatment for their substance use. Where people test positive for Hep C antibodies, they will be referred for a confirmatory test and treatment, where appropriate.

6.4 Enhanced and other locally commissioned services

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

No Specifically Commissioned Service

- Anticoagulant Monitoring: This service is provided by Portsmouth Hospitals University Trust.
- Care Home service: This service is directly provided by Health and Care Portsmouth (HCP) 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, independent and employed HCP 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. Some pharmacies also provide this service with a service charge.
- Language access service: NHS Portsmouth CCG (now part of the ICB) 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.
- 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 HCP 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.
- Emergency supply Pharmacy Urgent Repeat Medicine Service (PURMs): Commissioned by NHS England Wessex Area Team.

Service commissioned by NHS Portsmouth CCG (now NHS HIOW ICB)

- Medicines assessment and compliance support: Commissioned by NHS Portsmouth CCG.
- Minor ailment service: Commissioned by NHS Portsmouth CCG.

- On Demand Availability of Palliative Care Drugs: This service is aimed at the supply of specialist medicines, the demand for which may be urgent and/or unpredictable, for example palliative care. This service is commissioned from 2 pharmacies.

Service commissioned by Portsmouth City Council

- Public Health Needle and Syringe Exchange Service is commissioned by PCC, Public Health.
- Emergency Hormonal Contraception is commissioned by PCC, Public Health.
- Screening Service NHS Health Checks are commissioned by PCC, Public Health.
- Stop Smoking Service is commissioned by PCC, Public Health.
- A supervised consumption service is commissioned by PCC, Public Health.
- Take Home Naloxone service is commissioned as a pilot by PCC, Public Health.
- Alcohol Brief Intervention service is commissioned by PCC, Public Health.

6.4.1 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, the majority 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, synchronising 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 52 patients in the city.

6.4.2 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. Following 2018 NHSE Guidance on conditions for which over the counter items should not routinely be prescribed in primary care, the formulary was reduced to mainly paediatric formulations and the inclusion criteria comprised of individuals in receipt of income related benefits. The service is available in all areas of the city. 35 pharmacies actively took part in the scheme in 2020/21.

6.4.3 On Demand Availability of Palliative Care Drugs (ODAPCD)

This service is aimed at the supply of specialist medicines, the demand for which may be urgent and/or unpredictable, for example palliative care. The pharmacy contractor will stock a locally agreed range of specialist medicines and will make a commitment to ensure that users of this service have prompt access to these medicines at all times agreed with the commissioner. The pharmacy contractor will also provide information and advice to the user, carer and clinician. They may also refer to specialist centres, support groups or other health and social care professionals where appropriate. This service is commissioned from two pharmacies.

6.4.4 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. 32 pharmacies have a contract to provide Needle Exchange services in 2021/22.

6.4.5 Emergency Hormonal Contraception

The supply of Emergency Hormonal Contraception is available free through 35 of the community pharmacies with contracts in Portsmouth in 2021/22. 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.

6.4.6 Stop Smoking Service

The Stop Smoking 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 PCC service). 36 community pharmacies have contracts to provide this service in 2021/22.

6.4.7 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 be run through 34 pharmacies in 2021/22.

6.4.8 Take Home Naloxone

Naloxone is a drug which can reverse acute opiate overdose and prevent a drug related death and should be distributed as widely as possible to at risk drug users and their carers, with brief training provided on how to administer. Pharmacies are well placed to reach this group where they provide needle and syringe exchange and supervised consumption. The current Take Home Naloxone scheme is being piloted with eight pharmacies.

6.4.9 Alcohol Intervention and Brief Advice service.

This service is in two parts. The first is aimed at all adults and asks individuals 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. 31 community pharmacies have contracts to provide this service in 2021/22.

6.4.10 Wessex Pharmacy Urgent Repeat Medicines (PURM) Service

There is one enhanced service which is locally commissioned in Hampshire. Wessex Pharmacy Urgent Repeat Medicines (PURM) Service 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. This service is currently under review as it has been largely superseded by the CPCS with some exceptions such as walk-in provision. The number of pharmacies offering this service continues to decrease as a result. As of March 2022, 19 pharmacies in Portsmouth are providing this service.

6.4.10 COVID-19 Vaccination Service

Two pharmacies have reported COVID-19 vaccination service activity. These pharmacies offering COVID-19 vaccination service are located in the Southern and Central Locality of Portsmouth. There is currently no community pharmacy offering this service in Northern Locality.

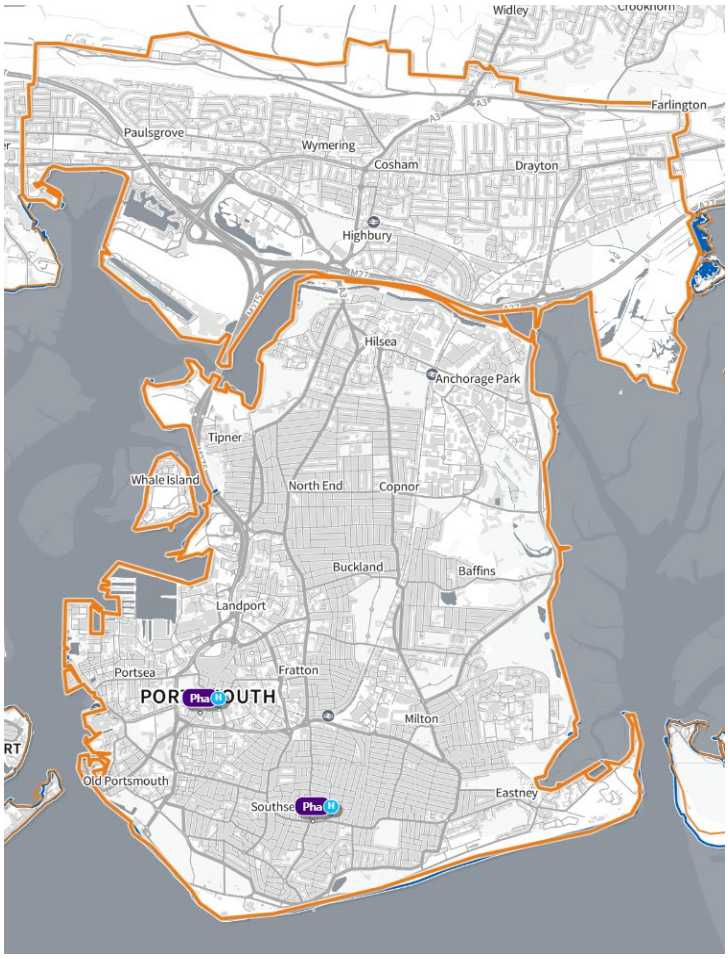

Figure 13: Map showing the locations of pharmacies providing COVID-19 vaccination service in Portsmouth. Source: SHAPE Place Atlas

7. Public Consultation

Public consultation will take place as part of statutory consultation process that will run throughout April and May, with members of the public able to respond to the survey via the council's website. Conclusions will be reflected in the final version of PNA in October 2022.

8 Demographic and health needs of Portsmouth

8.1 Population

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 (5,315 people per square kilometre in Portsmouth). [1]

In 2020, approximately 214,700 people are estimated to be resident in Portsmouth - the annual population estimate has been broadly similar since 2017. These estimates are largely based on births, deaths and estimated migration data and, to a lesser extent, changes in special populations (home armed forces, foreign armed forces and the prison population)—although there remain more births than deaths each year in Portsmouth, and a positive net international migration (more inflow than outflow), this is offset by a negative internal migration (more UK outflow than UK inflow). [2] Although the population increase is estimated to have slowed since 2017; nevertheless, the population is projected to increase (albeit projections based on 2018 estimates) by roughly 5,000 (2.3%) between 2021 and 2030 - from 217,330 to 222,300. The projected increase between this period is largely an anticipated increase in the number of 15-24 year olds and an increase in residents aged 65 years and over. [3]

As at 1st April 2021, nearly 230,100 people were registered with Portsmouth City GP Practices[4] - although the vast majority are resident to Portsmouth (roughly 95%), 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 (i.e. either in employment in Portsmouth, or not in employment but living in Portsmouth), which was higher than the 2011 population of 205,433. 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).

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

Portsmouth has a comparatively high proportion of young people aged 20-24 years, compared to England, largely due to the city's University and colleges (11.3% of Portsmouth's total population compared with 6.1% nationally). (Figure 14)

[1] Mid-2020 population estimates. Local Authorities in England, Office for National Statistics (ONS)

[2] Mid-2020 population estimates. Local Authorities in England, Office for National Statistics (ONS)

[3] SNPP Z1: 2018-based Subnational Population Projections. Local Authorities in England, mid-2018 to mid-2043, Office for National Statistics (ONS) © Crown Copyright 2020 via Portsmouth Joint Strategic Needs Assessment (JSNA) webpage: www.jsna.portsmouth.gov.uk

[4] Number of Patients Registered with a GP Practice, NHS Digital https://digital.nhs.uk/ Accessed 22 June 2021

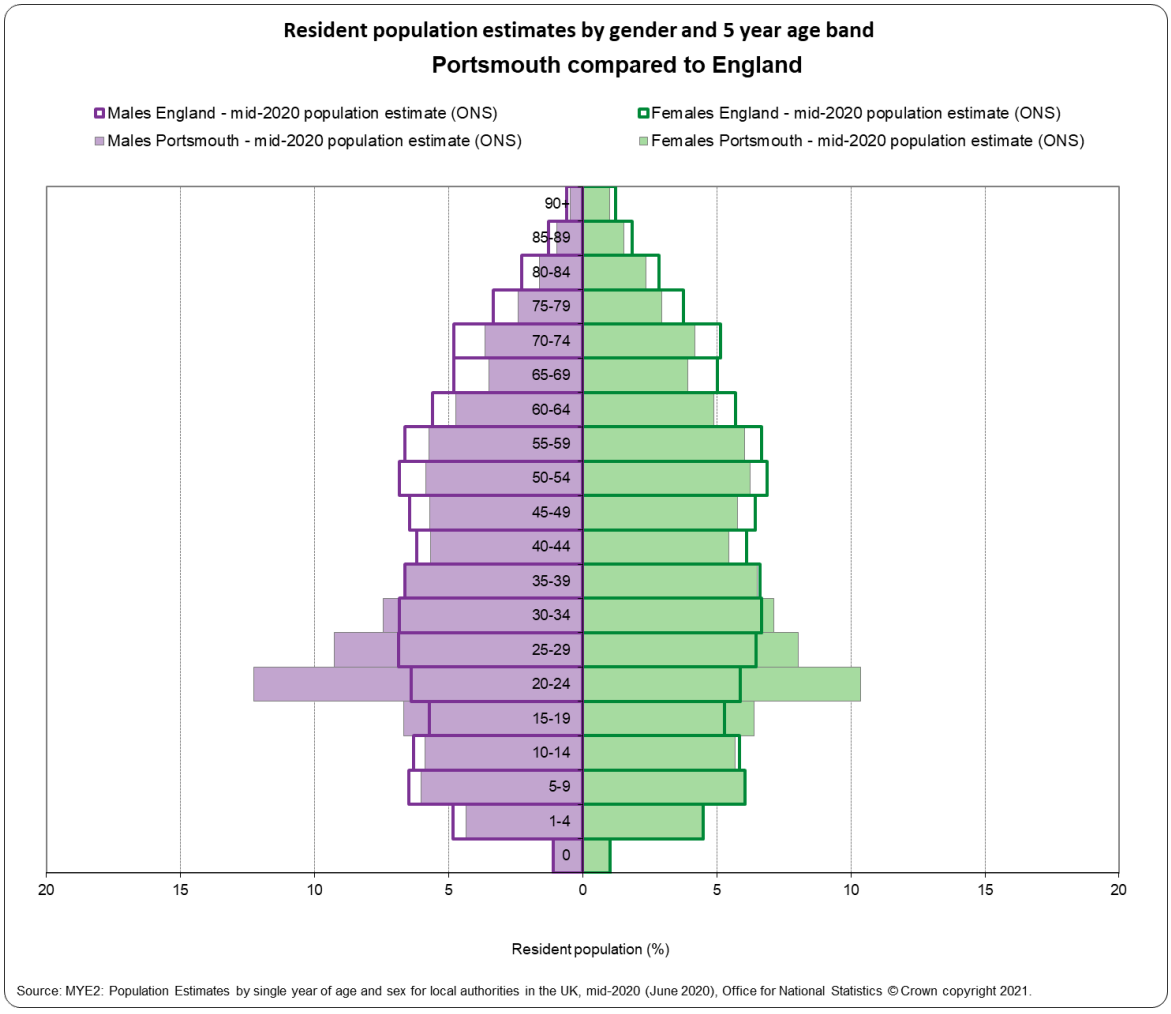

Figure 14. ONS mid-2020 resident population estimate by gender and 5 year age bands, Portsmouth City compared to England

In 2020, approximately 140,800 people aged 18-64 years are estimated to be resident in Portsmouth; and approximately 30,600 residents aged 65 years and over (of which approximately 4,300 are aged 85 years and over). [5]

[5] Mid-2020 population estimates. Local Authorities in England, Office for National Statistics (ONS)

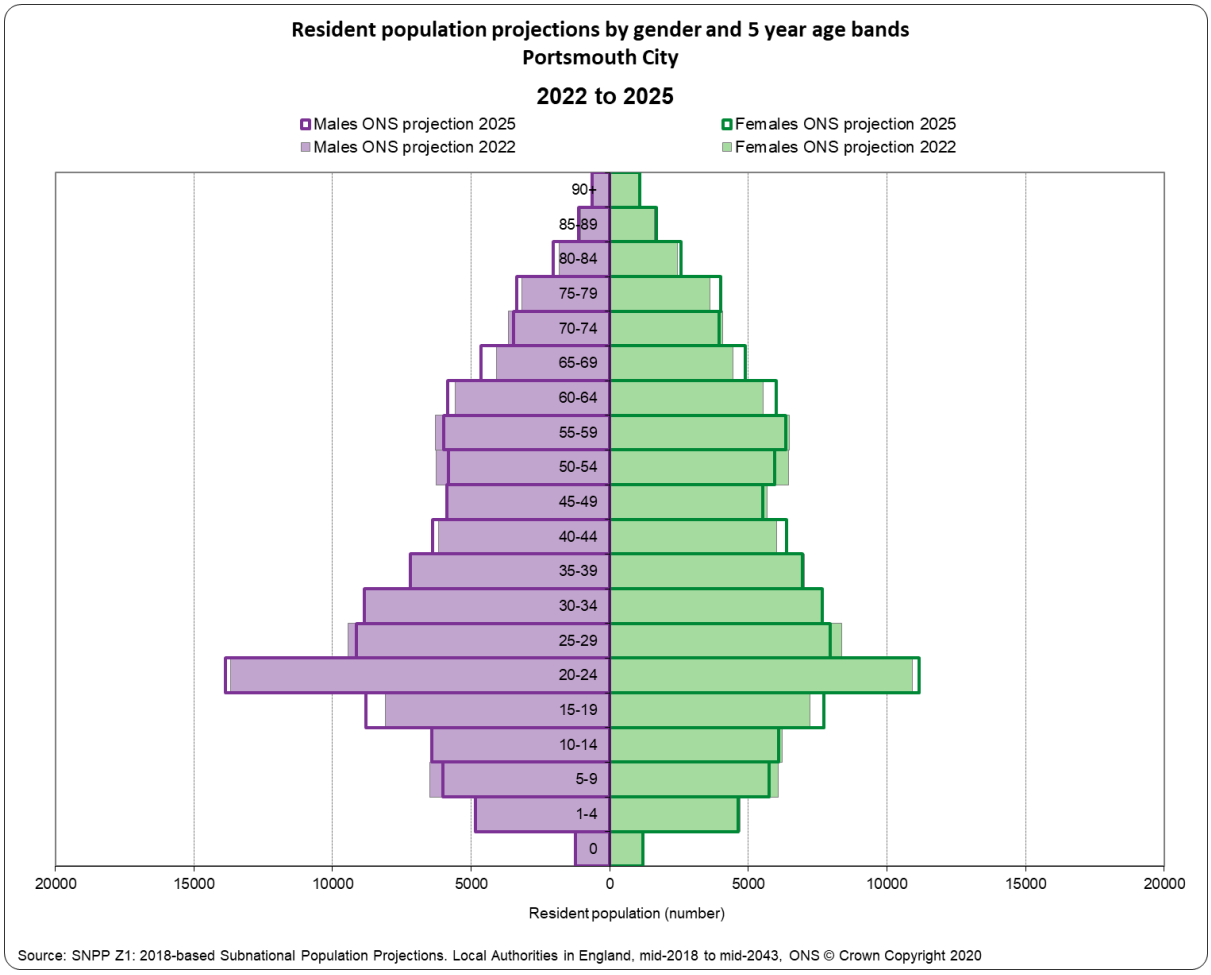

Figure 15. Resident population projections by gender and 5 year age bands, Portsmouth City, 2018-based 2022 projection compared to 2025 projection

8.1.1 Population by locality[6]

The North, Central and South localities mentioned below consist of the following electoral wards:
North locality: Paulsgrove; Cosham; Drayton and Farlington; Hilsea; and Copnor
Central locality: Nelson; Charles Dickens; Fratton; and Baffins
South locality: St. Thomas; St. Jude; Central Southsea; Milton; Eastney and Craneswater.

In 2022, 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 16). However, by 2025, the population in the North is forecast to increase the most for those aged 35-44 years, aged 75-79 years and males in particular aged 75 years and over; whilst the population is predicted to decrease the most in ages 5-9 years and aged 70-74 years (Figure 17).

[6] Hampshire County Environment Department's 2011 Census, 2020-based Small Area Population Forecasts (localities calculated from aggregating electoral ward data)

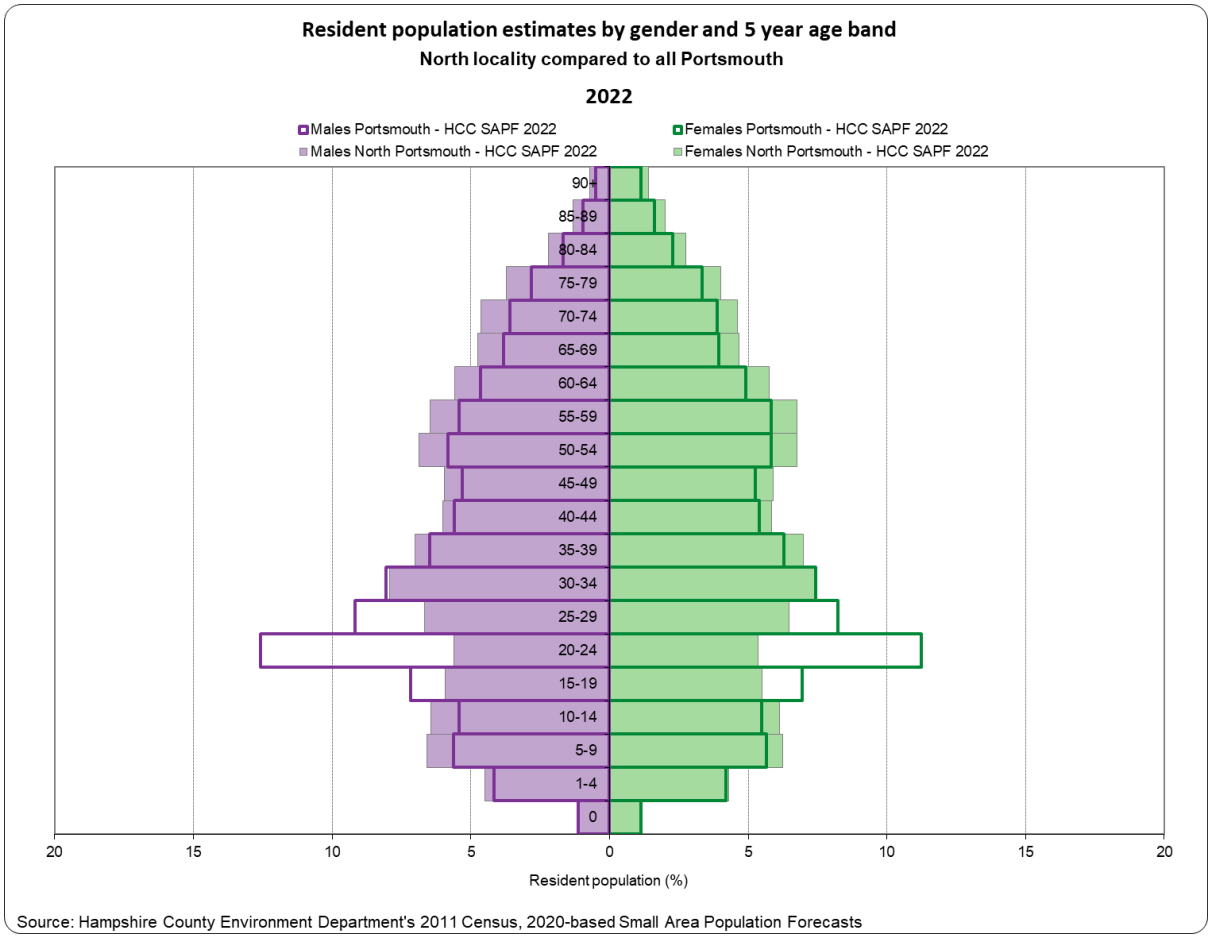

Figure 16. Resident population estimates by gender and 5 year age band, North locality compared to all Portsmouth, 2022.

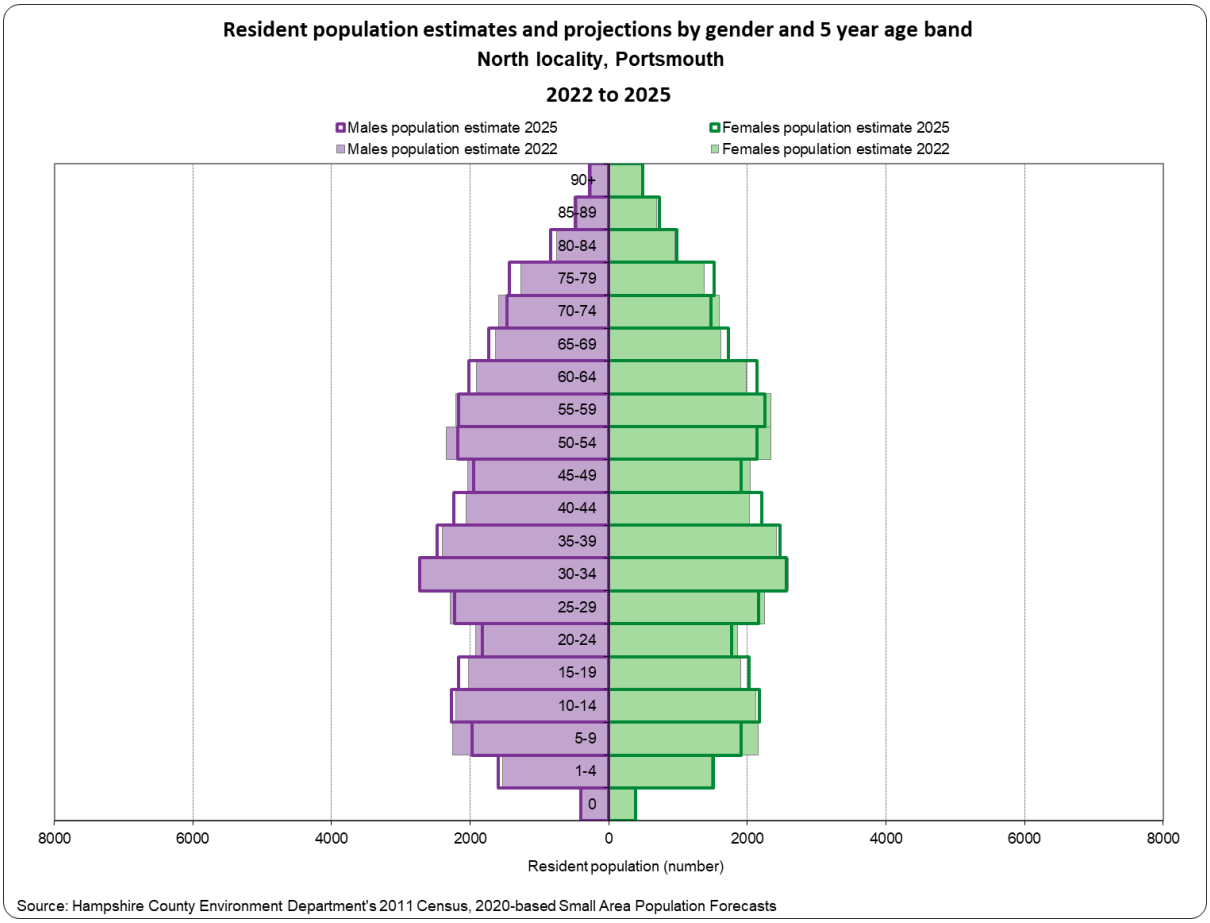

Figure 17. Resident population estimates and projections by gender and 5-year age band, North locality, 2022 compared to forecasted 2025.

In 2022, 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 50 years in general (except the aged 20-24 years group) (Figure 18). By 2025, the population in the Central locality is forecast to increase the most for those aged 15-19 years, aged 60-69 years and aged 75-79 years; whilst the population is forecast to decrease the most in ages 5-9 years, ages 50-54 years and 70-74 years (Figure 19).

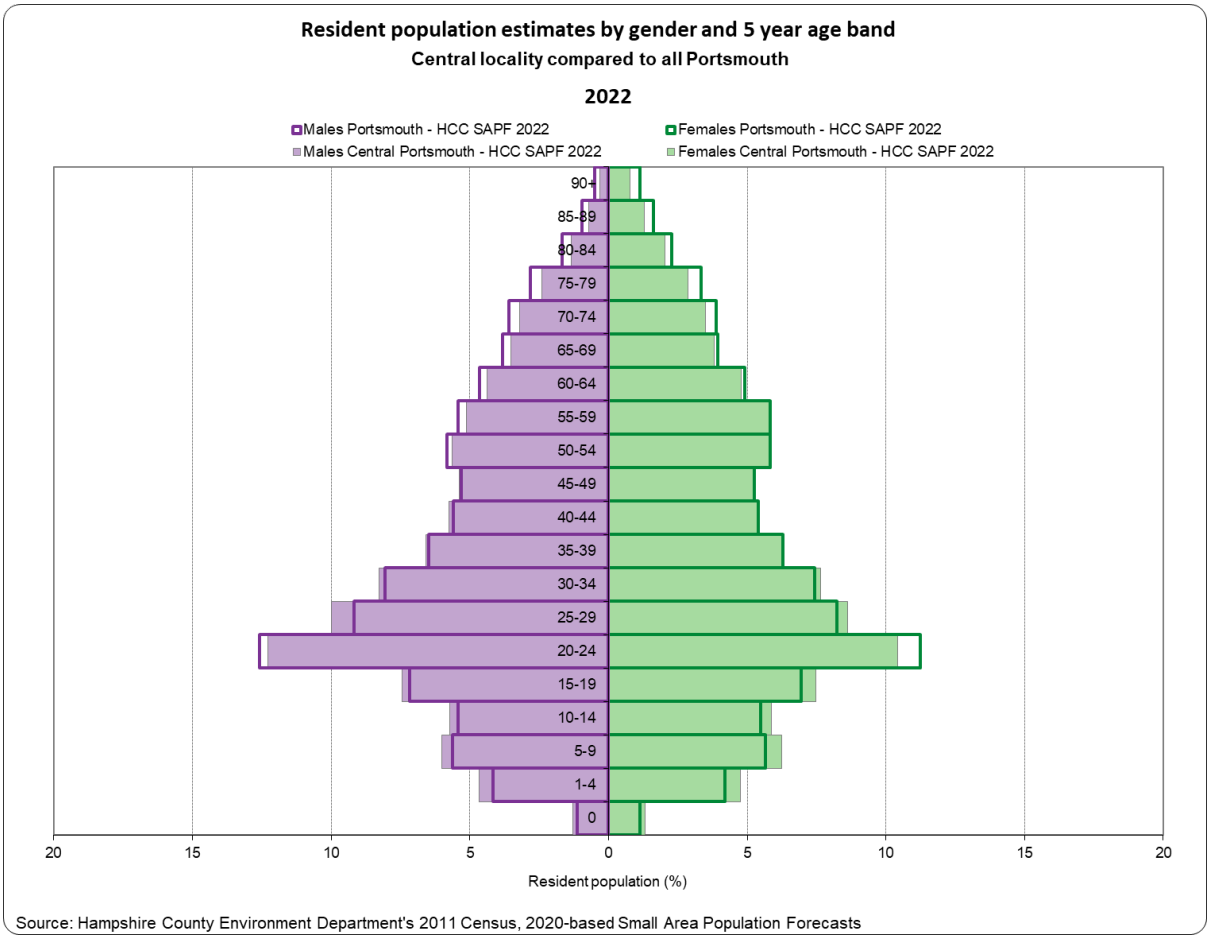

Figure 18. Resident population estimates by gender and 5 year age band, Central locality compared to all Portsmouth, 2022.

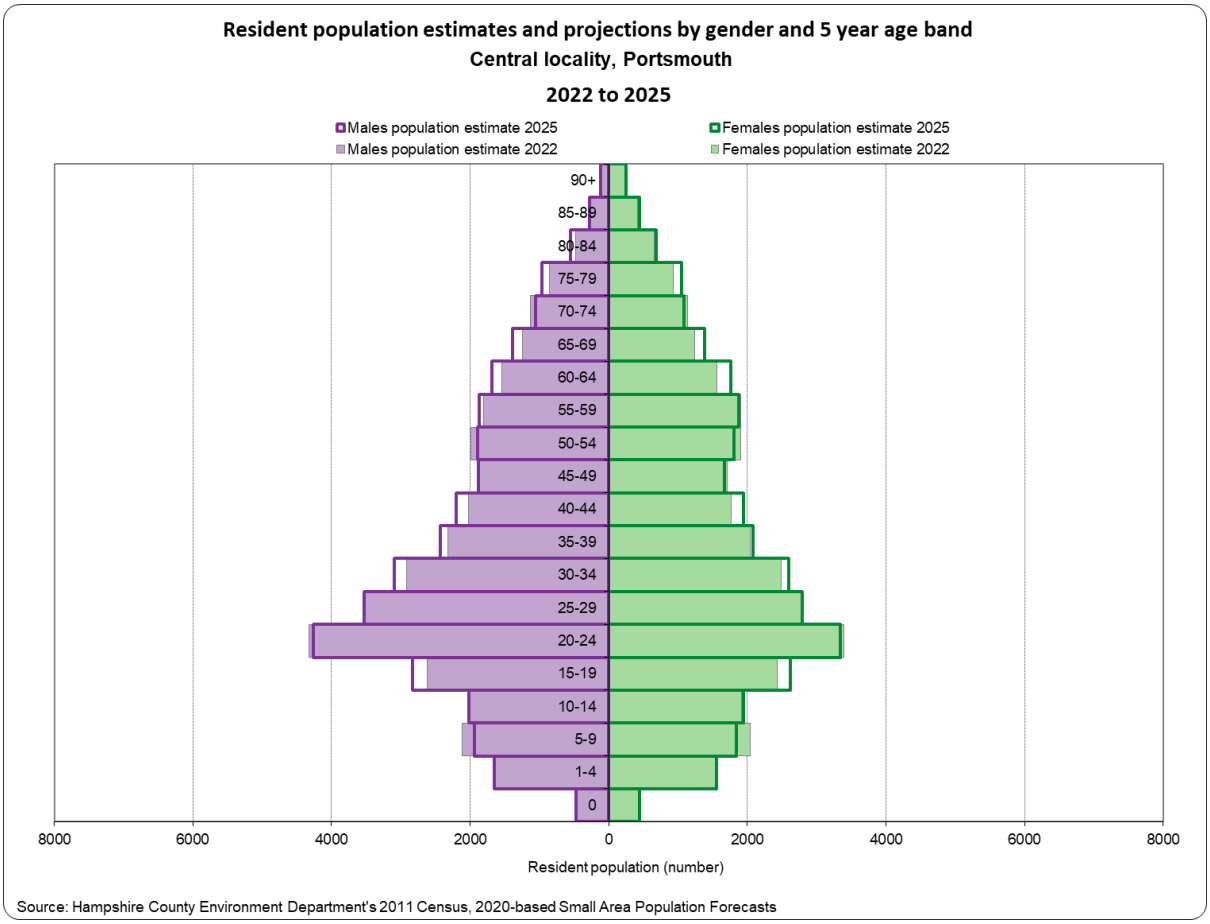

Figure 19. Resident population estimates and projections by gender and 5-year age band, Central locality, 2022 compared to forecasted 2025.

In 2022, 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 30-89 years (45-74 years in particular) than the Portsmouth average (Figure 20). However, by 2025, the population in the South is forecast to increase the most for those aged 30-44 years, aged 60-69 years and aged 75-79 years; whereas the population is predicted to decrease the most in aged 45-54 years and aged 70-74 years (Figure 21).

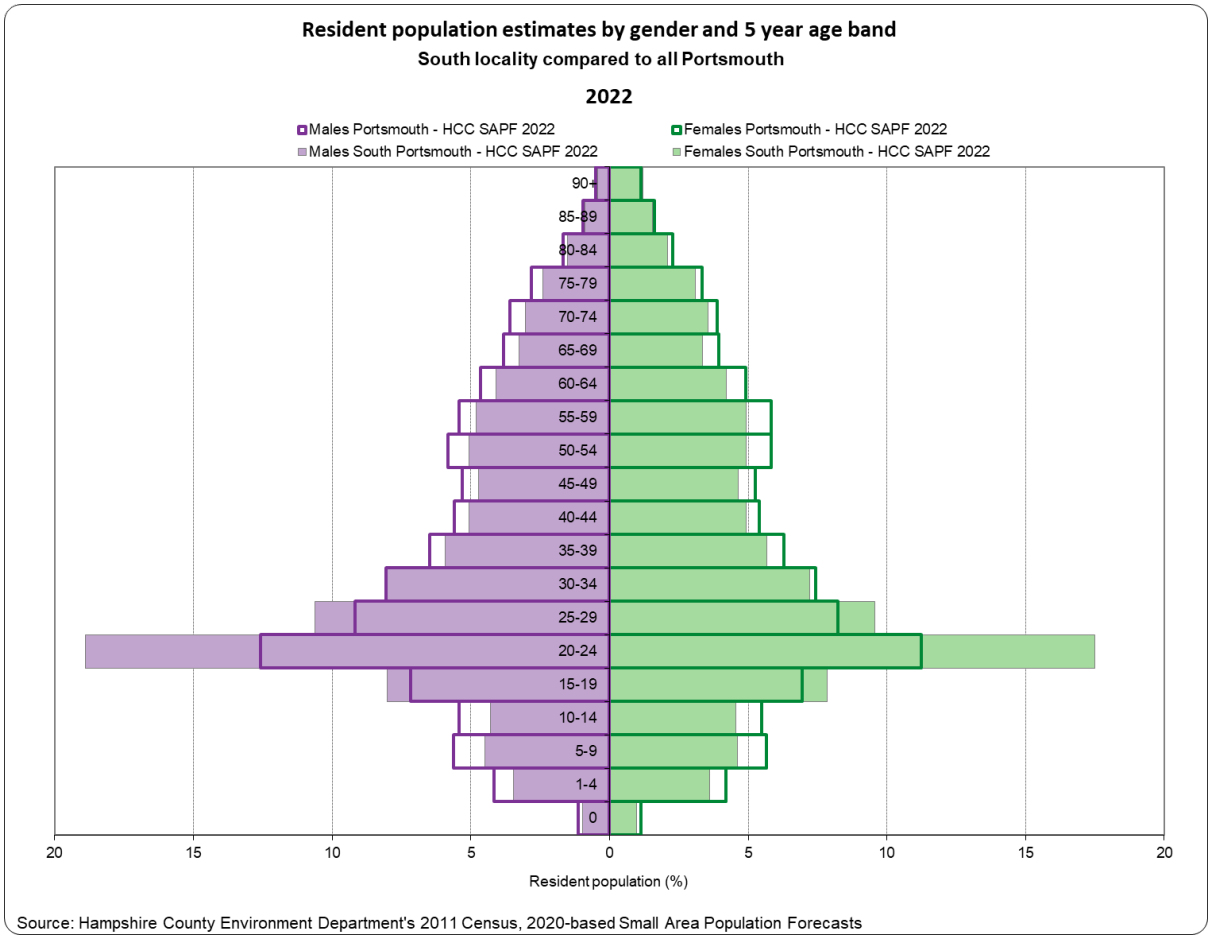

Figure 20. Resident population estimates by gender and 5 year age band, South locality compared to all Portsmouth, 2022.

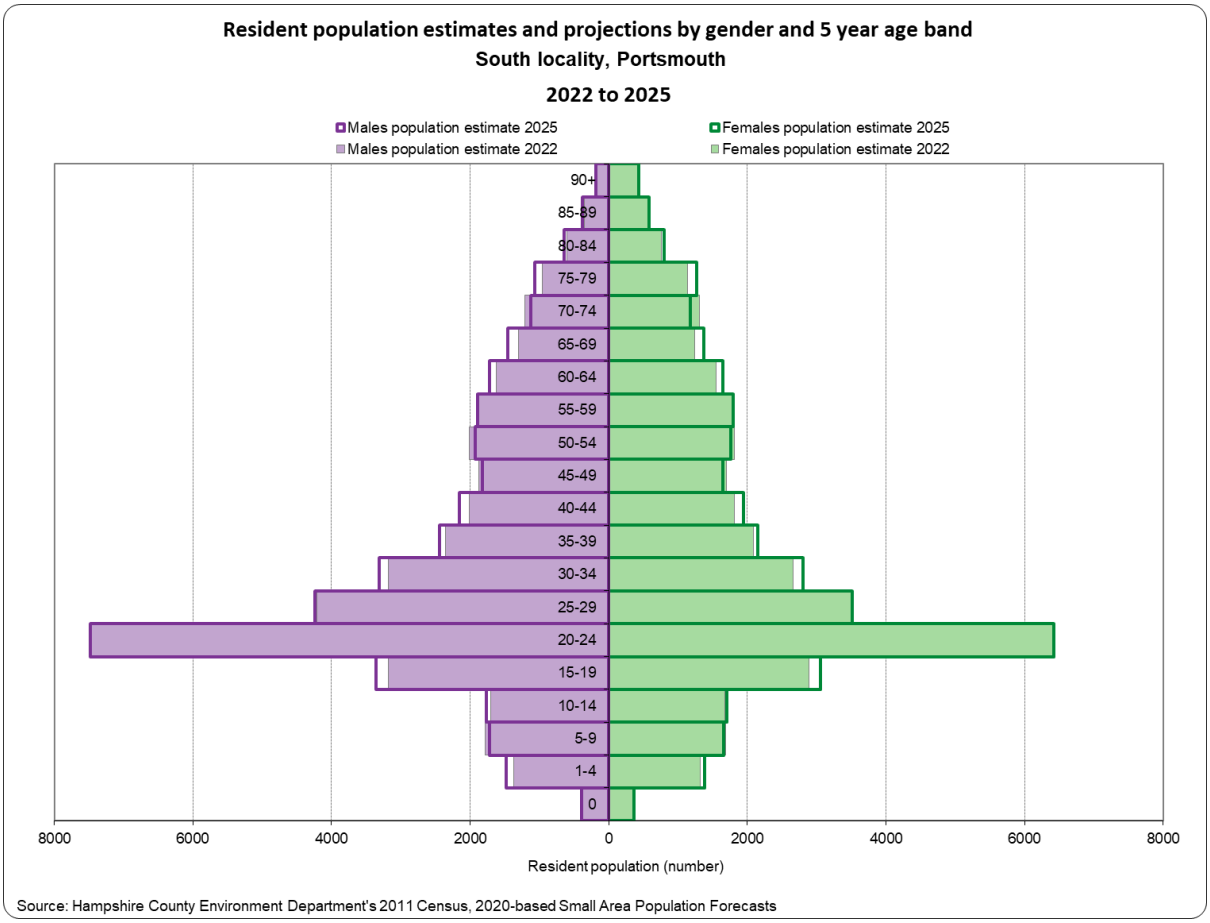

Figure 21. Resident population estimates and projections by gender and 5-year age band, South locality, 2022 compared to forecasted 2025.

8.2 Sub-national population projections

The total Portsmouth population is predicted to increase by nearly 1,500 from 2022 to 2025; and increase by roughly 9,300 between 2022 to 2043.

8.2.1 Children and young persons

Between 2021 and 2043, the population aged 0-4 years is projected to remain relatively stable albeit an increase of 9% (roughly 1,000 infants).

The 5-11 years age group is projected to decrease by 12% by 2030 (roughly 2,100 fewer children compared to 2021) before increasing again by 2043 (an additional 600 children compared to 2030).

The 12-17 years age group is projected to remain relatively stable albeit a decrease of 8% by 2043 (roughly 1,100 children).

The 18-24 years age group is projected to increase by 16% by 2030 (roughly 5,100 more young persons compared to 2021) before decreasing again by 2043 (roughly 3,100 fewer compared to 2030). [7]

[7] SNPP Z1: 2018-based Subnational Population Projections. Local Authorities in England, mid-2018 to mid-2043, Office for National Statistics (ONS) via Portsmouth Joint Strategic Needs Assessment (JSNA) webpage: www.jsna.portsmouth.gov.uk

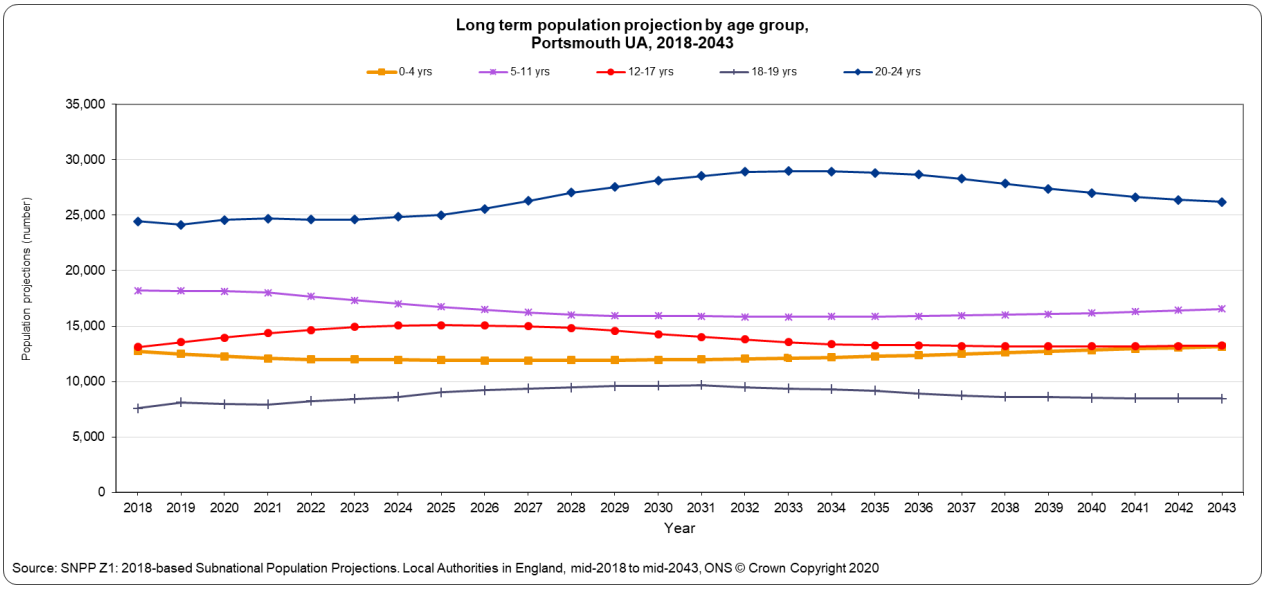

Figure 22. Long term population projections for children and young people, Portsmouth City, 2018- 2043 projection

8.2.2 Working age population

Between 2021 and 2030, the Portsmouth working age adult population aged 18–64 years (though for the purposes of dependency ratios this is usually 15-64 which will be covered later) is projected to increase by 1% (roughly 1,300 people); but this increase is largely due to the younger age group; whereas there is a projected decrease of 14% in the 50-59 year old age group. By 2043, the working age adult population is expected to decrease to a similar total number compared to 2021. [8]

8.2.3 Population aged 65 and over

Between 2021 and 2030, the population aged 65+ years is projected to increase by 19% (projected population of 37,200 in 2030) and those aged 80+ years by 28% (projected population of 11,000 in 2030). It is anticipated that this will increase further with a 35% increase by 2043 (compared to 2021) - that is 19% (roughly 42,100 people aged 65 years) of Portsmouth's population is expected to be aged 65 years and over by 2043 compared to 14% (roughly 32,000 people aged 65 years) of Portsmouth's population in 2020. [9]

[8] SNPP Z1: 2018-based Subnational Population Projections. Local Authorities in England, mid-2018 to mid-2043, Office for National Statistics (ONS) via Portsmouth Joint Strategic Needs Assessment (JSNA) webpage: www.jsna.portsmouth.gov.uk

[9] SNPP Z1: 2018-based Subnational Population Projections. Local Authorities in England, mid-2018 to mid-2043, Office for National Statistics (ONS) via Portsmouth Joint Strategic Needs Assessment (JSNA) webpage: www.jsna.portsmouth.gov.uk

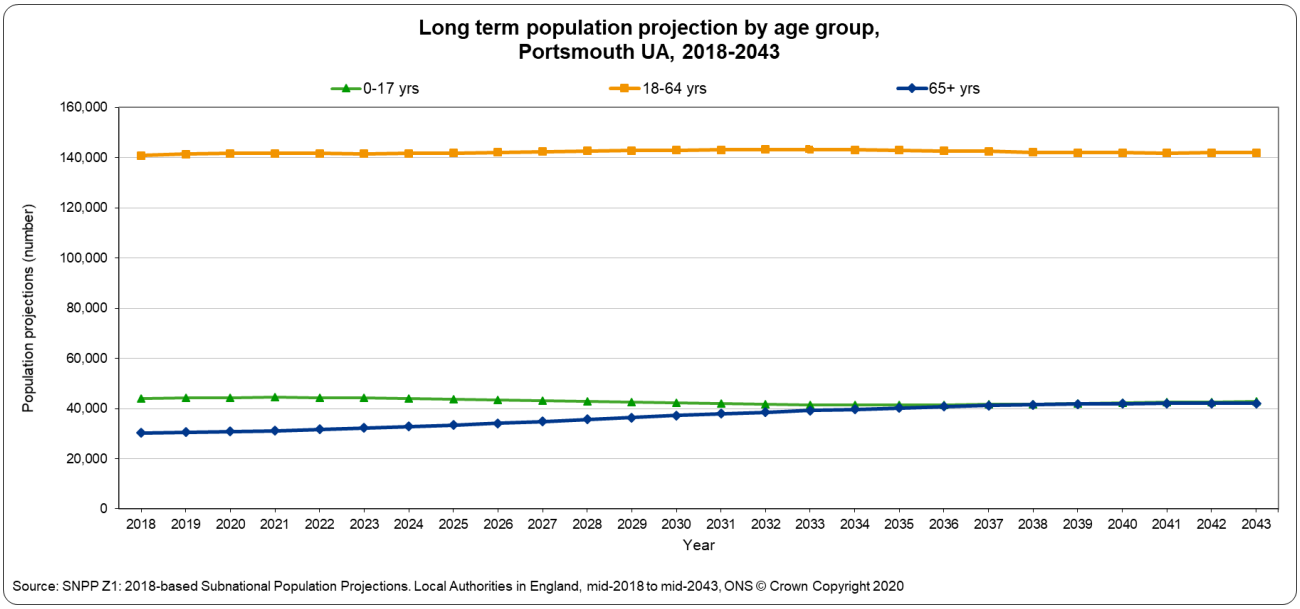

Figure 23. Long term population projections for children, working age adult population and aged 65+ years, Portsmouth City, 2018- 2043 projection

Important theme:
An ageing society - between 2022 and 2030 the population aged 65+ years is estimated to increase by 18% (5,550 people); between 2022 and 2025 the population aged 65+ years is estimated to increase by 6% (1,800 people).

8.3 Ethnicity

At the time of the 2011 Census, Portsmouth had a lower percentage of residents from Black and minority ethnic (BAME) 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 BAME groups (except Mixed) have a larger proportion of their group of working age than the White British group (Figure 24). Of the localities in Portsmouth, the South is the most ethnically diverse with 22% of the population belonging to BAME groups, compared to 16% of the Portsmouth population (Figure 25)[10].

Children and young people have a different ethnic profile with 25% of pupils of all ages being of non-White British ethnicity in January 2021. There was a change in methodology in 2018 to include all pupils at state-funded schools, rather than of compulsory school age prior to 2018, therefore 2018 onwards cannot be directly compared to earlier years. However, in 2017, 22% of compulsory school-age children were non-White British ethnicity compared to 15% in 2011. Of the localities, the South remains the most ethnically diverse with 33% of all pupils of non-White British ethnicity; 29% and 15% of pupils living in the Central and North localities, respectively, are of non-White British ethnicity. In the South, the wards of St. Jude and St. Thomas are the most ethnically diverse with 47% and 49% of all pupils of non-White British ethnicity. In the Central locality, the wards of Charles Dickens and Fratton are the most ethnically diverse with 37% and 32% of all pupils of non-White British ethnicity. In the North locality, the wards of Hilsea, Cosham and Copnor are the most ethnically diverse with 21%, 17% and 16% of all pupils of non-White British ethnicity.

[10] Portsmouth City Council and Health and Care Portsmouth JSNA webpage. Ethnic group by broad age group (2011 Census) www.jsna.portsmouth.gov.uk

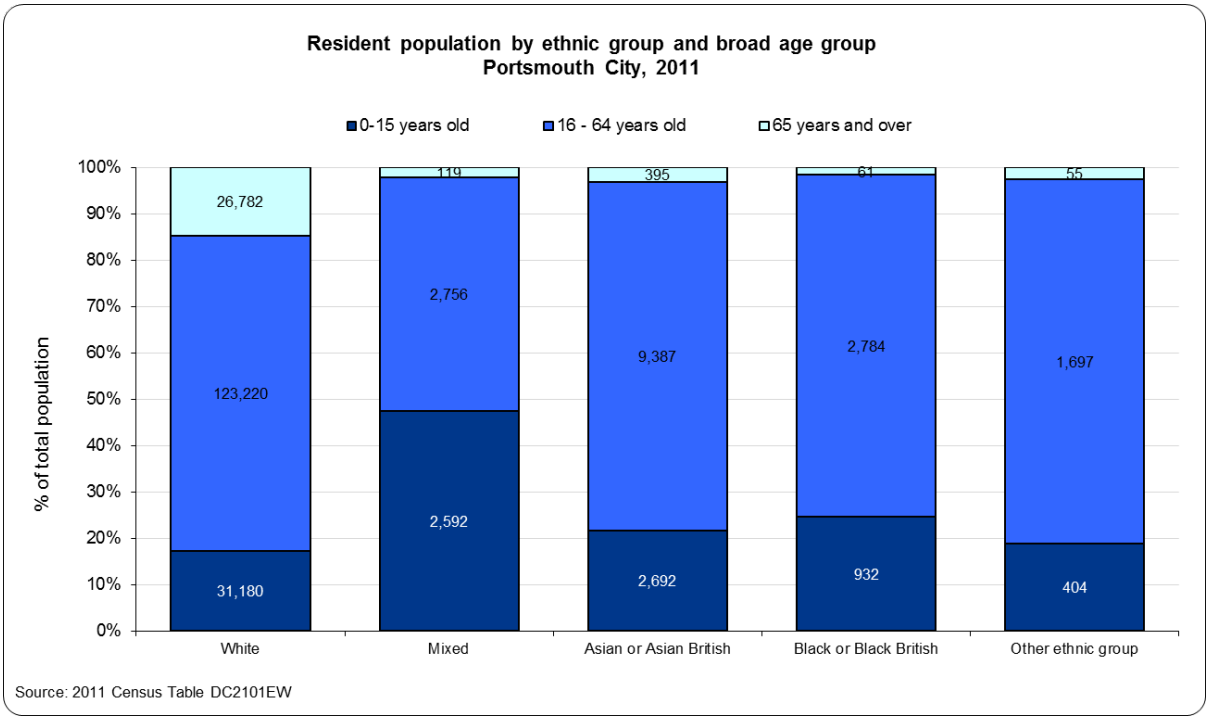

Figure 24 Proportion of population by ethnic group and broad age group, Portsmouth UA, 2011.

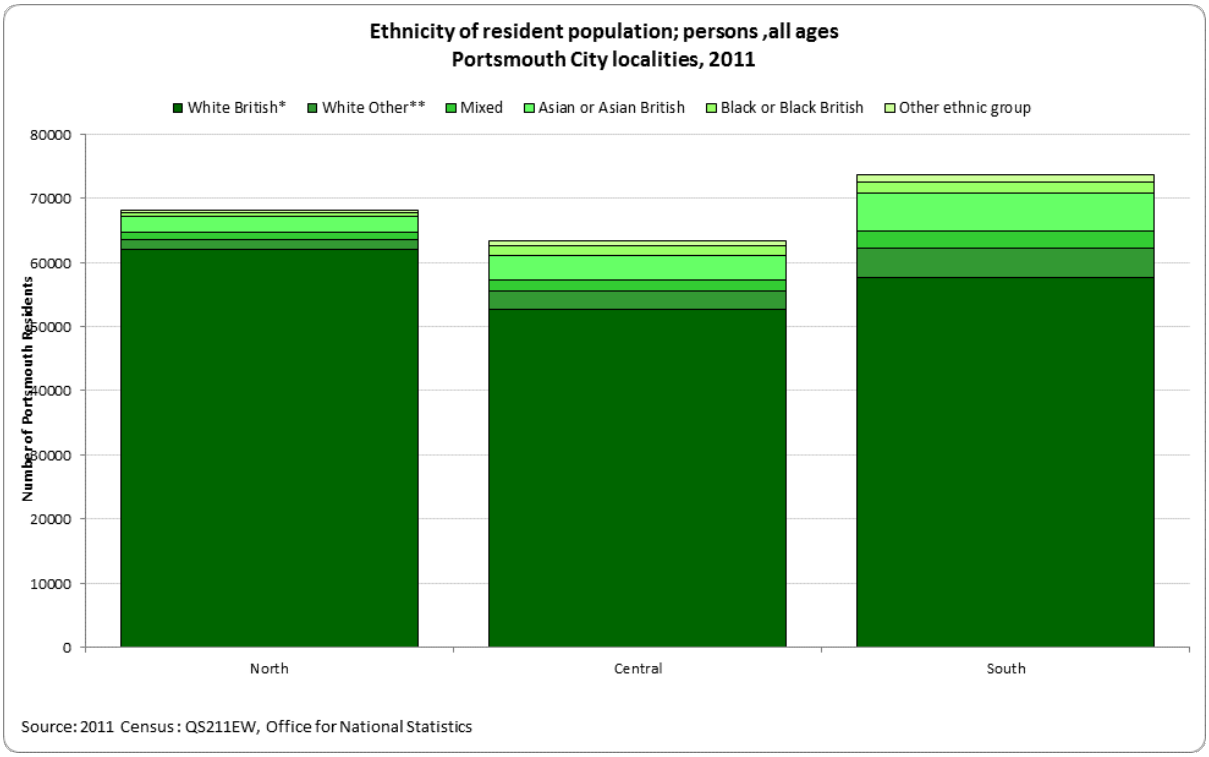

Figure 25. Number of people by ethnicity and locality, Portsmouth UA, 2011.

8.4 Sexual orientation/identity

Prior to 2014, official statistics on lesbian, gay, transgender (LGBT) communities had not been routinely collected nationally (e.g. Censuses) or locally; and the survey findings have been mixed. In 2019, the Office for National Statistics (ONS) estimated that 2.7% of England's population aged 16

years and over identified themselves as lesbian, gay or bi-sexual (LGB) which is an increase compared to previous year estimates; 93.3% identified as Heterosexual or straight, which is a decrease compared to previous years[11]—however, the ONS LGB estimate could be a low estimate due to the telephone and face-to-face survey methodology used[12]. The ONS have also provided local authority estimates; in 2016-18, ONS estimated there to be 2.3% of Portsmouth's population aged 16 years and over that identified themselves as LGB (applying that to the ONS 2018-based subnational population projection for 2021 equates to roughly 4,100 adults aged 16 and over); 95.8% identified as Heterosexual or straight; 0.5% identified as 'Other' (roughly 900 adults aged 16 and over[13]); 1.3% as Don't know or refuse (roughly 2,300 adults aged 16 and over[14]). The ONS estimates are much lower than the estimate quoted by the UK Department of Trade and Industry in 2003 that 5% to 7% of the UK population are LGB[15]. In 2019, the ONS estimates 2.7% of the UK population aged 16 years and over identified themselves as LGB; but the results are different by age group where people aged 16 to 24 years continue to be the most likely to identify as LGB: 6.7% aged 16-24 years in the UK in 2019 (5.9% for males and 7.4% for females aged 16-24 years). This compares to 3.6% aged 25-34 years; 2.5% aged 35-49 years; 1.7% aged 50-64 years; 1% aged 65+ years.

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% of Portsmouth residents described themselves as LGB (6% male and 2% female) which does not include those stating, 'I prefer not to say' nor 'none of these', so the percentage LGB 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.[16] Applying the 4% LGB estimates from the H&LS 2015 to the ONS 2018-based subnational population projection for 2021 suggests that roughly 7,100 of adults aged 16 and over identify themselves as LGB (5,400 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 16,900 LGB adults in Portsmouth aged 16 and over (9,900 male and 7,000 female). Comparing this to the GP patient survey (also a postal and online survey) results for Portsmouth CCG in 2021 (coterminous, but not all CCG patients are resident to Portsmouth); the estimates are quite similar; 5% LGB (persons) with 4% '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).[17]

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[11] Office for National Statistics. Annual Population Survey (Experimental Statistics).
[12] 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]
[13] ONS 2018-based subnational population projection for 2021 applied to the percentage identifying as 'Other'
[14] ONS 2018-based subnational population projection for 2021 applied to the percentage identifying as Don't know or refuse
[15] Producing modelled estimates of the size of the LGB population of England: Final report, Public Health England. https://www.gov.uk/government/publications/producing-estimates-of-the-size-of-the-lgb-population-of-england [Accessed 3 February 2017]
[16] Ipsos MORI for Portsmouth City Council. Health and Lifestyle Survey, 2015.
[17] Portsmouth City Council Equality & Diversity strategy 2014-17. Ibid.

8.5 Socio-economic

Portsmouth is ranked 59th 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 2019 (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. Thirty out of 125 LSOAs in Portsmouth are in the 20% most deprived in England. Of these 30 LSOAs (in the most deprived 20% in England), 11 (of 44) LSOAs are in the North locality; 17 (of 39) in Central locality; and 2 (of 42) are in the South[18]. (Figure 26)

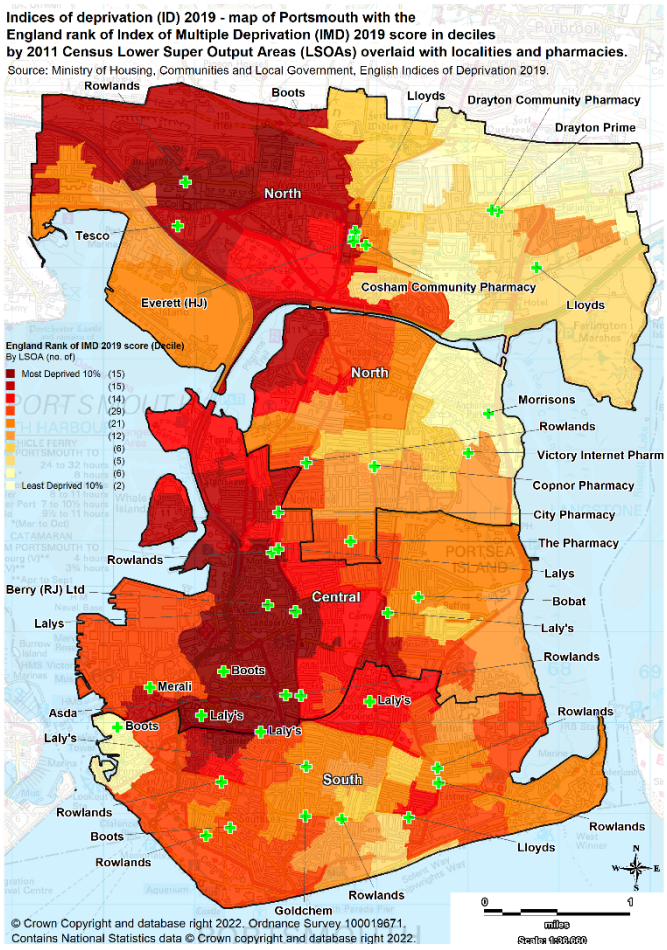

Figure 26. Map of Portsmouth with the England Rank of IMD 2019 score in deciles by 2011 Census LSOAs overlaid by localities and pharmacies.

The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy. There is also a wide variety of evidence to show that children who live in poverty are exposed to a range of risks that can have a serious impact on their mental health.

[18] English Indices of Deprivation, 2019. Ministry of Housing, Communities & Local Government. https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019 [Accessed 26 September 2019]

There are two indicators for measuring children in low-income families - an absolute and relative measure:

The children in absolute low-income families measure is useful for tracking changes over time in relation to a fixed reference point and is designed to assess how low incomes are faring with reference to inflation. So, the absolute low income takes the 60 per cent of median income threshold from 2010/11 and then fixes this in real terms (i.e. the line moves with inflation). It measures the number and proportion of individuals who have incomes below this threshold. The percentage of individuals in absolute low income will decrease if individuals with lower incomes see their incomes rise by more than inflation.

The children in relative low-income families measure is useful for comparing the situation in local areas and measuring the number and proportion of individuals who are currently in low income compared to the current median income. Relative low income sets a threshold as 60% of the UK average (median) income and moves each year as average income changes. It is used to measure the number and proportion of individuals who have income below this threshold. The percentage of individuals in relative low income will decrease if:

- Average (median) income stays the same or rises, and individuals with lower incomes see their incomes rise more than the average; or
- Average (median) incomes fall, and individuals with lower incomes see their incomes fall less than average incomes. [19]

In 2019/20, 16.5% of children aged under 16 years (6,528 children) in Portsmouth were in absolute low-income families (before housing costs). The gap between Portsmouth and England for children in absolute low-income families had previously been widening. In 2014/15, the Portsmouth percentage was similar to England, then from 2015/16 Portsmouth was significantly worse than England with the gap increasing in 2017/18. This gap between Portsmouth and England narrowed in 2019/20 and although Portsmouth remains significantly higher than the England average for this indicator, it has also reduced significantly compared to the previous year [20]. The percentage of children living in absolute low-income families (before housing costs) at smaller geographies in Portsmouth is contrasting. In 2019/20, the electoral ward with the highest number and percentage of children living in absolute low-income families remains Charles Dickens with 29% of children living in absolute low-income families; followed by St Thomas and Paulsgrove (both 21%), Fratton (19%) and Nelson (18%). Drayton and Farlington ward (7%) remains the ward with the lowest percentage of children living in absolute low-income families in the city. [21]

In 2019/20, 20.2% of children aged under 16 years (7,989 children) in Portsmouth were in relative low-income families (before housing costs); increasing (although not significantly) from 19.9% in 2018/19. The percentage of children aged under 16 years in Portsmouth in relative low-income families has been significantly worse (higher) than England between 2016/17 and 2019/20. Before this, the Portsmouth rate had been similar to England (since at least 2014/15) [22]. The percentage of children living in relative low-income families (before housing costs) at smaller geographies in

[19] Public Health Outcomes Framework. Public Health Profiles. Date accessed 29/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021'
[20] Public Health Outcomes Framework. Public Health Profiles. Date accessed 29/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021'
[21] Children in low-income families: local area statistics, United Kingdom: financial years ending (FYE) 2015 to 2020, Department for Work and Pensions. Accessed via Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[22] Public Health Outcomes Framework. Public Health Profiles. Date accessed 29/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021'

Portsmouth also varies greatly. In 2019/20, the electoral ward with the highest number and percentage of children living in relative low-income families remains Charles Dickens with 35% of children living in relative low-income families; followed by Paulsgrove (26%), St Thomas (25%), Fratton (23%) and Nelson (22%). Drayton and Farlington ward (8%) remains the ward with the lowest percentage of children living in relative low-income families in the city. [23]

Based on data from 2015/16, the Income Deprivation Affecting Older People Index (IDAOPI) (a sub-domain of IMD 2019) estimate that 17% of Portsmouth residents (about 6,540 people) aged 60 years and over in the city lived in income-deprivation (12.7%, 24.8% and 15.8% in the North, Central and South localities respectively). Thirteen (out of 125) LSOAs in Portsmouth are within the most deprived 10% of LSOAs in England on the Income Deprivation Affecting Older People Index. Of these, only one is in the north of the city (in Paulsgrove) with the rest clustered in Charles Dickens and adjoining neighbourhoods.

The most recent Annual Population Survey, for the period April 2020 to March 2021, show that Portsmouth's percentage of people in employment aged 16-64 years at 76.4% was the highest since April 2011 to March 2012; however, this is not statistically significantly different to any of the previous periods. In 2020/21, Portsmouth's employment rate aged 16-64 years is higher but not significantly than England; and lower but not significantly than the South East region. However, in 2020/21, 66.1% of Portsmouth residents aged 50-64 years were in employment, which is lower but not significantly than England; and significantly lower than the South East region (74.7%).[24]

In 2020, the estimated unemployment rate (aged 16 years and over) for Portsmouth was 5.4% (roughly 6,200 residents), which was an increase on the previous year (4.0%). This remains higher, but not significantly than the England rate (4.7% in 2020 and 3.9% in 2019); and the Portsmouth rate is now significantly higher than the South East region (4.0% in 2020 and 3.0% in 2019).

The unemployed and the economically inactive represent two distinct categories. Groups comprising the economically inactive include: the long-term sick or disabled, the temporary sick (with no employment), people looking after family/home, students, and retired people. In 2020/21 (April to March), the Portsmouth economic inactivity rate[25] was estimated to be 19.3% of residents aged 16-64 years, which was the lower than in 2019/20 (23.3%). The Portsmouth economic inactivity rate was similar to England (20.9%) in 2020/21; but was significantly higher than England in 2019/20 (20.6%).[26] In 2020/21, of the approximately 27,600 economically inactive residents in Portsmouth, roughly 7,300 (26.3%) wanted a job (roughly 20,400 or 73.7% did not want a job). [27]

As at March 2020, the unemployment Claimant Count rate for Portsmouth was 3.1% of residents aged 16-64 years (3.0% in England and 2.1% in the South East). However, the Claimant Count rate increased to 7.1% by March 2021, due to the impact of the Covid-19 pandemic (6.5% in England and 5.3% in the South East). As at December 2021, the Claimant count rate was 5.0% of residents aged 16-64 years (4.5% in England and 3.5% in the South East). Amongst electoral wards in Portsmouth, the Claimant

[23] Children in low-income families: local area statistics, United Kingdom: financial years ending (FYE) 2015 to 2020, Department for Work and Pensions. Accessed via Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[24] Public Health Outcomes Framework (PHOF), Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 14/2/2022.
[25] defined as those not classed as employed or unemployed according to ILO definitions
[26] Wider Determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 14/2/2022.
[27] Data from ONS Claimant Counts via https://www.nomisweb.co.uk ONS © Crown copyright 2022. Date accessed 14/2/2022.

Count rate per residents aged 16-64 years was above the Portsmouth rate in three of the electoral wards in the Central locality:

- Charles Dickens (5.1% of working age population in Mar 2020; 8.9% in Mar 2021; and 7.2% in Dec 2021);
- Nelson (4.4% in Mar 2020; 10.3% in Mar 2021; and 7.6% in Dec 2021);
- and Fratton (3.7% in Mar 2020; 8.9% in Mar 2021; and 6.4% in Dec 2021);
- Paulsgrove (3.9% in Mar 2020; 8.9% in Mar 2021; and 6.0% in Dec 2021) in the North locality;
- St. Jude (3.3% in Mar 2020; 7.1% in Mar 2021; and 5.3% in Dec 2021) in the South locality. [28]

As at March 2020, the unemployment Claimants as a proportion of economically active residents aged 16 years and over was 3.9% for Portsmouth (3.7% in England and 2.5% in the South East). However, the Claimant rate out of economically active increased to 8.9% by March 2021, due to the impact of the Covid-19 pandemic (8.0% in England and 6.3% in the South East). As at December 2021, the Claimant rate out of economically active was 6.3% of residents aged 16 years and over (5.5% in England and 4.1% in the South East). [29]

Job density (the number of filled jobs relative to the working age resident population - e.g. a job ratio of 1.0 is one job per person) provides further insight into the economic performance in an area when interpreted together with the unemployment rate. For example, an area with high unemployment combined with low job density is indicative of an underperforming economy, with too few jobs for the population. In contrast, high unemployment together with a high job density may indicate a skills mismatch between workers and jobs in the local economy. In 2019, the job density ratio in Portsmouth was 0.89, which was higher than in previous years (since 2013). The Portsmouth job density ratio was higher than the England average (0.88) but lower than the South East region (0.90)

The link between income (in particular low income) and poor health is well established, and the relationship can operate in both directions: low income can lead to poor health and ill health can result in a lower earning capacity[30]. Earnings are the primary source of income; therefore, the Average Weekly Earnings indicator is designed to give insight into the variation of economic resources across areas and between subgroups (men and women, income decile). This measure of earnings includes full and part-time workers because the aim of the indicator is to provide insight into the economic resources available to people, not to compare wage rates per se (for which comparing full-time wages may be more appropriate). The measure excludes overtime payments because such earnings are potentially more erratic. In 2021, the median average weekly earnings in Portsmouth was £468, which is higher, but not statistically significantly, than in 2020 (£407). Portsmouth's median average weekly earnings in 2021 was lower, but not significantly than the England average (£496) and Southampton (£521.40); and significantly lower than the South East (£530.40). [31]

The most commonly used threshold for income poverty is below 60% of median income. The latest data on households in poverty at sub regional geography is from the 2013/14 ONS estimates - at that time 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

[28] Data from the Annual Population Survey via https://www.nomisweb.co.uk ONS © Crown copyright 2022. Date accessed 14/2/2022.
[29] Data from the Annual Population Survey via https://www.nomisweb.co.uk ONS © Crown copyright 2022. Date accessed 14/2/2022.
[30] Fair Society Healthy Lives (The Marmot Review): 'Fair Society Healthy Lives' 2010
[31] Wider Determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 14/2/2022.

poverty at smaller geographies in the city. In the North locality of the city, it is 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 is 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 is estimated that the Somerstown MSOA*[32] have roughly 44% of households below the after housing cost (AHC) threshold, compared to 17% of households in Prince Albert MSOA.[33]

8.5 Education

Children from poorer backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early in life. Children are defined as having reached a good level of development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy. In 2018/19, 69.4% of Portsmouth children achieved a good level of development at the end of Reception, which was significantly lower than the England average (71.8%) and the South East region (74.6%).

There is some evidence to suggest that the highest level of educational qualifications is a significant predictor of wellbeing in adult life; educational qualifications are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources. Educational attainment is influenced by both the quality of education children receive and their family socio-economic circumstances. In 2019/20, the Average Attainment 8 score of Portsmouth's 15-16 year-olds was 45.7, which was significantly lower than the England average (50.2) and the South East region (51.3). [34]

Parents of children of compulsory school age (aged 5 to 15 at the start of the school year) are required to ensure that they receive a suitable education by regular attendance at school or otherwise. In 2018/19, Portsmouth pupils aged 5-15 years missed 5.41% of school sessions due to overall absence - Portsmouth's pupil absence rate was significantly higher than England (4.73%) and the South East region (4.71%).[35]

Young people who are not in education, employment or training are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood. In 2020, the percentage of Portsmouth young people aged 16-17 years not in education, employment or training (NEET) or whose activity is not known was 5.6%, which is higher, but not significantly, than the previous four years. Portsmouth's 2020 NEET rate was higher, but not significantly than England (5.5%); and lower, but not significantly, than the South East region (6.4%). [36]

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[32]*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.

[33] Households in Poverty estimates for middle layer super output areas, England & Wales, 2013/14. Office for National Statistics.

[34] Wider Determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 14/2/2022.

[35] Wider Determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 14/2/2022.

[36] Wider Determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 14/2/2022.

8.6 Crime and disorder

The police recorded 22,882 crimes in Portsmouth during 2020/21, which is 11% (n2,832) fewer than last year. The reduction in crimes were largely due to reduction in violence with injury and many types of theft offences, particularly vehicle related thefts. However, increases were seen in other offences including: stalking and harassment, shoplifting, crimes flagged as domestic abuse, drug offences, sexual offences, robbery and possession of a weapon. The 2020/21 crime rate of 106.5 per 1,000 residents in Portsmouth is higher than the average for other similar local authority areas (96.5 per 1,000). The overall level of crime in Portsmouth was generally lower in 2020/21 than the previous three years, apart from July to September, when there were fewer restrictions on socialising during the Covid-19 pandemic. [37]

8.7 Students

In the academic year 2019/20, the University of Portsmouth had 26,755 registered students — 79% (21,000) came from the UK, 4% from EU and 17% from Non-EU. Of the 26,755 registered students, 22,150 were full-time (83% were full-time). Also, of the 26,755 registered students, 22,010 were undergraduate students (82%). In the academic year 2020/21, the University of Portsmouth had 28,280 registered students — 77% (21,905) came from the UK, 5% from EU and 18% from Non-EU. Of the 28,280 registered students, 24,065 were full-time (85% were full-time). Also, of the 28,280 registered students, 22,170 were undergraduate students (79%).[38] This shows an increase in student registrations during the Covid-19 pandemic, but it is not clear how many of these attend classes in person or remotely, although there was a large decrease in 'Other rented accommodation' in 2020/21 compared to 2019/20 (53% of all full-time students in 2019/20 compared to 30% of full-time students in 2020/21) as well as increases in 2020/21 in 'Provider maintained property' (28% of full-time compared to 19% in 2019/20); 'Private-sector Halls' (7% of full-time compared to 5% in 2019/20); 'Parental/guardian home' (14% of full-time compared to 10% in 2019/20) and 'Own residence' (12% of full-time compared to 10% in 2019/20)[39]. However, national data for 2020/21 indicates a large increase in students at parental/guardian home compared to previous years (456,870 in 2020/21; 379,205 in 2019/20 or 22% of full-time students compared to 19% of full-time students).[40]

Key issues identified for students nationally include sexual health, mental health, healthy behaviours and access to healthcare both for those coordinating care of long-term conditions and international students. [41]

8.7.1 Student Sexual health

Nationally and regionally, STIs disproportionately affect young people. South East residents aged between 15 and 24 years accounted for 50% of all new STI diagnoses in 2018.[42] Sexual health clinic activity for 18-22 year-olds peak and trough in line with University of Portsmouth term times. During the 2016/17 academic year, accessing sexual health support online (the first year of the online access) accounted for 4.9% of all initial contacts into the service. Booked and wait to be seen appointments accounted for over three-quarters of initial contacts in the service for this age group. Community

[37] ONS data via the Portsmouth Strategic Assessment 2020-21: https://www.saferportsmouth.org.uk/strategic-assessments Date accessed 17/2/2022.
[38] HESA: https://www.hesa.ac.uk/data-and-analysis/students/table-1 Date accessed 17/2/2022.
[39] HESA: https://www.hesa.ac.uk/data-and-analysis/students/table-57 Date accessed 17/2/2022.
[40] HESA: https://www.hesa.ac.uk/data-and-analysis/students/chart-4 Date accessed 17/2/2022.
[41] Portsmouth JSNA: https://www.portsmouth.gov.uk/wp-content/uploads/2020/04/portsmouth-student-health-needs-assessment-2018.pdf Date accessed 18/2/2022.
[42] Public Health England. Spotlight on sexually transmitted infections in the South East: 2018 data https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/827649/2019_08_SE_STISpot2018.pdf Date accessed 18/2/2022.

pharmacy provision of EHC was the most frequently used route to access EHC accounting for 90% of EHC provided in the 6 months September 17 to February 18 inclusive (10% through the sexual health service). 41% of EHC accessed through pharmacies between September 2017 to February 2018 (inclusive) were for individuals recorded to be a student. A local survey carried out in 2018 of University students found the majority of who had used the sexual health service or via the Let's Talk About It website, reporting that it was quite or extremely easy to use, with the vast majority of students reporting that local provision of sexual health services met their needs. In 2018, the findings of the Student Health Needs Assessment found that the service provision at the time appeared to meet the needs of students in Portsmouth in regards to ease of use and access.[43]

8.7.2 Student Mental health

Nationally, 2% of first year undergraduate students disclosed a mental health condition to their educational institution in 2015/16. In a local survey of Portsmouth University students in 2018, 72% of respondents reported mental ill-health (which included depression, worry, anxiety or stress in the measure) in the past year but this was from a small sample (47 out of 65 respondents)). Of these 47, 16 (34%) respondents also reported that they had not accessed any support. It is not known what type of mental health and wellbeing problem was being experienced by these individuals. [44]

8.8 Lifestyle and behaviour

8.8.1 Smoking

Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix. Smoking is a modifiable behavioural risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population. [45]

In 2020, based on the national Annual Population Survey (APS)[46] (which is designated as a National statistic), it is estimated that 14.3% of Portsmouth adults (aged 18+ years) are current smokers - higher, but not significantly than the estimated prevalence for England and the South East region[47]. The 2020 prevalence estimate is based on a new telephone survey design, whereas previously was conducted as a face-to-face interview; this means that the 2020 prevalence estimate cannot be compared to the previous years because ONS found that selection bias would have impacted the final prevalence estimates. [48]

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[43] Portsmouth JSNA: https://www.portsmouth.gov.uk/wp-content/uploads/2020/04/portsmouth-student-health-needs-assessment-2018.pdf Date accessed 18/2/2022.

[44] Portsmouth JSNA: https://www.portsmouth.gov.uk/wp-content/uploads/2020/04/portsmouth-student-health-needs-assessment-2018.pdf Date accessed 18/2/2022.

[45] Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.

[46] From 2016, the APS survey question was 1) Have you ever smoked cigarettes regularly? (yes/no) 2) And do you smoke cigarettes at all nowadays? (yes/no)

[47] Data for 2020 is based on Q2-Q4 survey collection only due to the impact of the COVID-19 pandemic. As such, the confidence limits are wider than observed for a typical year of the APS which has resulted in fewer local areas being statistically significantly higher or lower than the England average. (Source: Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.)

[48] C18 - Smoking Prevalence in adults (18+) - current smokers (APS) (2020 definition), Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.

The smoking prevalence (from APS) in Portsmouth had estimated to have generally decreased from 2011-2019 and each of the 2017-2019 single year estimates were significantly lower than each of the 2011-2013 single year estimates. The Portsmouth smoking prevalence estimate was 16.4% of adults in 2019 compared to 22.0% in 2013 (Figure 27). [49]

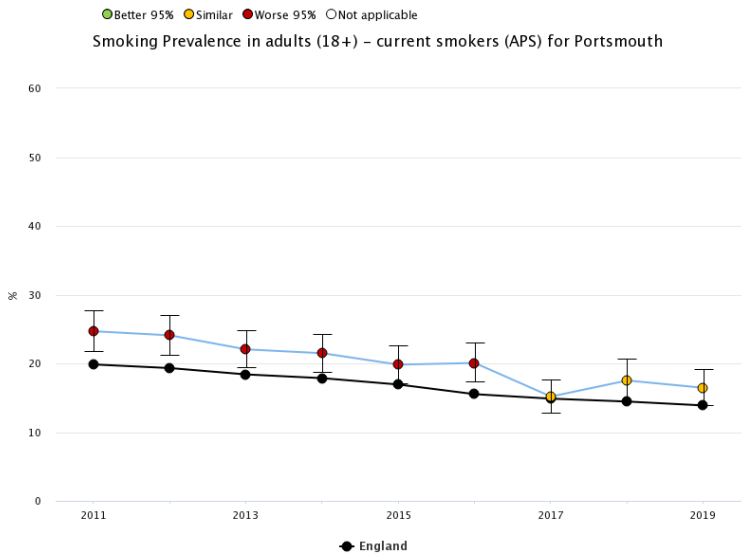

Figure 27. Smoking prevalence in adults (aged 18+ years) - current smokers (APS survey), Portsmouth and England, 2011-2019

An alternative smoking prevalence estimate for Portsmouth is from the GP patient survey (GPPS), which is an online or paper questionnaire and therefore a different research methodology; the smoking questions[50] are also different to the APS, therefore the GPPS estimate offer an alternative view. The latest 2019/20 GPPS estimate 18.1% of Portsmouth adults aged 18 years and over are current smokers, which is significantly higher than the England average (14.3%). The 2019/20 Portsmouth GPPS smoking prevalence estimate is also higher, but not significantly, than the previous two years (16.4% in 2018/19 and 17.5% in 2017/18). [51]

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).[52]

[49] C18 - Smoking Prevalence in adults (18+) - current smokers (APS), Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.
[50] The number of people who responded either "regular smoker" or "occasional smoker" to the question "Which of the following best describes your smoking habits?"
[51] Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.
[52] Ipsos MORI for Portsmouth City Council. Health and Lifestyle Survey, 2015.

Smoking prevalence also has a strong association nationally with deprivation, socio-economic classification, age, gender, sexuality, housing tenure, health status, ethnic groups, country of birth, religion and mental health. In 2020, the APS smoking prevalence estimate amongst Portsmouth adults (aged 18-64 years) in 'routine and manual occupations' (a national statistics socio-economic classification) was 27.2%, which is higher, but not significantly, than the prevalence in this group in England (21.4%), the South East (20.1%) and Southampton (22.2%). In 2019/20, the GPPS smoking prevalence estimate amongst Portsmouth adults (aged 18+ years) with a long term mental health condition was 36.8%, which is significantly higher, than adults with a long term mental health condition in England (25.8%), the South East region (24.9%) and Southampton (21.0%). In 2019/20, the GPPS smoking prevalence estimate amongst Portsmouth adults (aged 18+ years) with a long-term mental health condition was 36.8%, which is significantly higher than adults with a long term mental health condition in England (25.8%), the South East region (24.9%) and Southampton (21.0%).[53]

Smoking during pregnancy causes premature births, miscarriage and perinatal deaths. It also increases the risk of stillbirth, complications in pregnancy, low birthweight, and of the child developing other conditions in later life. In 2018/19, the percentage of Portsmouth women smoking at time of booking an appointment with a midwife was 13.5% - similar to Southampton (13.8%) but significantly higher than the South East region (11.3%) and higher, but not significantly than England (12.8%). In the same year, the percentage of Portsmouth women smoking at time of delivery (SATOD) was 13.0% (albeit a different data source to the smoking at booking estimate in 2018/19). In 2020/21, the percentage of Portsmouth women smoking at time of delivery (SATOD) was 12.1%, which was a decrease on the previous two years - the 2020/21, Portsmouth's percentage SATOD of 12.1% remained significantly higher than England (9.6%) and the South East region; and higher, but not significantly than Southampton (10.7%).[54]

Admissions to hospital due to smoking related conditions not only represent a large demand on NHS resources, but can also be used as a proxy for variations in smoking related ill health in the general population across England. High smoking attributable admission rates are indicative of poor population health and high smoking prevalence; however, smoking attributable admissions are based on the primary diagnosis of the admission episode and subsequent episodes which relate to smoking but where the admission episode is not related to smoking are not included, therefore this is likely to be an underestimate of smoking related admissions. In 2019/20, the rate of smoking attributable hospital admissions for Portsmouth residents (aged 35+ years) remained similar since 2016/17. The Portsmouth smoking attributable admission rate in 2019/20 was higher (but not significantly) than England and significantly higher than the South East region; but the Portsmouth rate was significantly lower than Southampton. COPD is a serious lung disease for which smoking is the biggest preventable risk factor - the rate of emergency hospital admissions for COPD for Portsmouth residents aged 35 years and over has remained similar since 2014/15 (up to 2019/20). The Portsmouth COPD emergency hospital admission rate (aged 35+ years) in 2019/20 was significantly higher than England and the South East region; but the Portsmouth rate was significantly lower than Southampton. [55]

Lung cancer registration and oral cancer registration are both a direct measure of smoking-related harm. Given the high proportion of lung cancer registrations and oral cancer registrations are due to smoking, a reduction in the prevalence of smoking would reduce the incidence of both lung cancer

[53] Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.
[54] Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.
[55] Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.

and oral cancer. The lung cancer registration rate for Portsmouth residents (all ages) has remained similar since 2007/09 (up to 2016-18). The Portsmouth lung cancer registration rate in 2016/18 was significantly higher than England and the South East region; but the Portsmouth rate was lower, but not significantly, than Southampton. The oral cancer registration rate for Portsmouth residents (all ages) has remained statistically similar since 2007/09 (up to 2016-18); but in 2016-18, the rate was the highest since 2007/09 and was for the first time significantly higher than the England rate. The Portsmouth oral cancer registration rate in 2016/18 was also significantly higher than the South East region; but the Portsmouth rate was higher, but not significantly, than Southampton.[56]

Smoking remains the biggest single cause of preventable mortality and morbidity in the world[57]. It still accounts for 1 in 6 of all deaths in England, and there exist huge inequalities in smoking related deaths: areas with the highest death rates from smoking are about three times as high than areas with the lowest death rates attributable to smoking. In 2017-19, Portsmouth had a significantly higher rate of smoking-attributable deaths in persons aged 35+ years compared to England and the South East region; but a similar rate to Southampton. The Portsmouth rate has remained similar since 2014-16. Also, compared to England, Portsmouth had significantly higher rates of deaths from lung cancer (2017-19) and deaths from chronic obstructive pulmonary disease (2017-19). [58]

8.8.2 Alcohol

Alcohol-related harm is determined by the volume of alcohol consumed and the frequency of drinking occasions. As such, the risk of harm is directly related to levels and patterns of consumption. Drinking very large amounts of alcohol on a single occasion increases the likelihood of experiencing acute alcohol-related harms. [59]

Alcohol use is the biggest risk factor in Portsmouth adults aged 15-49 years from 2017-2019, in terms of Years Lived with Disability (YLD) per 100,000 (695 YLD per 100,000 in 2019). In 2009, Drug use was the biggest risk factor, with Alcohol use (610 YLD per 100,000 in 2009) ranked second in Portsmouth. Alcohol use is the second biggest risk factor in 2019 in England (646 YLD per 100,000). [60]

The local Health and Lifestyle Survey from 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

[56] Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.
[57] World Health Organization Report on the Global Tobacco Epidemic 2009 http://www.who.int/tobacco/mpower/2009/en/index.html via Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.
[58] Local Tobacco Control Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 18/2/2022.
[59] Local Alcohol Profiles for England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 22/2/2022.
[60] GBD compare, Global Burden of Disease: https://vizhub.healthdata.org/gbd-compare/. Date accessed 22/2/2022.

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. [61]

Data from the Health Survey for England allows for comparisons to be made with statistical neighbours and in 2015-2018, Portsmouth had a higher percentage of adults (aged 18 years and over) binge drinking on the heaviest day in the last week (16.7%) compared to England (15.4%), the South East (14.9%) and Southampton (14.5%), 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 2015-2018, Portsmouth had a lower (but not significantly) percentage drinking more than 14 units of alcohol a week (19.3%) than England (22.8%), the South East region (22.9%) and Southampton (20.6%).[62]

Alcohol-related hospital admissions are used as a way of understanding the impact of alcohol on the health of a population. There are two measures used to assess this burden: the Broad and the Narrow measure. 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 2019/20 and 2020/21 (both years included due to the impact of Covid-19 on hospital activity in 2020/21, in particular) for Portsmouth males and females were significantly higher than the rate for England. The narrow measure (better than the broad measure for measuring alcohol harm that is less sensitive to the changes that have occurred in coding over the years) of the directly aged-standardised rate (DSR) of alcohol-related hospital admissions of all ages in 2020/21 for Portsmouth males was significantly higher than the rate for England, but the Portsmouth rate decreased compared to 2019/20 (although the rate of decrease was not as great as England) - however, the 2020/21 rate may have been impacted on due to the impact of Covid-19 on hospital activity in 2020/21. Both the Portsmouth and England rates for males had been increasing up to 2019/20 (Figure 28). A similar trend can be seen for Portsmouth females for the narrow alcohol-related hospital admissions, where the Portsmouth rate was slowly increasing (although the rate was highest in 2018/19) then decreased in 2020/21; but unlike Portsmouth males, the female rate remained similar to the England rate (Figure 29) .

When it comes to hospital admissions wholly attributable to alcohol, the alcohol-specific admission rate for Portsmouth males and females had been increasing since 2018/19 and in both 2019/20 and 2020/21 the alcohol-specific admission rate for both Portsmouth males and females remained significantly higher than the England rate. [63]

[61] Ipsos MORI for Portsmouth City Council. Health and Lifestyle Survey, 2015.
[62] Local Alcohol Profiles for England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 22/2/2022.
[63] Local Alcohol Profiles for England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 22/2/2022.

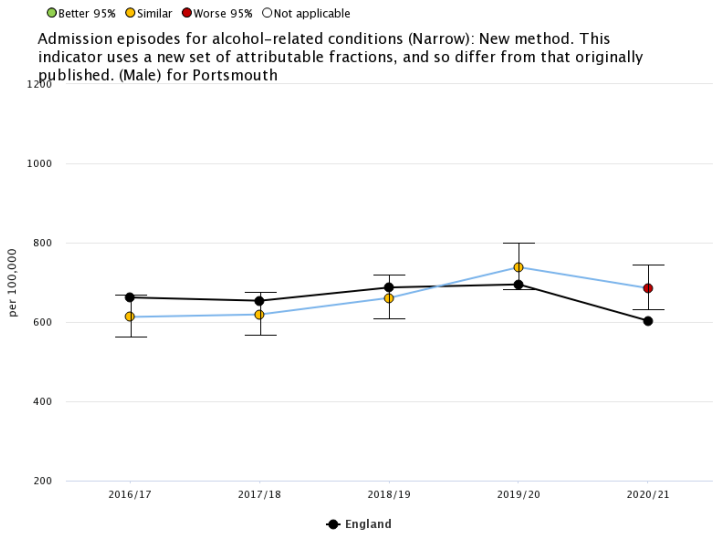

Figure 28. Alcohol-related admission rate for males (Narrow definition), Portsmouth and England, 2016/17 to 2020/21

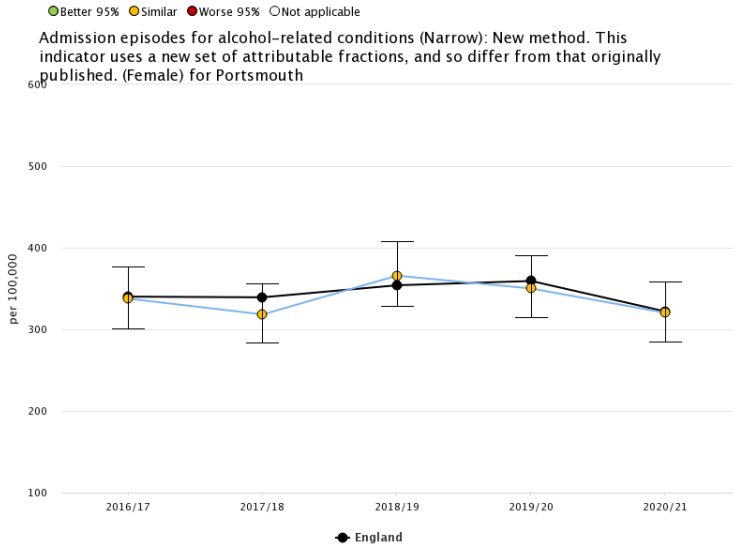

Figure 29. Alcohol-related admission rate for females (Narrow definition), Portsmouth and England, 2016/17 to 2020/21

In 2018/19 (the most recent estimate), it was estimated that between 2,600 and 4,400 adults were alcohol dependent and potentially in need of specialist treatment - at 1.90 adults per 100 adults, this is a higher, but statistically different, rate to the England average (1.37 per 100 adults). [64]

In 2020/21, there were 336 adults in treatment for alcohol dependency only at a specialist alcohol service in Portsmouth plus an additional 146 adults in treatment for alcohol and a non-opiate substance - an increase from 303 alcohol only receiving treatment (plus 109 alcohol and a non-opiate substance) in 2019/20. Of the 336 people in treatment for alcohol dependency only, 208 of these were new presentations in 2020/21. In 2019/20, it is estimated that, of the estimated number of alcohol dependent Portsmouth adults in need of treatment, 12% received treatment, leaving

[64] Alcohol dependence prevalence in England, Public Health England https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england © Crown copyright 2022. Date accessed 22/2/2022.

potentially an estimated 88% of unmet need. [65] However, demand for treatment in 2020/21 was 100% met within three weeks of waiting for treatment i.e. out of first alcohol treatment interventions starting in 2020/21, no one in Portsmouth waited over three weeks to commence treatment. In 2020, there were 104 Portsmouth adults successfully completing treatment (free of alcohol dependence and who do not re-present within 6 months), which was 30.7% of all adults receiving structured treatment - this percentage is lower, but not statistically significantly, than the England average (35.3%). In 2018/19-2020/21 (three-years pooled), there were 10 deaths amongst adults in alcohol treatment which is a mortality ratio of 1.08 out of expected deaths (if Portsmouth experienced the same the same age-specific mortality rates as in the whole alcohol treatment population in England) - therefore, Portsmouth's mortality ratio is higher, but not significantly, than England (mortality ratio of 1.00) [66]

Portsmouth's alcohol-related mortality rate for males and females has remained broadly similar from 2016 to 2020. In 2020, the alcohol-related mortality rate for males and females was higher, but not significantly, than England.

Portsmouth's alcohol-specific mortality rate for males has generally decreased since 2009-11, but the 2017-19 rate is not significantly different between periods since then. The Portsmouth alcohol-specific mortality rate for males in 2017-19 was higher, but not significantly, than England. Portsmouth's alcohol-specific mortality rate for females increased in 2009-11 and has remained broadly similar since. The Portsmouth alcohol-specific mortality rate for females in 2017-19 was significantly higher than England. The Portsmouth premature (under 75 years) mortality rate from alcoholic liver disease for females in 2017-19 was significantly higher than England. [67]

8.8.3 High body-mass index, physical inactivity and poor diet

There is national ambition to "significantly reduce childhood obesity" as set out in "Child Obesity - A Plan for Action". There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older. [68]

In 2019/20, 23.8% of Year R pupils (aged 4-5 years) and 38.1% of Year 6 pupils (aged 10-11 years) residing in Portsmouth were overweight, including obesity (i.e. "excess weight"). The proportion overweight, including obesity, for Year R pupils residing in Portsmouth is statistically significantly similar to Southampton and England (24.1% and 23.0% respectively). The proportion overweight, including obesity, for Year 6 pupils residing in Portsmouth is similar to Southampton, and statistically significantly higher than England (37.6% and 35.2% respectively). 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. [69]

In 2019/20, 11.0% of Year R pupils (aged 4-5 years) and 22.1% of Year 6 pupils (aged 10-11 years) residing in Portsmouth were obese, including severe obesity - the former having reduced since

[65] National Drug Treatment Monitoring System (NDTMS). Office for Health Improvement and Disparities. https://www.ndtms.net/ Date accessed 22/2/2022.
[66] Local Alcohol Profiles for England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 22/2/2022.
[67] Local Alcohol Profiles for England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 22/2/2022.
[68] Obesity Profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 23/2/2022.
[69] NCMP profile, PHE. https://fingertips.phe.org.uk/profile/national-child-measurement-programme Accessed 21 April 2021

2018/19 (previously 12.5%). The proportion obese, including severe obesity, for Year R pupils residing in Portsmouth is similar to Southampton, and statistically similar to than England (9.9% and 9.9% respectively). The proportion of obese, including severe obesity, for Year 6 pupils residing in Portsmouth is similar to Southampton and England (23.8% and 21.0% respectively).[70]

Due to the data collection limitations arising from the Covid-19 pandemic, the National Childhood Measurement Programme data from the 2020/21 has not been provided at local authority level. National data for 2020/21 has, however, been published by NHS digital. In 2020/21, 14.4% of Year R pupils (aged 4-5 years) and 25.5% of Year 6 pupils (aged 10-11 years) residing in England were obese, including severe obesity. This represents a significant increase for both Year R and Year 6 when compared to 2019/20 when 9.9% of Year R pupils and 21.0% of Year 6 pupils were considered obese (including severe obesity).[71]

Good physical activity habits established in childhood and adolescence are also likely to be carried through into adulthood. If we can help children and young people to establish and maintain high volumes of physical activity into adulthood, we will reduce the risk of morbidity and mortality from chronic non-communicable diseases later in their lives. In 2020/21, Sport England's Active Lives Children and Young People Survey found 55.7% of Portsmouth children (aged 5-16 years) were 'physically active'[72] - significantly higher than in 2018/19 (38.1%); however, in 2018/19 and 2019/20 no data was collected in Years 1 and 2[73], which may have impacted on the response profile between survey years. In 2020/21, Portsmouth's percentage of physically active children was significantly higher than England (44.9%). [74]

Obesity is a priority area for Government. The Government's "Call to Action" on obesity (published Oct 2011) included national ambitions relating to excess weight in adults, which is recognised as a major determinant of premature mortality and avoidable ill health[75]. In 2017/18, Sport England's Active Lives Survey found 28.6% of Portsmouth adults (aged 18 years and over) were obese, which is significantly worse than England (23.4%) and the South East (21.4%) and worse (but not significantly) than Southampton (24.3%).[76]

The same survey in 2019/20 found that 67.4% of Portsmouth adults (aged 18 years and over) were overweight or obese (66.5% in 2018/19). This is significantly worse than the South East which found that 61.5% of adults were overweight or obese in 2019/20 (60.9% in 2018/19 and 59.7% in 2017/18). This is also higher than Portsmouth's JSNA Unitary Authority comparator group average in 2019/20

[70] NCMP profile, PHE. https://fingertips.phe.org.uk/profile/national-child-measurement-programme Accessed 21 April 2021
[71] NHS Digital, National Child Measurement Programme, England 2020/21, National Child Measurement Programme, England 2020/21 School Year - NHS Digital Accessed 03 February 2022
[72] Defined as children meeting the UK Chief Medical Officers' recommendation of an average of at least 60 minutes moderate-vigorous intensity activity per day across the week
[73] Sport and Physical Activity Levels amongst children and young people in school years 1-11 (aged 5-16), Active Lives Survey, Sport England https://sportengland-production-files.s3.eu-west-2.amazonaws.com/s3fs-public/2021-12/ALS%20CYP%2020-21%20Tables%201-4%20Levels%20of%20activity..xlsx?VersionId=2cULHc35FT.GDerJFPNayav.RB9XbiQa Date accessed 23/2/2022.
[74] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 23/2/2022.
[75] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 23/2/2022.
[76] Adjusted BMI from the Active Lives Survey, Public Health England.

(61.8%) and significantly worse than England where 62.8% of adults were classed as overweight or obese in 2019/20 (62.3% in 2018/19 and 62.0% in 2017/18) [77].

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 costs of diet related chronic diseases to the NHS and more broadly to society are considerable. Average intakes of saturated fat, sugar, and salt are above recommendations while intakes of fruit and vegetables, oily fish, fibre and some vitamins and minerals in some groups are below recommendations. In 2019/20, the Active Lives Survey found that 49.7% of Portsmouth adults met the '5-a-day on a usual day' recommendation - this was lower than in 2018/19 when 51.9% of adults met this recommendation. The 2019/20 percentage of Portsmouth adults meeting the recommended '5-a-day' on a 'usual day' was significantly lower than England (55.4%), lower than Portsmouth's JSNA Unitary Authority comparator group average (54.1%) and was significantly lower than the South East region (58.3%). [78]

The H&LS 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). [79]

People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health. In older adults physical activity is associated with increased functional capacities. The estimated direct cost of physical inactivity to the NHS across the UK is over £0.9 billion per year. In 2019/20, Sport England's Active Lives Survey found 69.7% of Portsmouth adults (aged 19 years and over) were physically active[80] which is higher (but not significantly) than England (66.4%) and the South East Region (69.5%). The percentage of adults in Portsmouth who were physically active was also higher than Portsmouth's JSNA Unitary Authority comparator group average (66.9%). The same survey found that 17.3% of Portsmouth adults (aged 19 years and over) were physically inactive[81] which is significantly lower than England (22.9%) and lower (but not significantly) than the South East Region (20.1%). It was also lower than Portsmouth's JSNA Unitary Authority comparator group average which was 22.0%. [82]

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[77] Public Health Outcomes Framework, indictor 2.12 (current method), Public Health England. https://fingertips.phe.org.uk Accessed 3rd June 2021

[78] Public Health Outcomes Framework, Public Health England. Public Health Profiles. 2021 https://fingertips.phe.org.uk © Crown copyright 2021, Accessed 03/06/2021

[79] 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

[80] 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.

[81] 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.

[82] Public Health Outcomes Framework, Public Health England. Public Health Profiles. 2021 https://fingertips.phe.org.uk © Crown copyright 2020, Accessed 03/06/2021

The 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 localities (and the Portsmouth average) - 66% in the South compared to 55% and 54% in North and Central.[83]

8.8.4 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 2018 (2014 was part of a wider 'measuring wellbeing survey'). Key findings from the 2018 survey include:

- Using cannabis use as an approximation for overall drug use, over 90% of pupils have never tried drugs
- Cannabis is the most frequently tried drug—9% of pupils have tried it at least once (2% in Year 8, but 18% 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 (5%) since 2012, including significantly lower than 2014 survey (15%).

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

- Have ever tried, or be a regular user of cannabis, ecstasy, ketamine, cocaine and speed. They were more likely to have tried all other substances included in the survey with the exception of solvents (glue, gas or aerosols) where the proportions were very similar;
- Think that about half, most, or all of people their age takes drugs;
- Have received advice at school on drugs and alcohol

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

- Think that none or a few people their age take drugs. [84]

The latest estimate from 2016/17 for the number of opiate and/or crack cocaine users (OCUs) aged 15-64 years in Portsmouth is 1,541 (or between 1,329 and 1,838 users) - as a crude rate this is 10.6 per 1,000 population aged 15-64 years, which is estimated to be higher, but not significantly, than England and Southampton; but significantly higher than the South East region. The 2016/17 estimates that OCUs in Portsmouth are more likely to be aged 25-34 or 35-64 (12.4 and 12.9 per 1,000 respectively), compared to the aged 15-24 age group (4.5 per 1,000), but the difference is not statistically different - as estimated numbers this is 949 users aged 35-64 years, 419 users aged 25-34 years and 173 users aged 15-24 years.[85] In 2019/20, it is estimated that, of the estimated number of OCU Portsmouth adults in need of treatment, 49% received treatment, leaving potentially an

[83] Ipsos MORI for Portsmouth City Council. Health and Lifestyle Survey, 2015.
[84] Portsmouth City Council, 2018. 'You Say' Survey Secondary Schools.
[85] Opiate and crack cocaine use: prevalence estimates by local area, Public Health England. https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations [Accessed 24 February 2022]

estimated 51% of unmet need. [86] In 2020/21, there were 1,056 adults aged 18 years and over in treatment at specialist drug misuse services in Portsmouth.

Mental health problems are common amongst those needing and/or in treatment for drug use. In 2016/17, there were 82 adults in Portsmouth entering into a specialist drug misuse service who were in concurrent contact with a mental health service - 27.8% of all adults entering into a specialist drug misuse service. The 2016/17 Portsmouth proportion in concurrent contact with mental health services was higher, but not significantly, than England. [87]

Persons who inject drugs are at increased risk of contracting hepatitis B and C infections. In 2016/17, of Portsmouth residents entering substance misuse treatment and eligible for a Hep B vaccination, 3.2% (n=6) of these completed a course of Hep B vaccination, which is significantly lower than the England average (8.1%). However, in 2017/18, of Portsmouth residents entering substance misuse treatment who inject drugs, 487 received a Hep C test (90.9%) - significantly higher than the England average (84.2%).[88]

In 2020, there were 766 clients aged 18 years and over resident to Portsmouth in treatment for opiate use [89]. Portsmouth's percentage of successful completion of drug treatment for opiate users (ie the percentage who do not re-present within 6 months) was 4.8% (n=37) - similar compared to England (4.7%); and lower but not significantly than the South East Region (5.7%) and higher, but not significantly than Southampton (3.9%). In the same year (2020), 27.1% (n=79) of Portsmouth residents receiving treatment for non-opiate drug use was successful, which was significantly lower than England (33.0%); and lower, but not significantly, than the rate for the South East region (33.3%) and Southampton (28.9%).[90]

In 2020/21, 24.6% (n=32) of Portsmouth adults with substance misuse treatment need successfully engaged in community-based structured treatment following release from prison. This was significantly lower than England (38.1%) and the South East region (37.5%); but similar compared to Southampton (22.2%).[91]

In 2018-20, the death rate from drug abuse for Portsmouth males was significantly higher than England, the South East; higher, but not significantly than Southampton; and lower but not significantly compared to Brighton and Hove and Plymouth (Figure 30 column chart). The Portsmouth male drug abuse death rate was also higher, but not significantly, than 2017-19 (Figure 30 line chart). Deaths from drug abuse for Portsmouth females was rising since 2013-15 and the rate was significantly higher than England until 2017-19. In 2018-20, the death rate from drug abuse for Portsmouth females was not significantly different to England, but remained significantly higher than the South East. The Portsmouth female drug abuse death rate was also lower, but not significantly, than 2017-19. [92]

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[86] National Drug Treatment Monitoring System (NDTMS). Office for Health Improvement and Disparities. https://www.ndtms.net/ Date accessed 23/2/2022.
[87] Co-occurring substance misuse and mental health issues, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 23/2/2022.
[88] Health Protection Profile, Office for Health Improvement and Disparities. https://fingertips.phe.org.uk © Crown copyright 2022. [Accessed 25 February 2022]
[89] National Drug Treatment Monitoring System (NDTMS). Office for Health Improvement and Disparities. https://www.ndtms.net/ Date accessed 23/2/2022.
[90] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 28/2/2022.
[91] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 28/2/2022.
[92] Mortality Profiles. Public Health Profiles. Date accessed 9/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021'

Compared with England ■■■ Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

Deaths from drug misuse (Male) 2018 - 20 — Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	5,912	7.3	7.1	7.5
JSNA UA	–	-	-	-	-
Newcastle upon Tyne	–	73	17.5	13.5	22.1
Liverpool	–	112	17.1	13.8	20.3
Brighton and Hove	–	65	14.3	10.9	18.3
Plymouth	–	50	13.8	10.2	18.2
Bristol	–	88	13.2	10.5	16.4
Portsmouth	–	35	11.2	7.7	15.6
Sheffield	–	82	10.4	8.2	12.9
Southampton	–	30	8.3	5.4	12.1
Nottingham	–	33	7.8	5.4	11.1
Coventry	–	35	6.7	4.6	9.4
Bournemouth	–	-	-	-	-

Figure 30. Chart to compare Portsmouth males deaths from drug abuse to England and comparator areas, 2018-20

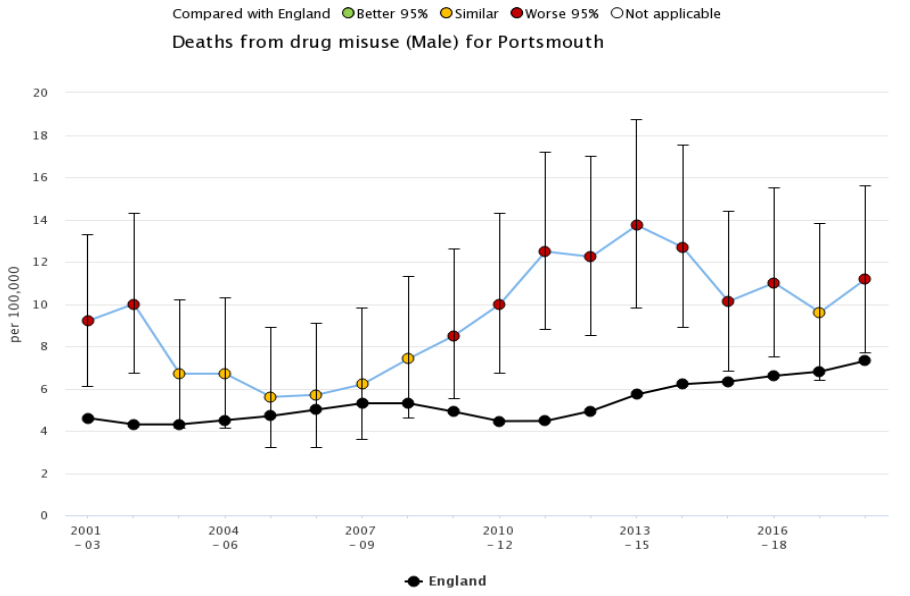

Figure 30 Line chart to show trend in Portsmouth male deaths from drug abuse and compared to England rate, 2001-03 to 2018-20

8.9 Sexual health

In 2020, there were 2,038 new STIs diagnosed Portsmouth residents as a rate Portsmouth had a significantly higher rate of all new STIs compared to England (949 per 100,000 population, all ages compared to 562 per 100,000 population, all ages). In 2020, the Portsmouth rate for new STI diagnoses excluding Chlamydia aged under 25 years was also significantly higher than England (770 per 100,000 population, aged 15-64 years compared to 619 per 100,000 population, aged 15-64 years). Perhaps unsurprisingly, Figure 31 shows the new STI diagnoses rate is strongly correlated with the STI testing rate (i.e. the more people tested often leads to higher diagnosis rates) - in 2020, Portsmouth had a significantly higher STI testing rate (excluding Chlamydia aged under 25 years) than

England; but has a similar testing rate compared to the following comparator local authorities: Southampton, Nottingham and Derby. Of these local authorities, in 2020, Portsmouth had a significantly higher new STI diagnosis rate (excluding Chlamydia aged under 25 years) than Derby; but a similar rate compared to Southampton and Nottingham. Portsmouth's positivity rate has been increasing and in 2020 the positivity rate in Portsmouth was 7.6% which is similar to 7.3% in England. In 2020, Portsmouth also had a similar STI testing positivity rate to Nottingham and Southampton. Portsmouth's STI diagnosis rate (excluding chlamydia in under 25 year-olds) remains higher than England from 2017 to 2020, which given an increasing positivity rate and a higher testing rate, it may be indicative of a high burden of infection in Portsmouth relative to England.

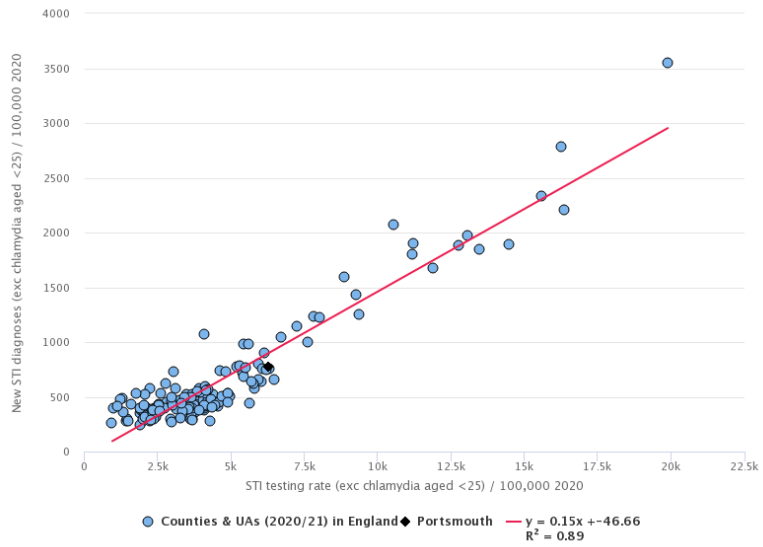

Figure 31. New STI diagnoses (exc chlamydia aged <25) per 100,000 aged 15-64 years, 2020 compared to STI testing rate (exc chlamydia aged <25) aged 15-64 years, 2020; by Unitary Authorities. Source: Sexual and Reproductive Health Profiles, Office for Health Improvement & Disparities.

Chlamydia is more common in younger people aged 15-24 years and in Portsmouth, in 2020, over half (63%) of all the diagnoses are from this age group (891 diagnoses). Chlamydia is most often asymptomatic, a high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. A higher diagnosis rate is usually associated with a higher chlamydia proportion of the population tested (screened), especially in the 15-24 years age group. It is recommended that local authorities achieve a detection rate (diagnosis rate) of a least 2,300 per 100,000 residents aged 15 to 24 years and Portsmouth's detection rate in 2020 was 2,323 per 100,000 population (891 positives out of 5,871 screened), higher than the 2,300 target. In 2020, in Portsmouth, 15.3% of 15-24 year-olds were screened for chlamydia, compared to 14.3% in England. Figure 32 shows a close relationship nationally between the proportion screened for Chlamydia and the Chlamydia detection rate, aged 15-24 years, but also shows that Portsmouth has an above average diagnosis (detection) rate aged 15-24 years compared to comparator unitary authorities with a similar proportion of the population screened - a higher detection rate than Bristol (15.8% screened), Plymouth (14.8% screened), Newcastle-upon-Tyne (15.4% screened) and Southampton (14.4% screened), although the Southampton detection rate is also above average compared to Bristol,

Plymouth and Newcastle-upon-Tyne. [93] Variation in rates of chlamydia detection may represent differences in prevalence, but are influenced by screening coverage and whether most at risk populations are being reached (i.e. the proportion testing positive). [94]

In June 2021, the National Chlamydia Screening Programme (NCSP) changed to focus on reducing the harms from untreated chlamydia infection. These harms occur predominantly in young women and other people with a womb or ovaries - this includes transgender men, non-binary people assigned female at birth, and intersex people with a womb or ovaries. Therefore, opportunistic screening should focus on these groups, combined with reducing time to test results and treatment, strengthening partner notification and re-testing after treatment. In practice this means that chlamydia screening in community settings (e.g. GP and Community Pharmacy) will only be proactively offered to young women and other people with a womb or ovaries. Services provided by sexual health services remain unchanged and everyone can still get tested if needed. [95]

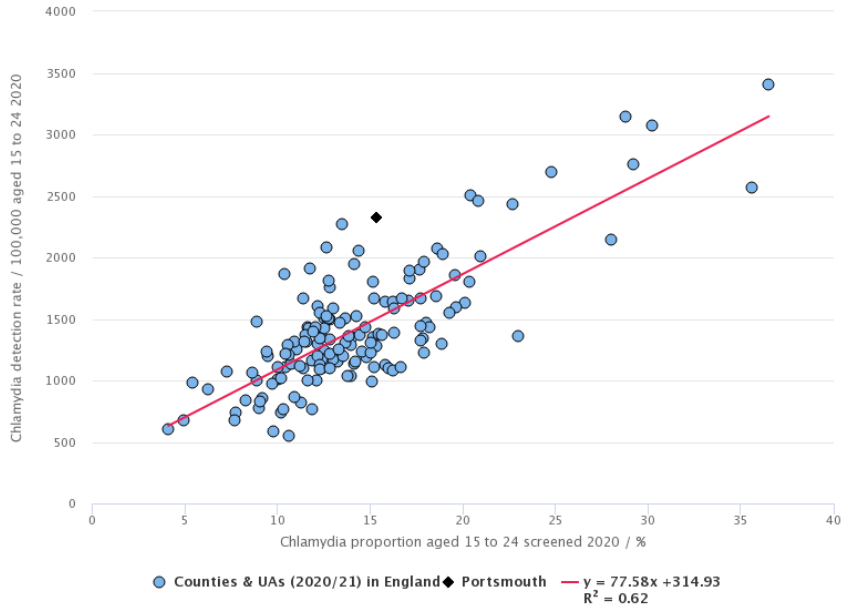

Figure 32. Proportion of aged 15-24 population screened for Chlamydia, 2020 compared to Chlamydia detection rate per 100,000 young people aged 15-24, 2020, by Unitary Authorities. Source: Sexual and Reproductive Health Profiles, Public Health England.

Common STIs in Portsmouth are genital warts (161 diagnoses or 75.0 diagnoses per 100,000 persons of all ages, in 2020); herpes (113 diagnoses or 52.6 diagnoses per 100,000 persons of all ages, in 2020); gonorrhoea (206 diagnoses or 96.0 diagnoses per 100,000 persons of all ages, in 2020) and syphilis (31 diagnoses or 14.4 diagnoses per 100,000 persons of all ages, in 2020). [96] It should be noted that if

[93] Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 28/2/2022.
[94] Summary profile of local authority sexual health (SPLASH) report, Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[95] Summary profile of local authority sexual health (SPLASH) report, Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[96] Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 28/2/2022.

high rates of gonorrhoea and syphilis are observed in a population, this reflects high levels of risky sexual behaviour. [97]

In 2020, Portsmouth had higher rates of genital 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 and Southampton; and significantly higher than the South East region.

Between 2013 and 2020, the rate of genital warts diagnoses had decreased in Portsmouth (following national and regional trends) which can largely be attributed to the protective effect of HPV vaccination and are particularly evident in the younger age groups (aged 25 years and younger) who have been offered the vaccine since the national programme began[98]. Between 2013 and 2020, herpes diagnoses generally decreased in Portsmouth; but remained higher than England and SE region. Between 2013 and 2019, the rate of gonorrhoea diagnoses had increased nationally, regionally and in Portsmouth; and in 2019 the Portsmouth rate was significantly higher than England - the data reported in 2020 may have been impacted by the reconfiguration of sexual health services during the national response to COVID-19. Syphilis numbers and rates have increased in Portsmouth, regionally and nationally; however, the number of Portsmouth diagnoses in 2020 remain similar to previous years despite the data reported potentially impacted by reconfiguration of sexual health services during the national response to COVID-19 or theoretically reduced sexual behaviours due to national and regional lockdowns in 2020.[99]

Cervical screening checks a sample of cells from the cervix for certain types of human papillomavirus (HPV). HPV infections can come from any kind of skin-to-skin contact of the genital area, not just from penetrative sex. Nearly all cervical cancers are caused by an infection with certain types of human papillomavirus (HPV). Cervical screening and the HPV vaccination are the best way to prevent cervical cancer. 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 2021, Portsmouth's cervical screening coverage for women aged 25-49 years was 64.3% and coverage for women aged 50-64 years was 71.5% - both remained significantly lower than both the national and regional rates; however, screening coverage in 2020/21, in particular, decreased and may have been affected by the Covid-19 pandemic locally and nationally.[100]

Free and effective antiretroviral therapy (ART) in the UK has transformed HIV from a fatal infection into a chronic but manageable condition. People living with HIV in the UK can now expect to have a near normal life expectancy if diagnosed promptly and they adhere to treatment. In addition, those on treatment are unable to pass on HIV, even if having unprotected sex (undetectable=untransmissible [U=U]). The number of new HIV diagnoses among people aged 15 years and above in Portsmouth was 16 in 2020. In 2020, there were 321 Portsmouth residents aged 15 to 59 years and 36 residents aged 60 years and over who were seen at HIV services (the prevalence

[97] Summary profile of local authority sexual health (SPLASH) report, Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[98] Summary profile of local authority sexual health (SPLASH) report, Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[99] Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[100] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.

of diagnosed HIV). The diagnosed prevalence per 1,000 residents aged 15 to 59 years was 2.35, which is similar to 2.31 per 1,000 in England. The rank of Portsmouth was 52nd highest (out of 148 UTLAs/UAs) - since 2019, the increase in Portsmouth was 5%; in the 5 years since 2015, the increase was 25%.

Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality - in Portsmouth, in the three-year period between 2018-20, the percentage of HIV diagnoses made at a late stage of infection (all individuals with CD4 count ≤350 cells/mm3 within 3 months of diagnosis) was 47.4% (n=27 late stage diagnoses) - similar to 42.4% in England.

HIV testing is integral to the treatment and management of HIV infection. In 2020, amongst Portsmouth residents, the percentage of eligible Sexual Health Service attendees who received an HIV test was 37.4%, worse than 46.0% for England - this was a significant decrease in HIV testing coverage compared to 2019 both locally and nationally (in 2019, Portsmouth's HIV testing coverage was 58.1% and in England was 64.9%). For 2020, the percentage of men who have sex with men (MSM) in Portsmouth who had tested more than once in the previous year was 47.3%, similar to 52.0% in England. [101]

8.9.1 Teenage conception and abortions

Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS. While for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty.

In 2019, the teenage conception rate, aged under 18 years, in Portsmouth increased to 20.5 per 1,000 females aged 15-17 years (n=65) - the Portsmouth rate was significantly higher than England (15.7 per 1,000 females aged 15-17 years) and the South East (12.7 per 1,000 females aged 15-17 years); and higher, but not significantly, than Southampton (18.5 per 1,000 females aged 15-17 years). [102]

The three-year pooled trend in the under 16 years conception rate for Portsmouth continues to decrease (2.6 per 1,000 females aged 13-15 years in 2017-19, compared to 3.8 in 2016-18) and is similar to Southampton (2.5 per 1,000 females aged 13-15), and England (2.5 per 1,000 females aged 13-15). [103]

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, Fratton and Baffins in the Central locality; and St. Thomas ward in the South locality, all have higher rates than England, in 2017-19. (Figure 33)

[101] Summary profile of local authority sexual health (SPLASH) report, Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[102] Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[103] Table 7, VSOB, Office for National Statistics © Crown Copyright via Portsmouth JSNA: www.jsna.portsmouth.gov.uk

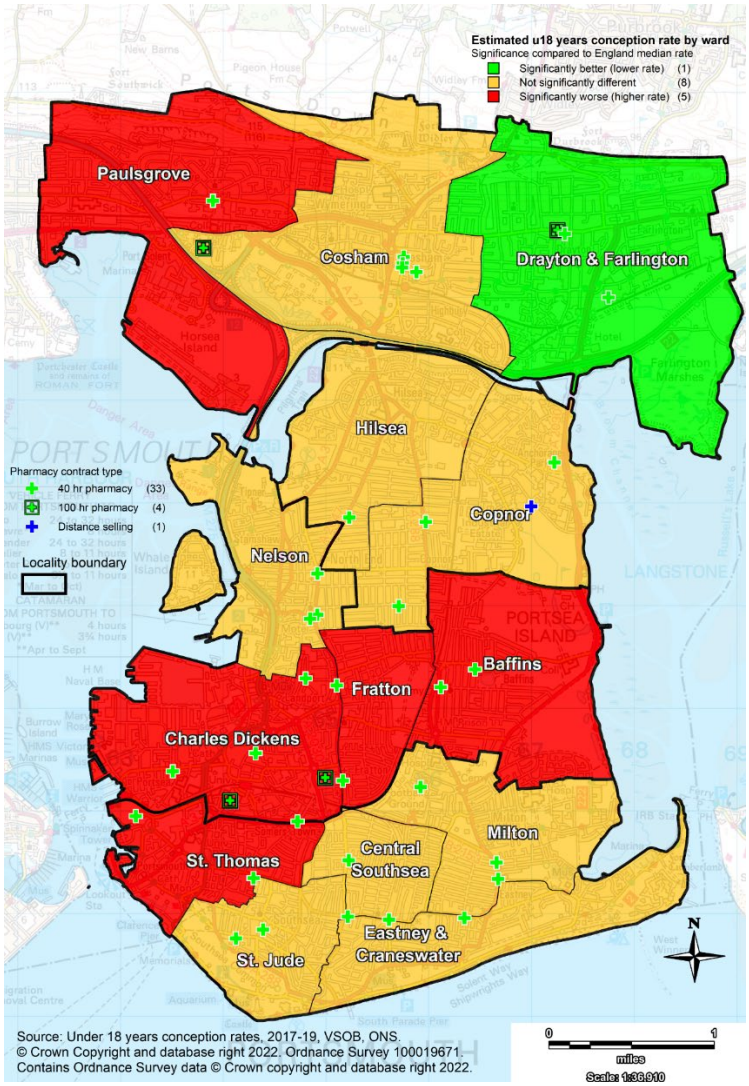

Figure 33. Map of Portsmouth comparing the estimated electoral ward under 18 years conception rate to the England median, 2017-19, overlaid by localities and pharmacies.

Teenagers are more likely to present late for abortion and to book late for antenatal care. The higher risk of unplanned pregnancy, late confirmation of pregnancy and fear of disclosure, all contribute to delays in accessing abortion and maternity services. Early pregnancy diagnosis, unbiased advice on pregnancy options and swift referral to maternity or abortion services are required to minimise delays. Young people who have experienced pregnancy are also at higher risk of subsequent unplanned conceptions [104]. In 2017-19, 69.2% of conceptions to under 16 year-olds in Portsmouth led to abortion—a higher (but not significantly) percentage than England, the South East region and Southampton. The percentage of under 16 years conceptions leading to abortion in Portsmouth in 2017-19 was the highest since 2008/10 [105]. In 2019, 56.9% of conceptions to Portsmouth women aged under 18 year-olds led to abortion - higher (but not significantly) than England and Southampton, but lower (but not significantly) than the South East region. [106]

[104] Summary profile of local authority sexual health (SPLASH) report, Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[105] Table 7, VSOB, Office for National Statistics © Crown Copyright via Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[106] Table 6, VSOB, Office for National Statistics © Crown Copyright via Portsmouth JSNA: www.jsna.portsmouth.gov.uk

In 2020, Portsmouth's abortion rate[107] in females aged under 18 years is 10.7 per 1,000 females aged 15-17 years. The Portsmouth abortion rate for females aged under 18 years was significantly higher than England and the South East region; and higher, but not significantly, than Southampton. The 2020 Portsmouth under 18 years abortion rate is higher, but not significantly than in 2018 and 2019. [108]

The total abortion rate, under 25 years repeat abortion rate, under 25 years abortions after a birth, and over 25 years abortion rates may be indicators of lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method. [109]

In 2020, there were 950 abortions for Portsmouth females of all ages. The age-standardised total abortion rate in Portsmouth was 18.7 abortions per 1,000 women aged 15-44 years - higher, but not significantly, than England and Southampton. In 2020, the over 25 years abortion rate per 1,000 women aged 25-44 years in Portsmouth was 19.5 (n=556), which is significantly higher than England (17.6 per 1,000) and the South East region (16.4 per 1,000); and similar to Southampton (19.4 per 1,000 women). Abortions are safer when carried out in early pregnancy—before 10 weeks[110]. The proportion of NHS-funded abortions carried out before 10 weeks has continued to increase in Portsmouth and nationally. In 2020, 91.3% of abortions were performed under 10 weeks – higher than the percentage for England, the South East region and Southampton. [111]

In 2020, of the Portsmouth women aged under 25 years having an abortion, 31% had a previous abortion which is the highest percentage since 2012 (in 2019, 22.8% had a previous abortion). The Portsmouth percentage having a previous abortion aged under 25 years, in 2020, was higher than England (29.2%) and the South East (28.7%). In 2020, of the Portsmouth women aged under 25 years having an abortion, 22.3% had previously given birth - this was significantly lower than England (27.1%).[112]

In 2020, of the Portsmouth women aged 25 years and over having an abortion, 49.6% had undergone a previous abortion, this was higher than England (48.9%) and represents a decrease from the previous year for Portsmouth (51.8% in 2019). [113]

8.10 Skin cancer

In 2017-19, Portsmouth's incidence of malignant melanoma of skin was 38.1 registrations per 100,000 persons of all ages (age-standardised rate) (n=196 registered tumours); and there was no significant difference between males and females for Portsmouth CCG. The 2017-19 Portsmouth incidence rate was significantly higher than the rate for England. [114]

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[107] Defined as abortions in the calendar year from DHSC, whereas an alternative source would be via ONS, which provides abortion rate but based on the year of conception, so may differ.
[108] Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[109] Summary profile of local authority sexual health (SPLASH) report, Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[110] DH Abortion Statistics © Crown Copyright. Table 10d via Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[111] DH Abortion Statistics © Crown Copyright. Table 11a via Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[112] Sexual and Reproductive Health Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 1/3/2022.
[113] DH Abortion Statistics © Crown Copyright. Table 11d via Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[114] CancerData, National Cancer Registration and Analysis Service (NCRAS) and NHS England. https://www.cancerdata.nhs.uk [accessed 2 Mar 2022].

8.11 Screening and protection

Hepatitis B is vaccine preventable and an important health protection issue that can cause serious disease. Variation in incidence rate may reflect outbreaks, differences in underlying population e.g. larger proportion of risk groups (e.g. migrants from countries with a high prevalence of hepatitis B, men who have sex with men, injecting drug users), in addition to variation in uptake of vaccination of risk groups. High rates of acute hepatitis B should prompt a review of cases to determine underlying reasons and to identify appropriate interventions. In 2018, there were 2 cases of Acute Hepatitis B in Portsmouth, which as a rate (0.93 per 100,000 population) is similar to the England rate (0.9 per 100,000).

Infants born to hepatitis B virus (HBV) infected mothers are at high risk of acquiring HBV infection themselves. Since April 2000 it has been recommended that all pregnant women in England and Wales should be offered testing for hepatitis B through screening for HBsAg, and that all babies of HBsAg seropositive women should be immunised (HSC 1998/127). In 2020/21, Hepatitis B vaccine coverage for both 1 and 2 year olds was 100% in Portsmouth (all 19 children at age 12 and 24 months received the full course of doses of hepatitis B vaccine).

Hepatitis C is an important health protection issue that increases people's risk of developing serious long-term disease. About a third of people infected with hepatitis C virus will eventually develop liver cirrhosis, where normal liver tissue is replaced by scar tissue, accompanied with an increased risk of developing liver cancer. Hepatitis C is difficult to diagnose. Variation in detection rates may reflect differences in local testing activity for a given population as well as the underlying population (eg larger proportion of risk groups, such as people who inject drugs). In 2017, there were 51 diagnoses of Hepatitis C in Portsmouth, which as a detection rate (25.9 per 100,000 population) is significantly higher than the England rate (18.4 per 100,000). [115]

In 2019/20[116], Portsmouth's immunisation coverage of children aged 1 year for Pneumococcal disease (PCV) (96.1%) was higher than the England rate and above the national target of 95% coverage. In 2020/21, Portsmouth's immunisation coverage of children aged 1 year for Diphtheria Tetanus, pertussis, polio and Haemophilus influenzae type b (DTaP/IPV/Hib) (94.9%); Meningococcal group B (MenB) (94.9%); Rotavirus (Rota) (93.3%) were higher than the England rate. The national target is 95% coverage or above for these vaccinations for children aged 1 year. [117]

In 2020/21, Portsmouth's immunisation coverage of children aged 2 years for PCV booster vaccine (98.4%); first dose of Measles, Mumps and Rubella (MMR) vaccine (94.3%); the combined Haemophilus influenza type b and meningitis C (Hib/menC) booster vaccine (93.2%); Meningococcal group B (menB) booster (96.6%); and DTaP/IPV/Hib (97.6%) were all higher than the England rate and all, but Hib/menC booster and MMR 1st dose, met the national target of 95% coverage.

[115] Health Protection profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 2/3/2022.

[116] Babies born from 1 January 2020 will be offered 1 dose of PCV at 12 weeks of age and a booster dose at 1 year. Due to this change, PCV 12m data is not available for 2020-21 (Source: NHS Digital, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-immunisation-statistics/england---2020-21/introduction)

[117] Health Protection profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 2/3/2022.

In 2020/21, Portsmouth's immunisation coverage for children at their fifth birthday completing MMR (1st and 2nd dose) (91.8% receiving both doses, although 96.3% received at least the 1st dose); and receiving a fourth dose of Diphtheria, Tetanus, Polio and Pertussis (DTaP/IPV) vaccine (booster) (90.8%) were all higher than the England rate, but only MMR 1st dose met the national target of above 95%.[118]

Immunisation against the human papillomavirus virus (HPV) (which causes at least 70% of cases of cervical cancer[119]) was introduced in 2008/09 and was initially a three dose programme for girls aged 12-13 years, but reduced to two doses in 2014/15; and is offered through educational establishments. In July 2018, it was announced that the HPV vaccine would be extended to boys aged 12 to 13 years in England. The national target is 90% coverage or above for the HPV vaccine. In 2019/20, Portsmouth's vaccination coverage for one dose of HPV for boys aged 12-13 years (Year 8) was 83.5%. In the same year, Portsmouth's vaccination coverage for one dose of HPV for girls aged 12-13 years (Year 8) was 91.7% and for the second dose for girls aged 13-14 years was 84.2% - a decrease on the previous year for both. However, coverage rates for both age groups were impacted on due to the Covid-19 pandemic affecting educational settings and the delivery of the programme, although Portsmouth was not affected to the same extent as nationally where the England rate was 59.2% for girls aged 12-13 years, 64.7% for girls aged 13-14 years and 54.4% for boys aged 12-13 years. [120]

The MenACWY vaccination was introduced into the national immunisation programme in autumn 2015 to respond to a rapid and accelerating increase in cases of invasive meningococcal group W (MenW) disease, which was declared a national incident. The MenACWY conjugate vaccine provides direct protection to the vaccinated cohort and, by reducing MenW carriage, will also provide indirect protection to unvaccinated children and adults. The national target is 90% coverage or above for the MenACWY vaccine. In 2019/20, Portsmouth's vaccination coverage for MenACWY aged 14-15 years was 80.0% - significantly lower than England (87.0%) and the South East region (88.9%). However, Portsmouth's uptake may have been impacted on when schools closed from 23rd March 2020. In 2018/19, Portsmouth's coverage rate met the national target. [121]

Pneumococcal disease is a significant cause of morbidity and mortality. Certain groups are at risk for severe pneumococcal disease, these include young children, the elderly and people who are in clinical risk groups. Pneumococcal infections can be non-invasive such as bronchitis, otitis media or invasive such as septicaemia, pneumonia, meningitis. Cases of invasive pneumococcal infection usually peak in the winter during December and January. The PPV protects against 23 types of Streptococcus pneumoniae bacterium. It is thought that the PPV is around 50-70% effective at preventing more serious types of invasive pneumococcal infection. In 2020/21, Portsmouth's vaccination coverage for PPV aged 65 years and over was 76.9% - above the national target of 75%; and higher than the England average (70.6%).

In 2020/21, the Portsmouth 'seasonal flu' vaccine coverage rate in the population aged 65 years and over was 82.5%, which was higher than the national target of 75% for the first time since 2013/14.

[118] Health Protection profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 2/3/2022.
[119] World Health Organisation (WHO) https://www.who.int/news-room/fact-sheets/detail/cervical-cancer [accessed 2 Mar 2022]
[120] Health Protection profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 2/3/2022.
[121] Health Protection profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 2/3/2022.

The rate for Portsmouth in 2020/21 was higher than the coverage rates for England and the South East region. [122] The big increase locally and nationally in coverage rates in 2020/21 may be due in part to a number of factors which is likely to be a positive effect from the Covid-19 pandemic: eg greater public desire and/or awareness to protect themselves and the NHS during the pandemic as a result of increased marketing and communications; perhaps improved planning and delivery of the immunisation programme, including additional funding of the programme; and improved accessibility.

In 2020/21, 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 57.3%, which is higher than the national target of 55% (an increase from 2019/20). The rate for Portsmouth in 2020/21 was higher than the coverage rate for the South East region and England. [123]

In 2013-14, a new childhood influenza vaccine programme was started. In 2020/21, the Portsmouth 'aged 2-3 years old' vaccine coverage rate was 61.8%, which is lower than the national target of 65% (but an increase compared to 53.2% in 2019/20). The rate for Portsmouth in 2020/21 was higher than the coverage rate for England; but similar to the South East region. [124]

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 2021, Portsmouth's coverage of breast screening for female residents aged 53 to 70 years was 68.2%. Portsmouth's coverage was higher than the rates for the South East (68.0%) and England (64.1%); but nationally breast cancer screening was impacted on by the Covid-19 pandemic. Portsmouth's coverage as at March 2020 was 69.2% - lower than England (74.1%). [125]

In 2021, 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 (61.0%) remained significantly lower than the coverage rate for England (65.2%). Portsmouth's coverage rate has been improving since 2019. [126]

In 2020/21, the Abdominal Aortic Aneurysm (AAA) screening coverage rate for males aged 65 years old in Portsmouth (72.3%) was higher than the England rate (55.0%). However, both 2019/20 and especially 2020/21, AAA screening coverage was impacted on by the Covid-19 pandemic.

[122] Health Protection profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 2/3/2022.
[123] Health Protection profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 3/3/2022.
[124] Health Protection profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 3/3/2022.
[125] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 3/3/2022.
[126] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 3/3/2022.

Portsmouth's AAA screening coverage in 2018/19 was 78.4% - significantly lower than England (81.3%). [127]

In 2018/19, 85.1% 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 (83.2%). [128]

In 2020/21, the newborn and infant physical examination screening coverage rate in Portsmouth (95.6%) was significantly lower than the rates for England (97.3%) and the South East region (97.1%). The newborn hearing screening coverage rate in Portsmouth (95.9%) was lower than the rates for England (97.5%) and the South East region (98.2%). Newborn screening coverage in 2019/20 and 2020/21 may have been impacted on by the Covid-19 pandemic. [129]

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 2016/17 to 2020/21) was 31.0% - this is significantly lower than the proportion for England (46.5%). [130]

8.12 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 34 and Figure 35) 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 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%).

[127] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 3/3/2022.
[128] Diabetic eye screening: 2018 to 2019 data: https://www.gov.uk/government/publications/diabetic-eye-screening-2018-to-2019-data. Date accessed 3/3/2022.
[129] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 3/3/2022.
[130] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 3/3/2022.

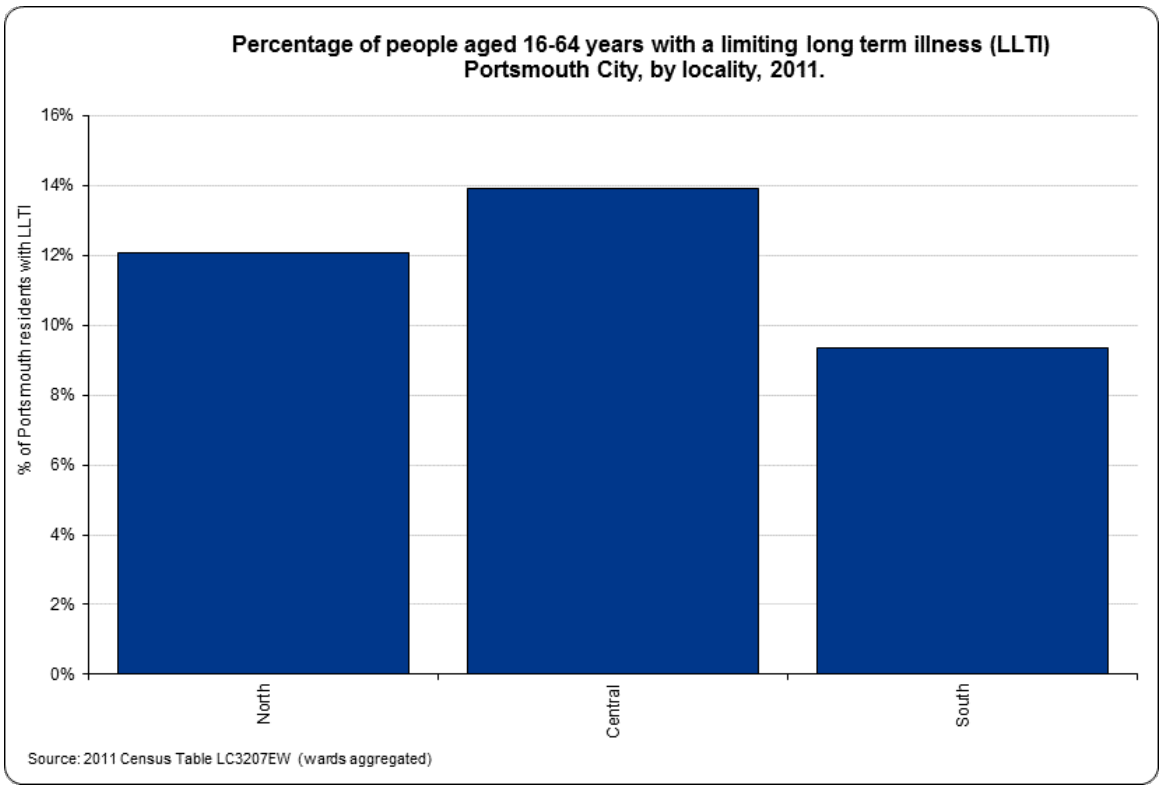

Figure 34. Percentage of people aged 16-64 years with a limiting long term illness (LLTI), Portsmouth City, by locality, 2011.

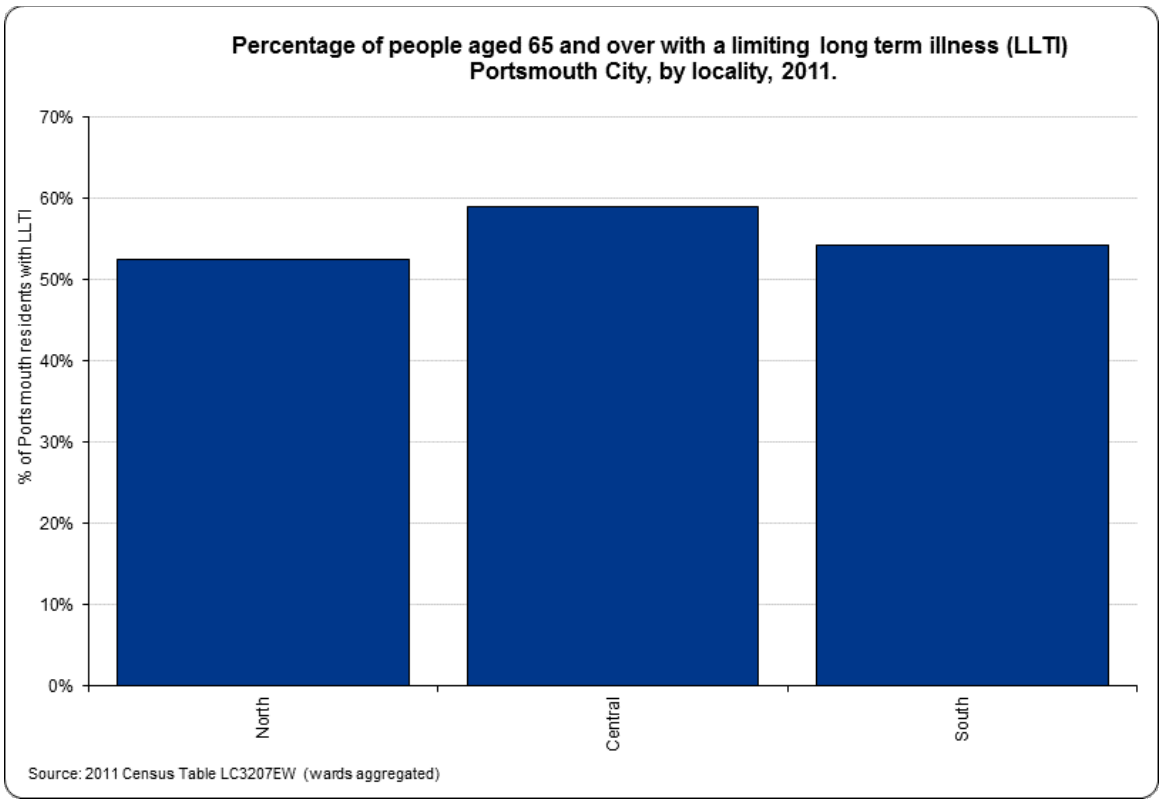

Figure 35 Percentage of people aged 65 and over with a limiting long term illness (LLTI), Portsmouth City, by locality, 2011.

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). [131]

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%).[132]

8.12.1 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).

8.12.2 Hypertension

In 2020/21[133], hypertension is the most common condition on GP registers with 27,634 patients or 12.0% of registered patients of all ages, on hypertension registers. The range at practice level was from 15.9% at North Harbour Medical Group to 10.8% at Lake Road Practice (excluding Guildhall Walk and the University Practice prevalence rates). Portsmouth CCG recorded prevalence is lower than the prevalence figures for England (13.9%)[134]. However, Portsmouth's recorded prevalence 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 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

[131] Ipsos MORI for Portsmouth City Council. Health and Lifestyle Survey, 2015 via Portsmouth JSNA.
[132] 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]
[133] Due to the impact of Covid-19 pandemic on activity in general practice in 2020/21, the data may not be inaccurate and therefore comparisons with previous years may be misleading. Quality and Outcomes Framework (QOF), NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2020-21/ Accessed 3 Mar 2022
[134] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 3/3/2022.

hypertensive and second, they did not report having been diagnosed high blood pressure) [135] - roughly 30,200 Portsmouth residents aged 16 years and over expected to be diagnosed with hypertension and there may be roughly, a further 19,100 residents aged 16+ years undiagnosed with hypertension (by applying the 2015 prevalence estimates to the ONS mid-2020 population aged 16+ years estimate).

8.12.3 Diabetes

In 2020/21, 12,851 people aged 17+ years (6.8% 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 (7.1%). Portsmouth's recorded prevalence of diabetes has increased annually from 4.9% in 2010/11. The range at practice level in 2020/21 was from 8.9% at Portsdown Group Practice to 5.7% at Trafalgar Medical Group Practice (excluding Guildhall Walk and the University Practice prevalence rates)[136]. However, due to the impact of Covid-19 pandemic on activity in general practice in 2020/21, the data may not be inaccurate and therefore comparisons with previous years may be misleading.[137]

However, modelled prevalence (based on national survey data from 2012-2014) of diagnosed and undiagnosed diabetes (taking into account age, sex, ethnicity and deprivation) estimated that in 2015, 7.4% of Portsmouth CCG registered patients aged 16+ years had diabetes and projected this to increase to 7.6% by 2020. In 2015/16, the recorded diabetes prevalence was 5.8% for Portsmouth CCG registered patients, which suggested there may have been roughly 3,000 undiagnosed Portsmouth patients at that time. The 2020 modelled estimate (assumes no increase in obesity levels since 2015) would suggest there would be 13,100 Portsmouth residents or 14,000 Portsmouth CCG registered patients with diabetes[138]. Compared with 12,851 registered patients aged 17+ years on the diabetes register in 2020/21, 6.8% prevalence[139] - the modelled prevalence suggests that there may be roughly 1,200 Portsmouth CCG registered patients undiagnosed/ not on the diabetes register. It's, therefore, unclear if the annual increasing recorded prevalence of diabetes on GP registers is due to increased diabetes prevalence in the Portsmouth population and/or due to improved identification of diabetic patients by GP practices leading to previously undiagnosed patients being recorded on registers.

Modelled diabetes prevalence (based on 2012-14 national survey data) for Portsmouth residents aged 16 years and over was 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[140]. 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):

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[135] 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]

[136] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 3/3/2022.

[137] Quality and Outcomes Framework (QOF), NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2020-21/ Accessed 3 Mar 2022

[138] Diabetes prevalence model for local authorities and CCGs. PHE. https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations Accessed 03 March 2022

[139] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 3/3/2022.

[140] Diabetes prevalence model for local authorities and CCGs. PHE. https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations Accessed 03 March 2022

Scenario: the 2015 level of obesity *increases by 5%* every 5 years –it is estimated there would be 14,600 (8.0%) Portsmouth residents aged 16+ years with diabetes in 2025. This represents an additional 600 people with diabetes compared to if obesity levels remained at the same level as 2015. 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 (5% every 5 years). 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 13,400 (7.4%) Portsmouth residents aged 16+ years with diabetes in 2025. This represents 600 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. [141]

Non-diabetic hyperglycaemia (NDH), 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. [142] In 2020/21, 10,364 people aged 18+ years (5.6% of people aged 18+ years registered with Portsmouth City GP Practices) are on GP registers with NDH - higher than England (5.3%). The range at GP practice level in 2020/21 was from 9.4% at Portsdown Group Practice to 2.9% at The Drayton Surgery (excluding Guildhall Walk and the University Practice prevalence rates). However, due to the impact of Covid-19 pandemic on activity in general practice in 2020/21, the data may not be inaccurate as accuracy of the data depends on:

- Clinical case finding by GPs: for example, information from Quality and Outcomes Framework (QOF) NDH register or about QOF NDH indicators depends on people with NDH being diagnosed.
- Clinical coding: for example, when patients are diagnosed with NDH, the quality of QOF data about people with NDH depends on the GP practice maintaining accurate and coded clinical records. [143]

Between 2011/12 and 2018/19, emergency hospital admissions for diabetes (where Insulin-dependent diabetes mellitus is the primary diagnosis) for Portsmouth children and young people aged under 19 years, had been a similar rate compared to England where nationally admissions had been decreasing each year. However, in 2019/20, emergency hospital admissions for diabetes for Portsmouth aged under 19 years increased (as did England) but the Portsmouth rate was significantly worse than England for the first time since 2010/11.

[141] Diabetes prevalence model for local authorities and CCGs. PHE. https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations Accessed 03 March 2022

[142] 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].

[143] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 4/3/2022.

8.12.4 Coronary heart disease

In 2020/21[144], there were 6,110 patients on the coronary heart disease (CHD) register (2.7% of registered patients of all ages compared with 3.0% in England). The range at GP practice level was from 3.5% of registered patients of all ages at The Drayton Surgery to 2.5% at the Derby Road practice (excluding Guildhall Walk Healthcare Centre and the University Practice). [145]

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[146] —roughly 3,400 people in 2015 (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 4,000 people aged 55-79 years by 2025 (applying the prevalence rate to the ONS 2018-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). [147]

In 2020, for Portsmouth males, the leading cause of death remained as coronary heart disease (also known as ischaemic heart disease) (101 deaths; 11% of all male deaths). For Portsmouth males aged 50-64 years, Ischaemic heart diseases was the leading cause of death each year from 2014 to 2020, except in 2015 where Malignant neoplasm of trachea, bronchus and lung was the leading cause. When looking at five-year age groups over six-year periods, the leading cause of death for Portsmouth males in each five-year age group from 45-49 years and over in 2002-07 and 2008-13 was Ischaemic heart diseases; in the most recent period in 2014-19, Ischaemic heart diseases remained a leading cause of death especially aged 50-84 years. [148]

For Portsmouth females, Ischaemic heart diseases was ranked third out of the leading causes of death in 2020, but was ranked second in the previous three years. [149]

In 2017-19, Portsmouth's female premature mortality (aged under 75 years) from coronary heart disease rate was significantly higher than England. In 2017/19, Portsmouth's male premature mortality (aged under 75 years) from coronary heart disease rate was higher, but not significantly, than England males. [150]

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[144] Due to the impact of Covid-19 pandemic on activity in general practice in 2020/21, the data may not be inaccurate and therefore comparisons with previous years may be misleading. Quality and Outcomes Framework (QOF), NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2020-21/ Accessed 3 Mar 2022

[145] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 4/3/2022.

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

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

[148] Civil Registration Data via Primary Care Mortality Database (PCMD), Copyright ©2021, re-used with the permission of HSCIC. All rights reserved. Accessed via JSNA Portsmouth www.jsna.portsmouth.gov.uk

[149] Civil Registration Data via Primary Care Mortality Database (PCMD), Copyright ©2021, re-used with the permission of HSCIC. All rights reserved. Accessed via JSNA Portsmouth www.jsna.portsmouth.gov.uk

[150] Public Health England. Public Health Profiles. Date accessed 4/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021' via JSNA Portsmouth www.jsna.portsmouth.gov.uk

8.12.5 Chronic obstructive pulmonary disease

In 2020/21, there were 4,490 registered patients of all ages recorded with COPD on GP practice registers (2.2% of all registered patients compared to 1.9% nationally). The range at GP practice level was from 3.3% of registered patients at North Harbour Medical Group to 1.8% at Trafalgar Medical Group Practice (excluding Guildhall Walk Healthcare Centre and University practice)[151]. Portsmouth's recorded prevalence of COPD is increasing (1.6% in 2010/11; 2.0% in 2015/16). However, due to the impact of Covid-19 pandemic on activity in general practice in 2020/21, the data may not be inaccurate and therefore comparisons with previous years may be misleading.[152]

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 Portsmouth residents of all ages[153] - 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[154]. 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 13,900 people (applying the prevalence rate to the ONS 2018-based subnational population estimates) estimated to have COPD. Estimating future prevalence might also be affected by an ageing population, smoking prevalence and deprivation.

Since 2015/16, emergency hospital admissions for COPD (where COPD is the primary diagnosis) for Portsmouth CCG registered patients of all ages has been significantly higher than England. In 2020/21, emergency admissions for COPD, all ages, decreased significantly for Portsmouth and England[155], which may be due to the impact of the Covid-19 pandemic.

In 2020, chronic lower respiratory disease (which includes COPD) was the third most frequent broad cause of death for Portsmouth males of all ages (72 deaths, 8% of all deaths) and fifth most frequent cause of death for Portsmouth females of all ages (45 deaths, 5% of all deaths). In 2020 (and 2016 and 2018), Chronic lower respiratory diseases was the leading cause of death for Portsmouth males aged 75-84 years. In 2017 and 2018, Chronic lower respiratory diseases was the leading cause of death for Portsmouth females aged 65-74 years (15% of all female deaths aged 65-74 years in 2017 and 13% in 2018). [156]

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[151] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 4/3/2022.

[152] Quality and Outcomes Framework (QOF), NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2020-21/ Accessed 3 Mar 2022

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

[154] 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]

[155] Inhale - INteractive Health Atlas of Lung conditions in England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 4/3/2022.

[156] Civil Registration Data via Primary Care Mortality Database (PCMD), Copyright ©2021, re-used with the permission of HSCIC. All rights reserved. Accessed via JSNA Portsmouth www.jsna.portsmouth.gov.uk

In 2017-19, the Portsmouth mortality rate from chronic obstructive pulmonary disease (COPD) remained similar to the previous period and was significantly higher than England and the South East, but similar to Southampton.[157] The mortality rate from COPD for Portsmouth males, in particular, is amongst the highest in the country although the Portsmouth female rate is also significantly higher than England.[158]

8.12.6 Asthma

In 2020/21, there were 14,621 registered patients of aged 6 years and over (6.8% of all registered patients aged 6 years and over) on GP Practice asthma registers. The national prevalence was 6.4% aged 6 years and over. Previously, Asthma recorded prevalence on GP registers included all ages so are not comparable. The range at GP practice level in 2020/21 was from 9.5% of registered patients aged 6 years and over at Sunnyside Medical Centre to 6.1% at Craneswater Group Practice (excluding Guildhall Walk Healthcare Centre and University practice) [159]

The 2010 Health Survey for England indicated 9.5% of adults and children reported having asthma. Most of the care for people with asthma is provided in primary care. NICE guidelines for the management of asthma state that people with asthma should not need emergency treatment if appropriate routine care is given. Between 2017/18 and 2019/20, emergency hospital admissions for asthma (where asthma is the primary diagnosis) for Portsmouth CCG registered patients, aged 19 years and over, was significantly lower than England. In 2020/21, emergency admissions for asthma in adults decreased significantly for Portsmouth and England[160], which may be due to the impact of the Covid-19 pandemic.

Since 2015/16, hospital admissions for asthma (where asthma is the primary diagnosis) for Portsmouth residents, aged under 19 years, was lower than England and significantly lower than England in 2016/17. In 2019/20 hospital admissions for asthma or Portsmouth residents, aged under 19 years was significantly lower than England. However, 2019/20 and especially 2020/21, emergency admissions for asthma, aged under 19 years, decreased significantly for Portsmouth and England[161], which may be due to the impact of the Covid-19 pandemic.

8.12.7 Stroke

In 2020/21, there were 3,583 patients on the Stroke or Transient Ischaemic Attacks registers in primary care (1.6% of registered patients of all ages compared with 1.8% in England). The range at GP practice level was from 2.1% at Craneswater Group Practice to 1.4% at North Harbour Medical Group and Derby Road Practice (excluding Guildhall Walk and the University Practice prevalence rates). [162]

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[157] Local Tobacco Control Profiles. Public Health Profiles. Date accessed 8/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021' via JSNA Portsmouth www.jsna.portsmouth.gov.uk

[158] Mortality Profiles. Public Health Profiles. Date accessed 9/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021' via JSNA Portsmouth www.jsna.portsmouth.gov.uk

[159] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 4/3/2022.

[160] Inhale - INteractive Health Atlas of Lung conditions in England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 4/3/2022.

[161] Inhale - INteractive Health Atlas of Lung conditions in England, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 4/3/2022.

[162] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 7/3/2022.

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[163] — roughly 1,600 people aged 55-79 years in 2015 (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 2018-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).[164]

Atrial fibrillation (AF) is a heart condition and is the most common form of cardiac arrhythmia. AF is associated with increased risk of stroke as well as reduced cardiac performance and early mortality. Stroke patients with uncontrolled AF are more likely to be diagnosed with severe stroke which can lead to poorer outcomes. AF is often asymptomatic, frequently unrecognised and consequently it is difficult to quantify the true prevalence in the general population. In 2020/21, there were 4,206 patients on the atrial fibrillation registers in primary care (1.8% of registered patients of all ages compared with 2.0 % in England). The range at GP practice level was from 2.6% at Craneswater Group Practice to 1.7% at Sunnyside Medical Centre, Lake Road Practice and Derby Road Practice (excluding Guildhall Walk and the University Practice prevalence rates). In 2019, the estimated prevalence of AF was 2.1% for Portsmouth, which suggests that, given a recorded prevalence of AF on GP registers of 1.7% in 2018/19, there could have been roughly 800 undiagnosed patients at that time. Assuming that the estimated prevalence of AF remains at the same rate as in 2019 at 2.1%, then there could be a further 600 undiagnosed patients in 2020/21. [165]

In 2020/21, hospital admissions for stroke (where stroke is the primary diagnosis) for Portsmouth residents of all ages was higher, but not significantly, than England. The Portsmouth rate has remained similar since 2015/16 [166]. Behavioural risk factors play a large part in the prevention of stroke with smoking, excessive alcohol use and an unhealthy diet being major risk factors. Emergency admissions are used as a proxy for the incidence of stroke and an indication of where public health interventions may be targeted for prevention of the condition - in 2015/16-2019/20 (5 years pooled), the emergency hospital admissions for stroke rate for Portsmouth persons of all ages was significantly higher than England. [167]

In 2020, Cerebrovascular diseases (which includes stroke) was the sixth most frequent broad cause of death for Portsmouth males of all ages (40 deaths, 4% of all deaths) and fourth most frequent cause of death for Portsmouth females of all ages (46 deaths, 6% of all deaths). In 2017-19, cerebrovascular diseases was third leading cause of death for Portsmouth males aged 50-64 years and fourth leading cause of death for Portsmouth males aged 65-74 years. In 2016, cerebrovascular diseases was the

[163] Disease and risk factor prevalence, Public Health England https://fingertips.phe.org.uk/profile/prevalence [Accessed 04 August 2017]
[164] Stroke prevalence model technical document, Disease and risk factor prevalence, Public Health England https://fingertips.phe.org.uk/profile/prevalence [Accessed 04 August 2017]
[165] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 7/3/2022.
[166] Cardiovascular disease, Diabetes and Kidney Disease profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 7/3/2022.
[167] Local health profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 7/3/2022.

leading cause of death for Portsmouth females aged 75-84 years (12% of all female deaths aged 75-84 years). [168]

In 2017-19, the premature mortality (aged under 75 years) rate from stroke for Portsmouth males was significantly higher than England and the South East region; and higher, but not significantly than Southampton. The premature mortality rate from stroke for Portsmouth females remained similar compared to England, the South East and Southampton.[169]

8.13 Physical disability

2011 Census data shows that 11.6% of Portsmouth residents of working age (aged 16-64 years) had a long-term health problem or disability that limits their day-to-day activity a lot or a little (limiting long term illness, LLTI). At electoral ward level, Charles Dickens had the highest percentage (17.5%) of working age people with a LLTI, followed by Paulsgrove (7.1%). Central Southsea had the lowest percentage (7.1%) of working age people with a LLTI.

For persons aged 65+ years, the Census shows that 54.9% of Portsmouth residents had a LLTI. At electoral ward level, Charles Dickens had the highest percentage (65.1%) of residents aged 65+ years with a LLTI, followed by Fratton (59.0%). Copnor had the lowest percentage (45.0%) of residents aged 65+ years with a LLTI.

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%).[170]

In 2022, it is estimated that there are approximately 6,600 Portsmouth adults aged 16-64 years with impaired mobility[171] and half of these are estimated to be in the aged 55-64 age group (3,300 residents). Assuming the prevalence rate doesn't change, then the number of residents aged 16-64 years with impaired mobility are not expected to increase between 2022 to 2040[172]. However, in Portsmouth aged 65 and over, there is expected to be an increase in residents with impaired mobility (albeit a different definition: unable to manage at least one mobility activity on their own) - in 2022, it is estimated that there are approximately 5,800 Portsmouth adults aged 65+ years unable to manage at least one mobility activity on their own and half of these are estimated to be in the aged 80 years and over age group (2,900 residents). Assuming the prevalence rate doesn't change, then the number of residents aged 65 years unable to manage at least one mobility activity on their own is expected to increase to 6,900 by 2030. [173]

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[168] Civil Registration Data via Primary Care Mortality Database (PCMD), Copyright ©2021, re-used with the permission of HSCIC. All rights reserved. Accessed via JSNA Portsmouth www.jsna.portsmouth.gov.uk
[169] Mortality Profiles. Public Health Profiles. Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 7/3/2022.
[170] 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]
[171] Based on national Life Opportunities Survey Office for Disability Issues (2011) where respondents indicated they had the following: they experience either moderate, severe or complete difficulty with mobility, and certain activities are limited in any way as a result, such as walking or climbing stairs (Source: pansi.org.uk).
certain activities are limited in any way as a result, such as walking or climbing stairs.
[172] Mobility, Projecting Adult Needs and Service Information www.pansi.org.uk Date accessed 7/3/2022
[173] Mobility, Older People Population Information System www.poppi.org.uk Date accessed 7/3/2022

In terms of Years Lived with Disability (YLD), musculoskeletal (MSK) disorders - in particular, low back pain is the biggest cause of disability/ill-health in Portsmouth adults aged 15-49 years (1,160 YLD per 100,000 in 2019) and 50-64 years (2,217 YLD per 100,000 in 2019). It is also the biggest cause in England for these age groups. [174] In terms of prevalence, it's estimated that in 2020, 16.9% of Portsmouth residents aged 16 years and over, have a long-term MSK problem, which is similar to the England average (18.6%). People with a musculoskeletal condition are also likely to have another long-term condition and in 2020, 12.9% of Portsmouth residents aged 16 years and over have at least two long-term conditions, at least one of which is MSK related - similar to the England average (13.2%).

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.

During 2020/21, in Portsmouth 300 Adult Social Care clients aged 18-64 years accessed long-term 'Physical support'[175] (as their primary reason) during the year; 610 ASC clients aged 18-64 years accessed 'Other support' (e.g. Learning Disability, Sensory, Mental Health) as their primary reason. As a percentage of clients accessing Long Term Support, 9.4% of Portsmouth clients aged 18-64 years accessed long-term support with Physical support as the primary reason - this is lower than the England average (10.2%). [176]

During 2020/21, in Portsmouth 1,730 Adult Social Care clients aged 65 years and over accessed long-term 'Physical support' (as their primary reason) during the year; 560 ASC clients aged 65 years and over accessed 'Other support' (e.g. Learning Disability, Sensory, Mental Health) as their primary reason. As a percentage of clients accessing Long Term Support, 54.1% of Portsmouth clients aged 65 years and over accessed long-term support with Physical support as the primary reason - this is lower than the England average (48.6%). [177]

8.14 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 2018-20, male life expectancy at birth in Portsmouth (78.5 years) remained similar to previous periods and is statistically significantly longer than in 2008-10; however, it continues to be significantly shorter than England (79.4 years in 2018-20) even though life expectancy at birth decreased by over a year in England in 2020 (80.0 in 2019 to 78.7 in 2020), which would largely be due to Covid-19 related mortality. In 2018-20, female life expectancy at birth in Portsmouth (82.4 years) remained significantly worse than England (83.1 years). Whilst life expectancy at birth for females across England had been improving before 2020, female life expectancy at birth in Portsmouth had remained similar from 2011

[174] GBD compare, Global Burden of Disease: https://vizhub.healthdata.org/gbd-compare/. Date accessed 22/2/2022.
[175] Physical support: Access and mobility and personal care support
[176] Adult Social Care: Overview by Region and Local Authority Analytical Hub, NHS Digital. Date accessed 7/3/2022.
[177] Adult Social Care: Overview by Region and Local Authority Analytical Hub, NHS Digital. Date accessed 7/3/2022.

to 2019. Unlike for the England average (where life expectancy decreased), female life expectancy at birth increased in 2020, although this was not significantly different to England. [178]

Life expectancy at birth (2018-20) for males in Portsmouth's most deprived 10% of Lower Super Output Areas (LSOAs) is 9.1 years shorter than males in Portsmouth's least deprived 10% of LSOAs - shorter, but not significantly, than the inequality gap in England (9.7 years). Life expectancy at birth (2018-20) for females in Portsmouth's most deprived 10% of LSOAs is 4.3 years shorter than females in Portsmouth's least deprived 10% of LSOAs (the slope index of inequality in life expectancy at birth for males and females) - the gap has decreased each period since 2014-16 and is significantly shorter than the inequality gap in England (7.9 years). [179]

In 2018-20, the healthy life expectancy (HLE) at birth in Portsmouth is shorter, but not significantly than England for both males and females. [180] Portsmouth males and females have a similar HLE at birth (62.1 years and 62.3 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). [181]

8.15 Mortality

Premature mortality in England is considered as deaths aged under 75 years (u75). In 2017-19, the u75 all-cause mortality rate for Portsmouth males and females (480 per 100,000 males of all ages (DSR) and 330 per 100,000 females of all ages (DSR)) was significantly higher than England (397 per 100,000 males of all ages (DSR) and 258 per 100,000 females of all ages (DSR)), the South East (351 per 100,000 males of all ages (DSR) and 229 per 100,000 females of all ages (DSR)); but similar to Southampton (465 per 100,000 males of all ages (DSR) and 316 per 100,000 females of all ages (DSR)) [182]. For small areas within Portsmouth there is variation in premature mortality for all causes - in 2015-19, the Buckland, City Centre and Somerstown middle super output areas (MSOAs) have a standardised mortality ratio about twice that of the England average (if those areas had the same age specific death rate as England) [183]

In 2017-19, Portsmouth's male premature mortality rates were significantly higher than England from the following major cause groups:

- U75 mortality from cardiovascular disease
- U75 mortality from stroke
- U75 mortality from cancer

[178] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.
[179] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.
[180] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.
[181] 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.
[182] Public Health England. Public Health Profiles. Date accessed 4/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021' via Portsmouth JSNA www.jsna.portsmouth.gov.uk
[183] Local health profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 7/3/2022.

- U75 mortality from respiratory disease

In 2017-19, Portsmouth's female premature mortality rates were significantly higher than England from the following major cause groups:

- U75 mortality from cardiovascular disease
- U75 mortality from heart disease
- U75 mortality from cancer
- U75 mortality from breast cancer (the highest rate in the country and increasing since 2015-17)
- U75 mortality from liver disease
- U75 mortality from respiratory disease

The effect of the Covid-19 pandemic makes it difficult to aggregate the data over three years (which is useful for robust statistical comparisons), therefore the following major cause groups are also available for single years up to and including 2020:

- U75 mortality from cardiovascular disease
- U75 mortality from cancer
- U75 mortality from liver disease
- U75 mortality from respiratory disease

In 2020, Portsmouth's male and female premature mortality rates were not significantly different compared to England for the four major cause groups.

The Portsmouth male u75 mortality rate from cardiovascular disease in 2020 was similar to the previous year, but the England rate had increased to similar to the rate in 2013. The Portsmouth female u75 mortality from cardiovascular disease rate in 2020 was lower but not significantly to the previous year; unlike England males, the female England rate was similar to the previous two years.

The Portsmouth male u75 mortality rate from cancer in 2020 was lower, but similar to the previous year and the England rate also continued to decrease. The Portsmouth female u75 mortality rate from cancer in 2020 was lower than the previous year and lower, but not significantly compared to the England rate.

The Portsmouth male u75 mortality rate from liver disease in 2020 was lower, but similar to the previous year; whilst the England rate increased compared to previous years. The Portsmouth female u75 mortality rate from liver disease in 2020 was lower, but not significantly than the previous year; the England rate increased in 2020.

The Portsmouth male u75 mortality rate from respiratory disease in 2020 remained similar to the previous year; but the England rate decreased compared to previous years. The Portsmouth female u75 mortality rate from respiratory disease in 2020 was lower, but not significantly than the previous year; the England rate decreased compared to previous years. [184]

[184] Public Health England. Public Health Profiles. Date accessed 4/11/2021. https://fingertips.phe.org.uk © Crown copyright 2021' via Portsmouth JSNA www.jsna.portsmouth.gov.uk

The leading cause death[185] for Portsmouth residents in 2020 (and since 2015 for persons of all ages was Dementia and Alzheimer's disease (213 deaths; 12% of all deaths). For Portsmouth males, the leading cause of death remained as Ischaemic heart diseases (101 deaths; 11% of all male deaths); however, deaths from Covid-19 were ranked second (98 deaths; 10% of all male deaths), but as a new disease which existed for just over 9 months of the year, if adjusted for the shorter time frame it may well be ranked as the leading cause of death over the year for males. For Portsmouth females, the leading cause of death remained as Dementia and Alzheimer's disease (142 deaths; 17% of all female deaths); deaths from Covid-19 were ranked second (67 deaths; 8% of all female deaths) (Figure 36).[186]

Males

Cause of death groups (ICD-10)	2014	2015	2016	2017	2018	2019	2020
Ischaemic heart diseases (I20-I25)	1	1	1	1	1	1	1
COVID-19 (identified or not: U071-U702; MIS associated: U109)*	New	New	New	New	New	New	2
Chronic lower respiratory diseases (J40-J47)	4	3	2	3	2	3	3
Dementia and Alzheimer's disease (F01, F03, G30)	3	2	3	2	3	2	4
Malignant neoplasm of trachea, bronchus and lung (C33, C34)	2	4	4	4	4	4	5
Cerebrovascular diseases (I60-I69)	5	5	5	5	5	5	6
Malignant neoplasm of prostate (C61)	6	6	8	7	7	6	7
Malignant neoplasm of colon, sigmoid, rectum and anus (C18-C21)	9	>10	7	10	8	9	8
Accidents (V01-X59)	>10	7	9	8	6	8	9
Influenza and pneumonia (J09-J18)	10	8	6	6	9	7	10
Malignant neoplasms of lymphoid, haematopoietic and related tissue (C81-C96)	7	9	>10	9	10	>10	>10
Aortic aneurysm and dissection (I71)	>10	>10	>10	>10	>10	10	>10
Diabetes (E10-E14)	>10	>10	>10	>10	10	>10	>10
Cirrhosis and other diseases of liver (K70-K76)	8	>10	10	>10	>10	>10	>10
Heart failure and complications and ill-defined heart disease (I50-I51)	>10	10	>10	>10	>10	>10	>10

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*Covid-19 deaths occurred from late March 2020 onwards, so just over 9 months of the calendar year.

Females

Cause of death groups (ICD-10)	2014	2015	2016	2017	2018	2019	2020
Dementia and Alzheimer's disease (F01, F03, G30)	1	1	1	1	1	1	1
COVID-19 (identified or not: U071-U702; MIS associated: U109)*	New	New	New	New	New	New	2
Ischaemic heart diseases (I20-I25)	2	2	3	2	2	2	3
Cerebrovascular diseases (I60-I69)	4	3	2	3	4	4	4
Chronic lower respiratory diseases (J40-J47)	3	4	4	3	3	3	5
Malignant neoplasm of trachea, bronchus and lung (C33, C34)	5	7	6	5	5	5	6
Malignant neoplasms of breast (C50)	7	6	7	7	6	6	7
Influenza and pneumonia (J09-J18)	6	5	4	6	7	7	8
Diseases of the urinary system (N00-N39)	>10	>10	>10	>10	>10	>10	9
Malignant neoplasm of colon, sigmoid, rectum and anus (C18-C21)	8	9	8	8	8	8	10
Accidents (V01-X59)	>10	10	10	>10	8	>10	10
Cardiac arrhythmias (I47-I49)	>10	>10	>10	>10	>10	>10	10
Malignant neoplasms of lymphoid, haematopoietic and related tissue (C81-C96)	10	>10	9	9	>10	>10	>10
Malignant neoplasm of ovary (C56)	>10	>10	>10	10	>10	>10	>10
Hypertensive diseases (I10-I15)	>10	>10	>10	>10	10	9	>10
Malignant neoplasm of pancreas (C25)	9	>10	>10	>10	>10	10	>10
Nonrheumatic valve disorders (I34-I38)	>10	8	>10	>10	>10	>10	>10

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*Covid-19 deaths occurred from late March 2020 onwards, so just over 9 months of the calendar year.

Figure 36 Summary infographic of the top 10 ranking of leading causes of death by year of death by gender; all ages, Portsmouth residents. 2014 to 2020.

8.16 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

[185] The cause of death groups used are based on a list developed by the World Health Organization (WHO), modified for use in England and Wales by ONS - the list used is based on ONS revised 2016 list. It was modified in 2016 for use on 2015 mortality data. Minor changes were made in 2017 to ensure mutual exclusivity between groupings. This involved the removal of meningitis and meningococcal diseases (A39), sepsis due to haemophilus influenzae (A41.3), rabies (A82), certain mosquito-borne diseases (A83) and yellow fever (A95) from the vaccine preventable diseases grouping.

COVID-19 is a new novel disease since March 2020, therefore has been added as an addition to the 2016 list.

[186] Civil Registration Data via Primary Care Mortality Database (PCMD), Copyright ©2021, re-used with the permission of HSCIC. All rights reserved. Accessed via JSNA Portsmouth www.jsna.portsmouth.gov.uk

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. [187]

The APMS 2014 found prevalence of common mental health disorders is higher in females compared to males aged 16 years and over nationally - 20.7% of females compared to 13.2% of males. [188] Using the national prevalence rates identified in the APMS 2014 and apply to Portsmouth's population aged 16-64 years, then about 27,600 Portsmouth residents aged 16-64 years are predicted to be affected by common mental disorders in 2022; increasing to 27,700 by 2025 (assuming the prevalence rate remains the same)[189] [190]. However, Public Health England provided modelled estimates for CMD (based on APMS 2014) taking into account of local population differences in age structure, sex and deprivation to allow for comparisons with statistical neighbours: in 2017, the estimated prevalence of CMD aged 16 years and over for Portsmouth was 18.5% (approximately 32,330 people), which is higher than England (16.9%) and similar to Southampton (18.7%). Also, the estimated prevalence of CMD aged 65 years and over for Portsmouth was 11.4% (approximately 3,410 people), which is higher than England (10.2%) and similar to Southampton (11.5%).[191]

Between 2017 and 2021, nationally, the percentage of children aged 6-16 year-olds with a probable mental health disorder increased from 11.6% to 17.4%; and a similar increase was seen in young adults aged 17-19 years (10.1% with a probable mental health disorder in 2017 to 17.4% in 2021. The prevalence for both age groups was similar between 2020 and 2021. The 2020 and 2021 surveys were follow-up surveys to the Mental Health of Children and Young People (MHCYP) in 2017 to assess the impact of the COVID-19 pandemic, although comparisons between years may have been affected by the survey design (face-to-face in 2017 to online surveys for the follow-ups[192]. Applying these national prevalence rates to Portsmouth's population (using ONS mid-year estimates[193]) then it is estimated that in 2017 there were roughly 3,050 children aged 6-16 years with a probable mental disorder, rising to 4,500 in 2021. In 2017, there was an estimated 1,000 young people aged 17-19 years in Portsmouth with a probable mental disorder increasing to 1,700 in 2021.

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[187] 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.
[188] NHS Digital. Adult Psychiatric Morbidity Survey, 2014 (Table 2)
[189] NHS Digital. Adult Psychiatric Morbidity Survey, 2014 (Table 2) and ONS 2018 sub-national populations projections
[190] 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.
[191] Public Health England. Common Mental Health Disorders profile. Common Mental Health Disorders - PHE Accessed 25 June 2021
[192] Mental Health of Children and Young People in England 2021 - wave 2 follow up to the 2017 survey https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2021-follow-up-to-the-2017-survey Accessed 14 Mar 2022
[193] 2017 estimate using ONS mid-2017 estimated Portsmouth population aged 6-16 years and 17-19 years. The 2021 estimate using ONS mid-2020 estimated Portsmouth population aged 6-16 years and 17-19 years

In 2020/21 22,829 people aged 18+ years (12.3%) were recorded by Portsmouth CCG GPs as having depression which is similar to the prevalence for England (12.3%). The range at GP practice level in Portsmouth was from 18.6% (Portsdown Group Practice) to 5.3% (University Surgery). There were 1,944 new cases of depression in 2020/21— 1.0% of the GP practice register aged 18+ years in Portsmouth and this is significantly lower than the England incidence rate (1.4%)[194]. However, due to the impact of Covid-19 pandemic on activity in general practice in 2020/21, the data may not be inaccurate and therefore comparisons with previous years may be misleading.[195]

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)[196]. This also correlates closely to the 2015/16 estimated prevalence of depression and anxiety from the self-reported GP patient survey (GPPS) (15.3% of NHS Portsmouth patients aged 18+ years), although this increased to 16.3% of NHS Portsmouth patients aged 18+ years in 2016/17 (the latest year the question was included)[197] - using the 16.3% estimated prevalence from GPPS, then approximately 28,250 residents aged 18 years and over would be expected to have depression in 2022 (applying the prevalence rate to the ONS 2018-based subnational population estimates). Assuming the depression prevalence remains the same in future years, then roughly 28,600 people by 2025 (again, applying the prevalence rate to the ONS 2018-based subnational population estimates). However, depression prevalence is also can be impacted on from 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. [198]

In 2021, 12.9% of Portsmouth CCG registered patients aged 16+ years reported having a long-term mental health problem (from the self-reported GP patient survey (GPPS)) which is higher than the prevalence in England (11%)[199]. Using the 12.9% estimated prevalence from GPPS, then approximately 23,000 Portsmouth residents aged 16 years and over would be expected to have a long-term mental health problem in 2022 (applying the prevalence rate to the ONS 2018-based subnational population estimates).

In 2020/21 2,142 people of all ages (0.93%) were recorded by Portsmouth CCG GPs as having schizophrenia, bipolar affective disorder and other psychoses which is similar to the prevalence for England (0.95%). The range at GP practice level in Portsmouth was from 1.41% (Trafalgar Medical

[194] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.
[195] Quality and Outcomes Framework (QOF), NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2020-21/ Accessed 3 Mar 2022
[196] 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]
[197] Mental Health and Wellbeing JSNA, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.
[198] 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]
[199] Mental Health and Wellbeing JSNA, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.

Group Practice) to 0.27% (University Surgery)[200]. Using the national prevalence from the Adult Psychiatric Morbidity Survey (APMS) 2014 (by assuming no change in prevalence and applying it to the projected Portsmouth population), it is estimated that in 2022, 880 adults aged 16-64 years had a psychotic disorder in the past year (unless prevalence was to change then this estimate is expected to be similar up to 2030). However, psychotic disorders in the past year are expected to be an underestimate, so using the APMS 2014 probable psychotic disorders national prevalence, then there could be a further 300 (up to 1200) Portsmouth adults aged 16-64 years with a psychotic disorder.[201] [202]

Self-harm is an expression of personal distress and there are varied reasons for a person to harm themselves irrespective of the purpose of the act. There is a significant and persistent risk of future suicide following an episode of self-harm. Hospital admissions can be used as a proxy of self-harm incidence, but hospital admissions are a very small proportion of incidents of self-harm and the identification and coding of intent may be subject to recording bias. In 2020/21, the emergency hospital admissions rate for intentional self-harm for Portsmouth residents of all ages was significantly higher than England and the South East region. The 2020/21 intentional self-harm emergency admission rate for Portsmouth was significantly lower than the previous two years (2019/20 and 2018/19).[203]

Suicide is a significant cause of death in young adults, and is seen as an indicator of underlying rates of mental ill-health. Suicide is a major issue for society and a leading cause of years of life lost. Suicide is often the end point of a complex history of risk factors and distressing events, but there are many ways in which services, communities, individuals and society as a whole can help to prevent suicides. In 2018-20, Portsmouth's suicide and mortality from injury of undetermined intent directly age standardised rate (DSR) aged 10 years and over (10.3 per 100,000 population) was similar to England (10.4 per 100,000 persons aged 10+ years) and the South East region (10.1 per 100,000 persons aged 10+ years). [204]

8.17 Armed Forces personnel and veterans

The Ministry of Defence has a number of establishments in this area, with roughly 7,450 military personnel registered to Portsmouth (97% in Royal Navy/Royal Marines), as at April 2021. [205]

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 was Portsmouth. There were 1,251 associated people

[200] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.
[201] NHS Digital. Adult Psychiatric Morbidity Survey, 2014 (Table 5) ONS 2018 sub-national populations projections
[202] 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.
[203] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.
[204] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.
[205] Annual Locations statistics, 1 April Edition, Ministry of Defence (Tri Service). https://www.gov.uk/government/statistics/location-of-uk-regular-service-and-civilian-personnel-annual-statistics-2021 Accessed 9 March 2022.

(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.[206]

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 2017 estimates approximately 2.4 million veterans residing in Great Britain (GB) (5% of the GB adult population)—89% of whom are male and 99% of all veterans were of White ethnicity. The APS 2017 estimates 7% of Hampshire's (including Portsmouth) adult population are veterans (higher than the 5% of GB adults). APS 2017 found UK Armed Forces veterans residing in GB aged 16-64 years and aged 65+ years are significantly more likely than non-veterans to have health problems lasting or expected to last more than 12 months. GB veterans aged 16-64 years are significantly more likely than non-veterans to have arms/hands; legs/feet; and back/neck long-term health problems; whilst GB veterans aged 65 years and over are significantly more likely than non-veterans to have difficulty seeing and difficulty hearing as long-term health problems. GB veterans aged 18-64 years and 65+ years were more likely to have ever smoked (55% and 66% respectively). GB veterans aged 18-64 years who had ever smoked were significantly more likely to report suffering from chest/breathing problem compared to non-smoking GB veterans aged 18-64 years - however, this is also the case for GB non-veterans[207]. GB veterans were as likely to have bought their home (outright or with a mortgage) as non-veterans. There were 'no differences' between working age veterans and non-veterans who had a qualification (92% and 89% respectively). However, there were significant differences between working age veterans and non-veterans: where veterans are less likely to have a degree, but are more likely to have gained a qualification through work. Working age veterans were as likely to be employed as non-veterans (79% for both groups). But there were significant differences in occupation held, with veterans aged 16-34 years (when compared to non-veterans) being: more likely to work as 'process, plant and machine operatives' and less likely to work in 'professional occupations'. [208]

Locally, the H&LS 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).[209] 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).[210]

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[206] 2011 Census: AF001, AF003, AF004, AF005. Office for National Statistics © Crown Copyright 2014

[207] Annual Population Survey: Annual Great British Veteran Report, 2017 reference tables. Defence Statistics (Health), Ministry of Defence https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774939/20190128_-_APS_2017_Annex_A.xlsx Accessed 8 March 2022

[208] Annual Population Survey: UK Armed Forces Veterans residing in Great Britain, 2017 bulletin. Ministry of Defence https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774937/20190128_-_APS_2017_Statistical_Bulletin_-_OS.pdf Accessed 8 March 2022

[209] Portsmouth Health & Lifestyle Survey 2015, Ipsos MORI for Portsmouth City Council.

[210] Ipsos MORI Summary Report of findings for Portsmouth City Council. Health and Lifestyle Survey, 2015 via Portsmouth JSNA.

8.18 Prison health

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

8.19 Autistic spectrum conditions

Autism is a lifelong developmental disability that affects how people perceive, communicate and interact with others, although it is important to recognise that there are differing opinions on this and not all autistic people see themselves as disabled.[211]

One of the 6 key themes of the national strategy for children, young people and adults is: improving autistic children and young people's access to education, and supporting positive transitions into adulthood[212]. Schools are acutely aware of children who have particular difficulties in learning and the school census covers all pupils enrolled in state-funded primary, secondary or special schools. The extent to which children are assessed in relation to SEN has changed recently. At present, nationally, not all of the pupils recognised as autistic will have been formally assessed outside the school [213]. In 2020, there were 414 children with Autism known to schools in Portsmouth, which as a rate (15.5 per 1,000 school age pupils) is significantly lower than England, the South East region and Southampton. [214]

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[215]. 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 2022 between 700 and 4,330 adults in Portsmouth have ASD and that by 2030 this will increase to between 740 and 4,590 people. (Table 6). [216]

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[211] National strategy for autistic children, young people and adults: 2021-2026 https://www.gov.uk/government/publications/national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026/the-national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026 accessed 10 March 2022

[212] National strategy for autistic children, young people and adults: 2021-2026 https://www.gov.uk/government/publications/national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026/the-national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026 accessed 10 March 2022

[213] Learning disabilities profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 10/3/2022.

[214] Learning disabilities profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 10/3/2022.

[215] 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.

[216] 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

Table 6 Estimated number of adults with autism-spectrum disorders, Portsmouth, 2022 to 2030.

Estimated number of adults with autism spectrum disorders (ASD) Portsmouth, 2022, 2025 and 2030									
	2022			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	1,220	500	2,970	1,240	500	3,010	1,270	530	3,150
35-54	60	20	260	60	20	260	60	20	270
55-74	390	170	880	400	180	900	410	180	900
75+	50	10	220	50	10	230	60	10	280
Total	1,730	700	4,330	1,760	710	4,400	1,810	740	4,590

Sources:
(1) Table 6: 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 Copyright © 2016, HSCIC.
(2) SNPP Z1: 2018-based Subnational Population Projections. Local Authorities in England, mid-2018 to mid-2043, ONS.

8.20 Dementia

In May 2021, in Portsmouth there were 1,370 patients aged 65 and over, on the dementia register (4.1% of registered patients aged 65 years and over compared with 3.9% in England). The range at Practice level was from 4.8% of patients registered with Craneswater Group practice to 2.8% at North Harbour Medical Group (excluding Guildhall Walk Healthcare Centre and the University Practice)[217]. 97% of all dementia registrations are people aged 65 and over. In December 2020, there were 46 Portsmouth patients aged under 65 years on the dementia register (2.33 per 10,000 compared to 3.05 per 10,000 in England). [218]

Portsmouth's prevalence of dementia aged 65 years and over has not changed significantly between years (4.7% in May 2017; 4.6% in May 2018; 4.5% in May 2019 and 4.2% in May 2020). However, NHS Digital has noted that from 2020 data onwards COVID-19 has led to unprecedented changes in the work and behaviour of General Practices and as a result this data will be impacted.

In 2018/19, Portsmouth's crude rate of newly diagnosed dementia registrations is 10.4 per 1,000 patients registered aged 65+ years (342 patients newly diagnosed with dementia) is similar to the England rate (11.4 per 1,000 patients registered aged 65+ years). [219]

Modelled prevalence suggests that in 2022, it is estimated that approximately 2,260 people[220] aged 65+ years have dementia in Portsmouth. With an ageing population, by 2025 and 2035 the number of

[217] Recorded dementia diagnosis summaries https://digital.nhs.uk/data-and-information/publications/statistical/recorded-dementia-diagnoses Accessed June 2021.
[218] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 8/3/2022.
[219] Dementia Profile, Public Health England. https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia Accessed 1 June 2021 via Portsmouth JSNA
[220] 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.

people aged 65+ years with dementia is predicted to increase by 7% (about an additional 150 people (2,390 in total)) and 32% (approximately an additional 720 people (2,960 in total)), respectively.[221]

There are about 770 fewer people on GP dementia registers than is predicted by 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. The Portsmouth estimated diagnosis rate[222] in 2020 was 68.0%, which is similar to the national benchmark (66.7%) and similar to the England and Southampton rates (67.4% and 66.8% respectively).[223] However, comparing the May 2021 recorded prevalence to the dementia prevalence estimates[224] used by the Projecting Older People Population Information System (POPPI) indicates there are about 980 fewer people on GP dementia registers. [225]

The leading cause death[226] for Portsmouth residents in 2020 (and since 2015 for persons of all ages was Dementia and Alzheimer's disease (213 deaths; 12% of all deaths). For Portsmouth females, the leading cause of death in 2020 remained as Dementia and Alzheimer's disease (142 deaths; 17% of all female deaths). For Portsmouth males, Dementia and Alzheimer's disease was the fourth leading cause of death (71 deaths; 8% of all male deaths). The leading cause of death is usually age and gender dependent; for both males and females in Portsmouth, Dementia and Alzheimer's disease was the leading cause of death in aged 85 and over each year from 2014 to 2020. Dementia and Alzheimer's disease was also the leading cause of death for females aged 75-84 years, each year from 2014 to 2020, except in 2016 where Cerebrovascular diseases (stroke) was the leading cause of death. For females in 2014-19 (6 years pooled), in each five-year age group from 80-84 to 85-89 years as well as those aged 90 years and over, Dementia and Alzheimer's disease was the leading cause of death - for males in 2014-19, Dementia and Alzheimer's disease was also the leading cause of death in aged 85-89 years as well as those aged 90 years and over. [227]

[221] Projecting Older People Population Information System. www.POPPI.org.uk accessed June 2021 via Portsmouth JSNA
[222] The rate of persons aged 65 and over with a recorded diagnosis of dementia per person estimated to have dementia given the characteristics of the population and the age and sex specific prevalence rates of the Cognitive Function and Ageing Study II, expressed as a percentage with 95% confidence intervals. Significance is determined by the non-overlapping of confidence intervals with the 66.7% benchmark.
[223] Dementia Profile, Public Health England. https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia Accessed June 2021 via Portsmouth JSNA
[224] Recorded dementia diagnosis summaries https://digital.nhs.uk/data-and-information/publications/statistical/recorded-dementia-diagnoses Accessed June 2021. via Portsmouth JSNA
[225] Projecting Older People Population Information System. www.POPPI.org.uk accessed June 2021
[226] The cause of death groups used are based on a list developed by the World Health Organization (WHO), modified for use in England and Wales by ONS - the list used is based on ONS revised 2016 list. It was modified in 2016 for use on 2015 mortality data. Minor changes were made in 2017 to ensure mutual exclusivity between groupings. This involved the removal of meningitis and meningococcal diseases (A39), sepsis due to haemophilus influenzae (A41.3), rabies (A82), certain mosquito-borne diseases (A83) and yellow fever (A95) from the vaccine preventable diseases grouping.

COVID-19 is a new novel disease since March 2020, therefore has been added as an addition to the 2016 list.
[227] Civil Registration Data via Primary Care Mortality Database (PCMD), Copyright ©2021, re-used with the permission of HSCIC. All rights reserved. Accessed via JSNA Portsmouth www.jsna.portsmouth.gov.uk

In 2019, the dementia (directly age-standardised) mortality rate aged 65 and over in Portsmouth was 1,026 per 100,000 population, which was significantly higher than England and similar to Southampton (849 and 927 per 100,000 population, respectively). [228]

8.21 Learning disabilities

Schools are acutely aware of children who have particular difficulties in learning and the school census covers all pupils enrolled in state-funded primary, secondary or special schools. The extent to which children are assessed in relation to SEN has changed recently. At present, nationally, not all of the pupils recognised as moderate learning difficulty will have been formally assessed outside the school [229]. In 2020, there were 890 children with moderate learning difficulties known to schools in Portsmouth, which as a rate (33.4 per 1,000 school age pupils) is significantly higher than England. In the same year, there were 97 children with severe learning difficulties and 41 children with profound and multiple learning difficulties known to schools in Portsmouth, which as a rate (3.6 and 1.5 per 1,000 school age pupils respectively) are both similar to England. [230]

In 2020/21, there were 1,279 registered patients of all ages recorded with learning disabilities on GP practice registers (0.6% of all registered patients compared to 0.5% in England). The range at GP practice level was from 0.8% of registered patients at Portsdown Group Practice to 0.3% at Trafalgar Medical Group Practice (excluding The University practice).[231]

In 2019/20, 500 Portsmouth adults aged 18+ years with learning disability received long-term support from Adults Social Care which as a rate was significantly lower than England. This was a decrease of roughly 80 Portsmouth clients compared to 2018/19.

In 2018/19, 608 Portsmouth residents aged 14 years and over with learning disability received a GP health check - this was 54.7% of all eligible adults (out of those registered by their GP as having a learning disability) which was higher, but not significantly, than England (52.3%).[232]

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 2020/21, 83.2% (55.0% in 2019/20) of Portsmouth adults aged 18+ years with a learning disability known to Adult Social Care were in stable and appropriate accommodation (significantly higher than the percentage for England and the South East region) [233]. In 2020/21, the employment rate of Portsmouth adults aged 18-64 years with a learning disability known to Adult Social Care was 3.9% (this was lower than the percentage for England and the South East region). [234]

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[228] Dementia profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 22/2/2022.
[229] Learning disabilities profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 10/3/2022.
[230] Learning disabilities profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.
[231] National General Practice Profiles, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.
[232] Learning disabilities profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.
[233] Learning disabilities profile, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.
[234] HSCIC Adult Social Care Outcomes 2020/21 https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof/england-2020-21 1E Accessed 11 March 2022 via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.

In 2019/20, the percentage point gap in the employment rate of Portsmouth adults aged 18-64 years with a learning disability known to Adult Social Care and the overall employment rate had increased to 70.7% (65.7% in 2018/19), which is similar to England (70.6%). Nationally this gap has increased annually since 2011/12. [235]

In 2016/17, Adult Social Care provided a service in the community for 449 people with a learning disability aged 18+ years (2.7 per 1,000 residents aged 18+ years). The highest number and rate of clients receiving services in the community were in Hilsea ward (5.0 clients per 1,000 resident population aged 18+ years) in the North locality, followed by Fratton (3.6 clients per 1,000 resident population aged 18+ years) in the Central locality and Eastney and Craneswater (3.5 clients per 1,000 resident population aged 18+ years) in the South locality. [236]

8.22 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. [237] 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 37)

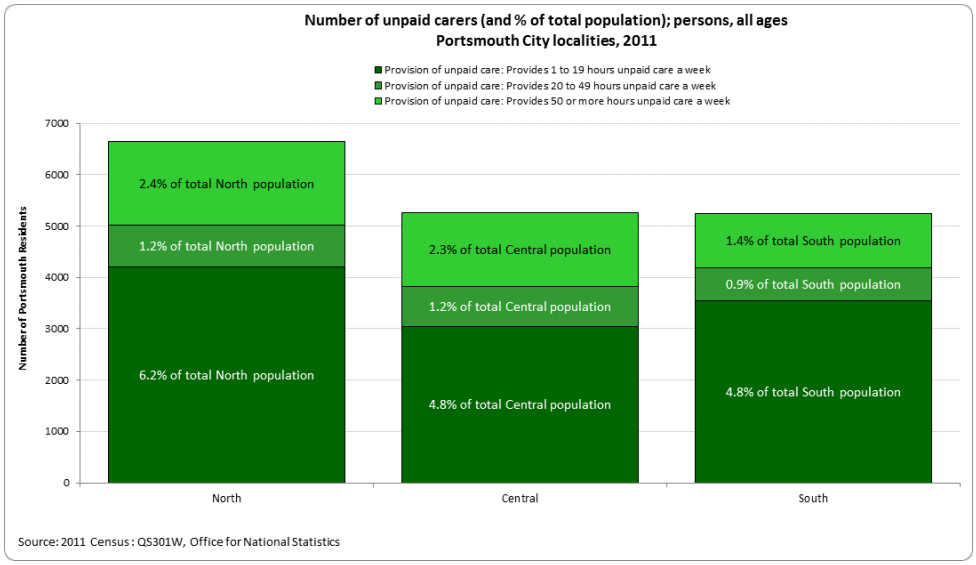

Figure 37. Number of unpaid carers (and percentage of total population); persons, all ages, Portsmouth City UA localities, 2011 Census.

The H&LS 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 council/social housing tenants or aged 55-64 years, as these two groups also have

[235] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.
[236] Short- and Long-Term Support (SALT) database, Portsmouth City Council via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.
[237] 2011 Census: QS301EW, Office for National Statistics.

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%).[238]

In November 2020, 2,875 (140 more than in November 2019) residents aged 16+ years claimed Carer's Allowance. This equates to 16.4 per 1,000 residents aged 16+ years. The highest number of claimants are in Paulsgrove MSOA (294 claimants, 48.4 per 1,000 residents aged 16+ years), which is in the North locality, followed by the Buckland MSOA (277 claimants, 45.2 per 1,000 aged 16+ years), which is in the Central locality. [239]

In 2020/21, Adult Social Care provided support to about 1,155 carers (including about 5 carers receiving 'Respite or Other Forms of Carer Support delivered to the cared-for person') - similar in number to 2019/20 (1,175 carers although that includes 200 carers receiving 'Respite or Other Forms of Carer Support delivered to the cared-for person'). [240]

The national survey of carers is carried out biennially. The 2018-19 postal survey of local carers aged 18+ years receiving services from Social Services was carried out in October/November 2018. The carers' survey found that, locally, 68.9% of people being cared for were aged 65+ years (65.8% in England). The three main reasons for caring for someone were physical disabilities (54.2%), dementia (36.3%) and long-standing illness (38.5%). High levels of the person being cared for had not accessed available services eg short-notice/in an emergency respite (86.0% not accessed), a break for more than 24 hours (86.8% not accessed), sitting service (72.6% not accessed), personal assistant (91.3%), home care/home help (72.1%), day centres or day activities (82.1%), lunch club (97.5%), meals services (95.6%), Lifeline Alarm (79.8%). Home equipment or adaptations (48% accessed) was most likely to have been accessed. Over half of all carers in Portsmouth themselves had at least one type of physical or mental health problem (38.8% had none). 47.5% of local carers (50.1% in England) had some social contact with people but said it was not enough; 13.8% felt socially isolated (17.4% in England). [241]

8.23 People threatened with homelessness

Homelessness is associated with severe poverty and is a social determinant of health. It often results from a combination of events such as relationship breakdown, debt, adverse experiences in childhood and through ill health. Homelessness is associated with poor health, education and social outcomes, particularly for children. The Homelessness Reduction Act (HRA) introduced new homelessness duties which meant significantly more households are being provided with a statutory service by local housing authorities than before the Act came into force in April 2018. [242]

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[238] Ipsos MORI Summary Report of findings for Portsmouth City Council. Health and Lifestyle Survey, 2015 via Portsmouth JSNA.

[239] Department for Work and Pensions, Nov 2020. https://stat-xplore.dwp.gov.uk (Claimant numbers) Accessed 11 March 2022. Rates calculated using ONS mid-2020 small area population estimates.

[240] HSCIC Adult Social Care Activity and Finance Report, England - 2019/20 and 2020/21 https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report Accessed 11 March 2022

[241] Personal Social Services Survey of Adult Carers in England, 2018-19. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-survey-of-adult-carers/england-2018-19 Accessed 11 March 2022

[242] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.

The HRA introduced new prevention and relief duties, that are owed to all eligible households who are homeless or threatened with becoming homeless, including those single adult households who do not have 'priority need' under the legislation. In 2020/21, Portsmouth had 1,986 households owed a prevention or relief duty under the Homelessness Reduction Act, which as a rate (22.0 per 1,000 households) was significantly higher than England (11.3 per 1,000 households), the South East and Southampton. [243]

Young people experiencing homelessness are extremely vulnerable, and face complex and compounding challenges. Of the 1,986 households in Portsmouth owed a duty under the HRA, the main applicant was aged 16-24 years for 392 households - as a rate this is also significantly higher than England, the South East and Southampton. [244]

In recent years, nationally, there has been a significant increase in homelessness experienced by older people. Households are increasingly living in the growing private rented sector, and loss of assured shorthold tenancy is the main cause of statutory homelessness. Many older households also live in poverty. Of the 1,986 households in Portsmouth owed a duty under the HRA, the main applicant was aged 55 years and over for 184 households - as a rate this is also significantly higher than England, the South East and Southampton. [245]

The UN Convention on the Rights of the Child highlights the right of every child to an adequate standard of living. Of the 1,986 households in Portsmouth owed a duty under the HRA, 482 households include one or more dependent children - as a rate this is also significantly higher than England, the South East and Southampton. [246]

In addition, as a result of the HRA, local authorities must provide temporary accommodation for households in a number of circumstances, which might include pending the completion of inquiries into an application, or they might spend time waiting in temporary accommodation after an application is accepted until suitable secure accommodation becomes available. The Public Accounts Committee's December 2017 report, Homeless Households, observed that temporary accommodation is often of a poor standard and does not offer value for money. In 2020/21, Portsmouth had 144 households in temporary accommodation, which as a rate (1.6 per 1,000 households) was significantly lower than England (4.0 per 1,000 households) and the South East region; but similar compared to Southampton. [247]

Local authorities across England take an autumn single night snapshot of people sleeping rough[248]. They either use a count-based estimate of visible rough sleeping, an evidence-based estimate meeting

[243] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.
[244] Wider determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.
[245] Wider determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.
[246] Wider determinants of Health, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.
[247] Public Health Outcomes Framework, Office for Health Improvement and Disparities. Public health profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022. Date accessed 11/3/2022.
[248] People sleeping rough are defined as follows: People sleeping, about to bed down (sitting on/in or standing next to their bedding) or bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes' which are makeshift shelters, often comprised of cardboard boxes).

with local agencies or an evidence-based estimate meeting including a spotlight count. As well as the Covid-19 pandemic, there are other factors that can affect the number of people who sleep rough on any given night. For example, the availability of night shelters, the weather, where people choose to sleep and the date and time chosen for the snapshot estimate. In Autumn 2021, it was estimated that there were 24 people sleeping rough, which was lower than the estimated 29 people sleeping rough in 2020. Both 2020 and 2021 were evidence based estimates, whereas the most recent count in 2019 found 26 people sleeping rough. In 2021, it was an evidence-based estimate following consultation with the Voluntary sector, Police, Outreach workers and Drug & alcohol treatment teams; but Faith groups, Mental health agencies, Substance misuse agencies and local residents/businesses were not consulted.[249]

8.24 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). [250] Also, the latest ethnicity data from the January 2021 school pupil census, identifies 30 pupils as 'White: Gypsy/Roma' resident to Portsmouth.[251]

Although not necessarily ethnic gypsies and travellers, as at July 2021, there were neither authorised nor unauthorised traveller caravans in Portsmouth.[252]

The 2018 Portsmouth City Council Gypsy, Traveller and Travelling Showpeople Accommodation Assessment (GTAA) sought to understand the accommodation needs of the Gypsy, Traveller and Travelling Showpeople population in the study area through a combination of desk-based research, stakeholder interviews and efforts to engage with members of the Travelling Community. However, the report found that despite all the efforts that were made during the course of the GTAA, no households were identified to interview living in bricks and mortar, despite a small number of households being identified in the 2011 Census. The 2018 assessment concluded that there is no current or future need for additional pitches or plots in Portsmouth over the GTAA period to 2036. [253]

9 Potential future need

9.1 Major developments

As the local planning authority, Portsmouth City Council is creating a new Local Plan that will set out where we build new homes, opportunities for local jobs and the facilities we need, and how we protect our environment and deliver the high-quality spaces we want to see.

The Council is currently in the process considering all the responses received to the draft new Local Plan consultation ('regulation 18' stage) that ran from the 17th of September to the 31st of October

[249] Annual Rough Sleeping Snapshot in England: autumn 2021, MHCLG Annual Rough Sleeping Snapshot: https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2021 Accessed 11 March 2022

[250] 2011 Census: QS211EW, Office for National Statistics.

[251] Department for Education Statistical First Release Schools, Pupils and their Characteristics: January 2021. © Crown Copyright via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.

[252] Tables 1 and 3: Count of Traveller Caravans, Department for Levelling up, Housing and Communities. https://www.gov.uk/government/statistics/traveller-caravan-count-july-2021 Accessed 11 March 2022

[253] Gypsy and Traveller Accommodation Assessment (GTAA), Final Report November 2018, Portsmouth City Council: https://www.portsmouth.gov.uk/wp-content/uploads/2020/05/development-and-planning-portsmouth-gypsy-and-traveller-needs.pdf Accessed 11 March 2022

2021. The document presented the draft approach to the sustainable development of Portsmouth, indicating what type of development can happen and where, guided by a number of draft policies.

Significant levels of development are proposed for the plan period, with an anticipated minimum of 17,701 new homes between 2020-2038.

The plan identifies strategic sites with the potential to deliver 11,112 homes by 2038 and a further 697 homes after this. This is currently allocated to the following sites, but will likely be subject to change:

- City Centre **4,605**
- St James' and Langstone Campus **436**
- Tipner **4,081**
- Cosham **740**
- Fratton Park / Pompey Centre **750**
- Lakeside Northharbour **500**

(see below Figure 38: Portsmouth Local Plan Draft Development Strategy, see pg. 26 Portsmouth Local Plan 2038).

The remainder will be provided on much smaller quantums, scattered across the city, with a very small contribution from student accommodation and other residential accommodation such as care homes.

Figure 38: Portsmouth Local Plan Draft Development Strategy, see pg. 26 Portsmouth Local Plan 2038

For the purposes of this PNA, it is unlikely that much of the proposed development will be built within the next 3-5 years, although housing proposals at St James' and Langstone Campus are relatively well progressed, with early proposals for City Centre North now underway. Planning permission for 1,090 homes has already been granted and new planning applications considered as major development will identify and address pharmacy needs through the planning process and the requirement for Health Impact Assessments.

10 GP extended opening

Plans are being developed for a new extended access offer from October 2022, based on:

- PCNs providing bookable appointments outside core hours within the Enhanced Access period of 6.30pm-8pm weekday evenings and 9am-5pm on Saturdays;
- utilising the full multi-disciplinary team;
- and offering a range of general practice services, including 'routine' services such as screening, vaccinations and health checks, in line with patient preference and need.

PCNs will also be able to provide a proportion of Enhanced Access outside of these hours if they wish, for example early morning or on a Sunday, where this is in line with patient need locally and it is agreed with the commissioner.

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

11.1 Necessary services

The HWB 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 are 17.2 community pharmacies per 100,000 Portsmouth population, which is slightly higher than the average for Hampshire and the Isle of Wight (HIOW) ICS and is broadly in line with national averages and is broadly in line with national averages.

• Over 99% of the Portsmouth population are within a 20-minute walk of 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 non-NHS 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.

11.2 Improvements and better access

The HWB 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, four 100-hour pharmacies, supplementary hours in other Portsmouth community pharmacies, as well as provision in a neighbouring HWB 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.

12 Conclusion

The HWB has considered the demographic and health needs (section 8), and pharmaceutical provision (sections 5 and 6) 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.

• There is good coverage across the city of Advanced, Enhanced and locally commissioned services in place.

• Despite consolidations and changes in provision and extended hours in the last three years which have reduced the availability of pharmaceutical services, we still believe that there is a good range of pharmaceutical services provided in the city. However, further reductions in provision of services could require an updated assessment of the needs of the local population.

• 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 could be met by the current pharmaceutical service providers.

Appendix A: Maps showing weekday and weekend community pharmacies opening hours for accessing pharmaceutical services in Portsmouth as at 1st August 2022.

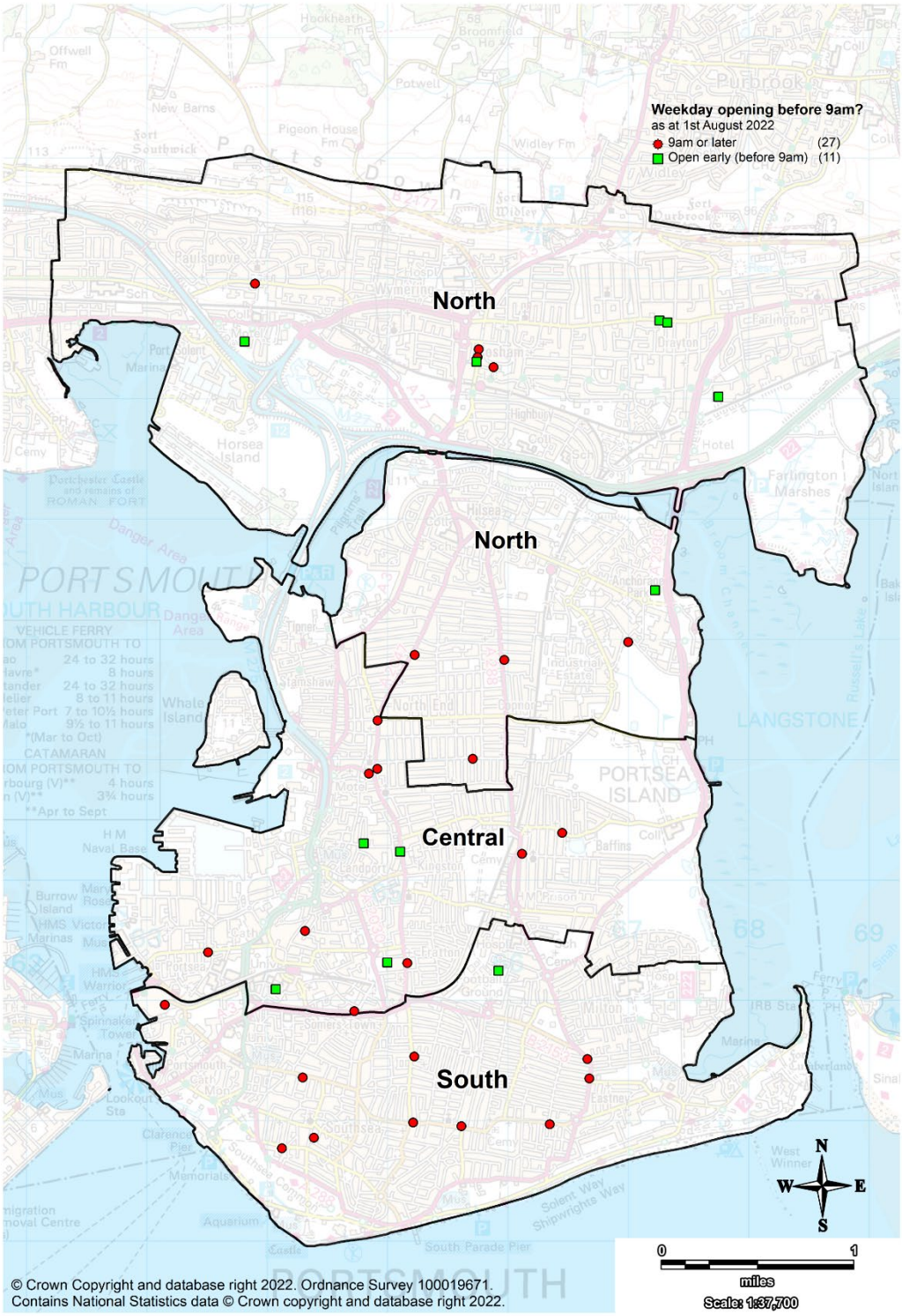


Figure 39. Map of weekday morning opening times for community pharmacies in Portsmouth, as at 1st August 2022.

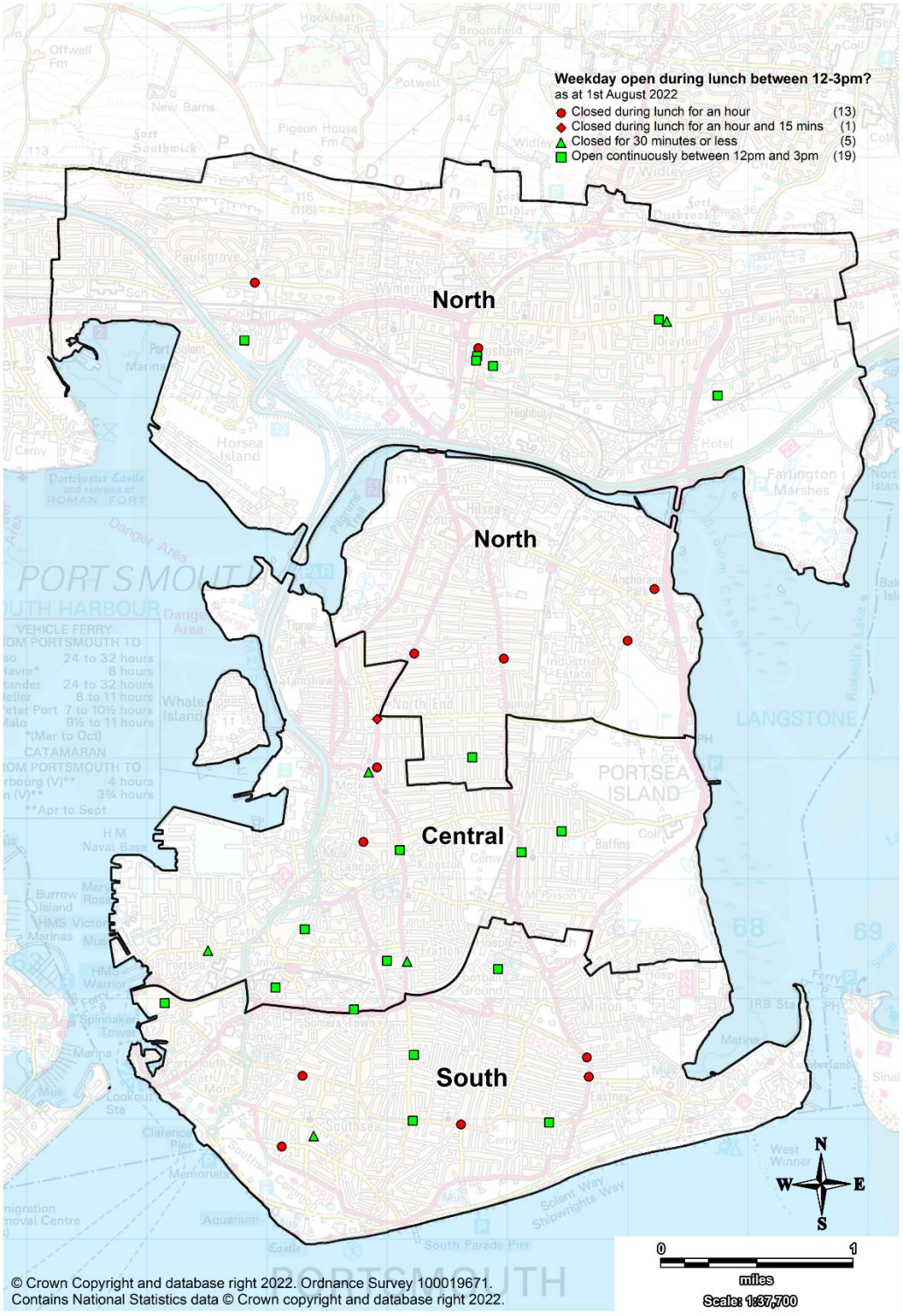


Figure 40. Map of weekday lunch time opening times for community pharmacies in Portsmouth, as at 1st August 2022.

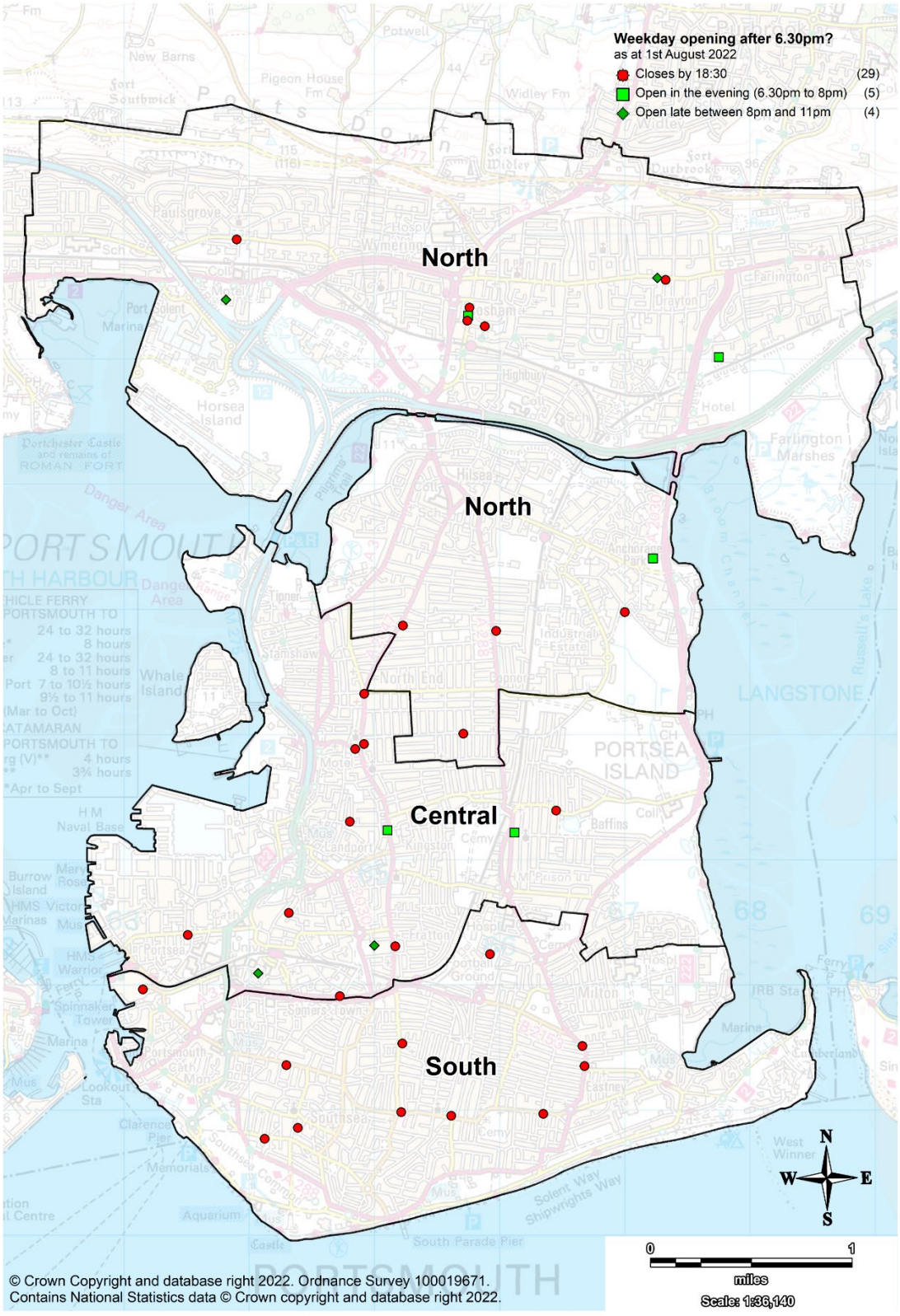


Figure 41. Map of weekday evening opening times for community pharmacies in Portsmouth, as at 1st August 2022.

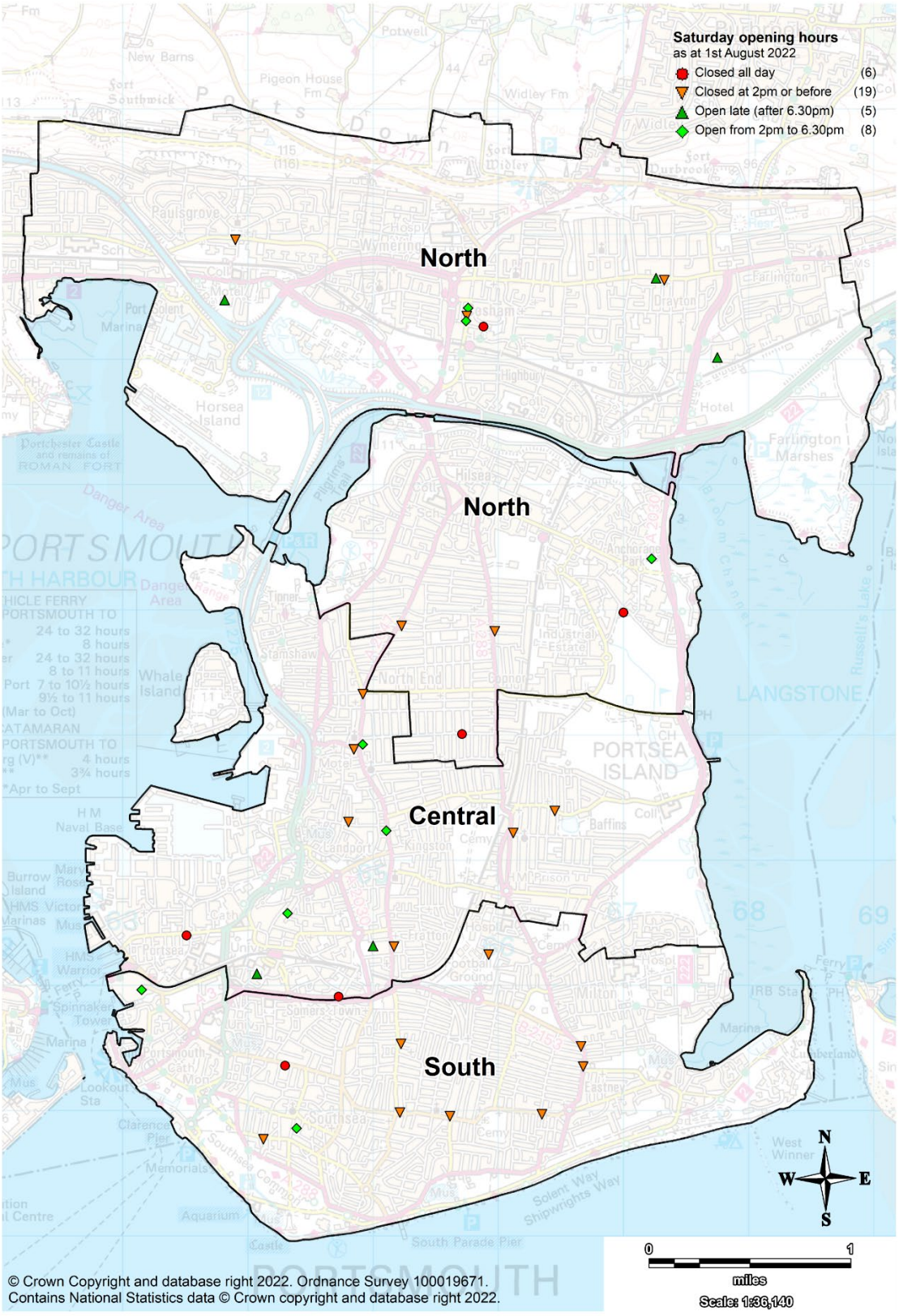


Figure 42. Map of Saturday opening times for community pharmacies in Portsmouth, as at 1st August 2022.

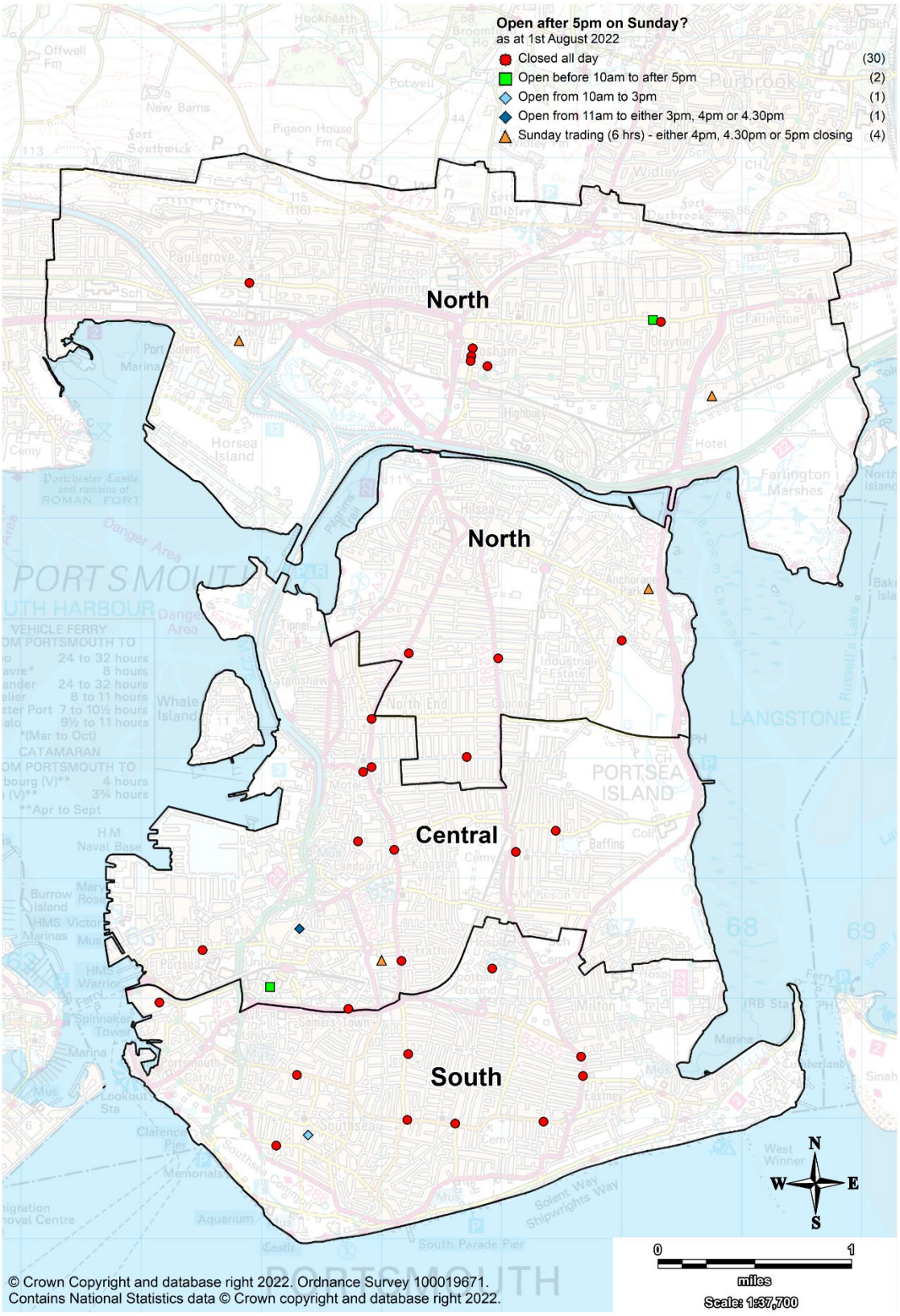


Figure 43. Map of Sunday opening times for community pharmacies in Portsmouth, as at 1st August 2022.

Portsmouth CITY COUNCIL

Integrated Impact Assessment (IIA)

Integrated impact assessment (IIA) form December 2019

www.portsmouth.gov.uk

The integrated impact assessment is a quick and easy screening process. It should:

- identify those policies, projects, services, functions or strategies that could impact positively or negatively on the following areas:
  - Communities and safety
  - Regeneration and culture
  - Environment and public space
  - Equality & - DiversityThis can be found in Section A5

Directorate: Public Health

Service, function: Public Health Intelligence

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

Pharmaceutical Needs Assessment (PNA) 2022

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

- ☐ Existing
- ☐ New / proposed
- ★ Changed

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

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.

Has any consultation been undertaken for this proposal? What were the outcomes of the consultations? Has anything changed because of the consultation? Did this inform your proposal?

Yes, the draft PNA publicly consulted on for 60 days in line with the statutory requirements. The responses to the consultation supported the findings in the draft PNA and no further changes are proposed.

A - Communities and safety	**Yes**	**No**

Is your policy/proposal relevant to the following questions?

A1-Crime - Will it make our city safer?	☐	★

In thinking about this question:

- How will it reduce crime, disorder, ASB and the fear of crime?
- How will it prevent the misuse of drugs, alcohol and other substances?
- How will it protect and support young people at risk of harm?
- How will it discourage re-offending?

If you want more information contact Lisa.Wills@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/cou-spp-plan-2018-20.pdf

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?

n/a

How will you measure/check the impact of your proposal?
n/a

A - Communities and safety	**Yes**	**No**

Is your policy/proposal relevant to the following questions?

A2-Housing - Will it provide good quality homes?	☐	★

In thinking about this question:

- How will it increase good quality affordable housing, including social housing?
- How will it reduce the number of poor quality homes and accommodation?
- How will it produce well-insulated and sustainable buildings?
- How will it provide a mix of housing for different groups and needs?

If you want more information contact Daniel.Young@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/psh-providing-affordable-housing-in-portsmouth-april-19.pdf

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?

n/a

How are you going to measure/check the impact of your proposal?

A - Communities and safety	Yes	No

Is your policy/proposal relevant to the following questions?

A3-Health - Will this help promote healthy, safe and independent living?	★	☐

In thinking about this question:

- How will it improve physical and mental health?
- How will it improve quality of life?
- How will it encourage healthy lifestyle choices?
- How will it create healthy places? (Including workplaces)

If you want more information contact Dominique.Letouze@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/cons-114.86-health-and-wellbeing-strategy-proof-2.pdf

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?

The PNA informs commissioning decisions by NHSE with regard to pharmacies in the city. Access to services provided by pharmacies supports a range of health outcomes. The PNA aims to ensure that the location, number, distribution and choice of pharmaceutical services serving the Portsmouth residents meets the needs of the population

How are you going to measure/check the impact of your proposal?

n/a

A - Communities and safety	Yes	No

Is your policy/proposal relevant to the following questions?

A4-Income deprivation and poverty-Will it consider income deprivation and reduce poverty?	☐	★

In thinking about this question:

- How will it support those vulnerable to falling into poverty; e.g., single working age adults and lone parent households?
- How will it consider low-income communities, households and individuals?
- How will it support those unable to work?
- How will it support those with no educational qualifications?

If you want more information contact Mark.Sage@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/cou-homelessness-strategy-2018-to-2023.pdf
https://www.portsmouth.gov.uk/ext/health-and-care/health/joint-strategic-needs-assessment

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?

n/a

How are you going to measure/check the impact of your proposal?
n/a

A - Communities and safety	Yes	No

Is your policy/proposal relevant to the following questions?

A5-Equality & diversity - Will it have any positive/negative impacts on the protected characteristics?	★	☐

In thinking about this question:

- How will it impact on the protected characteristics-Positive or negative impact (Protected characteristics under the Equality Act 2010, Age, disability, race/ethnicity, Sexual orientation, gender reassignment, sex, religion or belief, pregnancy and maternity, marriage and civil partnership,socio-economic)
- What mitigation has been put in place to lessen any impacts or barriers removed?
- How will it help promote equality for a specific protected characteristic?

If you want more information contact gina.perryman@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/cmu-equality-strategy-2019-22-final.pdf

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?

The PNA is based on a thorough analysis of the health needs of the whole population and includes any specific needs related to protected characteristics where such information is available. By ensuring that the services available match local needs, the PNA supports provision of services that promote equality for specified protected characteristics

How are you going to measure/check the impact of your proposal?
This has been done through the production of the PNA and public consultation on the draft document.

B - Environment and climate change	Yes	No

Is your policy/proposal relevant to the following questions?

B1-Carbon emissions - Will it reduce carbon emissions?	☐	★

In thinking about this question:

- How will it reduce greenhouse gas emissions?
- How will it provide renewable sources of energy?
- How will it reduce the need for motorised vehicle travel?
- How will it encourage and support residents to reduce carbon emissions?

If you want more information contact Tristan.thorn@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/cmu-sustainability-strategy.pdf

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?

n/a

How are you going to measure/check the impact of your proposal?
n/a

B - Environment and climate change	Yes	No

Is your policy/proposal relevant to the following questions?

B2-Energy use - Will it reduce energy use?	☐	★

In thinking about this question:

- How will it reduce water consumption?
- How will it reduce electricity consumption?
- How will it reduce gas consumption?
- How will it reduce the production of waste?

If you want more information contact Triston.thorn@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/pln-portsmouth-plan-post-adoption.pdf
https://democracy.portsmouth.gov.uk/documents/s24685/Home%20Energy%20Appendix%201%20-%20Energy%20and%20water%20at%20home%20-%20Strategy%202019-25.pdf
Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?

n/a

How are you going to measure/check the impact of your proposal?
n/a

B - Environment and climate change	Yes	No

Is your policy/proposal relevant to the following questions?

B3 - Climate change mitigation and flooding-Will it proactively mitigate against a changing climate and flooding?	☐	★

In thinking about this question:

- How will it minimise flood risk from both coastal and surface flooding in the future?
- How will it protect properties and buildings from flooding?
- How will it make local people aware of the risk from flooding?
- How will it mitigate for future changes in temperature and extreme weather events?

If you want more information contact Tristan.thorn@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/env-surface-water-management-plan-2019.pdf
https://www.portsmouth.gov.uk/ext/documents-external/cou-flood-risk-management-plan.pdf
Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?

n/a

How are you going to measure/check the impact of your proposal?
n/a

B - Environment and climate change	Yes	No

Is your policy/proposal relevant to the following questions?

B4-Natural environment-Will it ensure public spaces are greener, more sustainable and well-maintained?	☐	★

In thinking about this question:

- How will it encourage biodiversity and protect habitats?
- How will it preserve natural sites?
- How will it conserve and enhance natural species?

If you want more information contact Daniel.Young@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/pln-solent-recreation-mitigation-strategy-dec-17.pdf
https://www.portsmouth.gov.uk/ext/documents-external/pln-portsmouth-plan-post-adoption.pdf

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?

n/a

How are you going to measure/check the impact of your proposal?
n/a

B - Environment and climate change	Yes	No

Is your policy/proposal relevant to the following questions?

B5-Air quality - Will it improve air quality?	☐	★

In thinking about this question:

- How will it reduce motor vehicle traffic congestion?
- How will it reduce emissions of key pollutants?
- How will it discourage the idling of motor vehicles?
- How will it reduce reliance on private car use?

If you want more information contact Hayley.Trower@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/env-aq-air-quality-plan-outline-business-case.pdf

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?

n/a

How are you going to measure/check the impact of your proposal?
n/a

B - Environment and climate change	Yes	No

Is your policy/proposal relevant to the following questions?

B6-Transport - Will it improve road safety and transport for the whole community?	☐	★

In thinking about this question:

- How will it prioritise pedestrians, cyclists and public transport users over users of private vehicles?
- How will it allocate street space to ensure children and older people can walk and cycle safely in the area?
- How will it increase the proportion of journeys made using sustainable and active transport?
- How will it reduce the risk of traffic collisions, and near misses, with pedestrians and cyclists?

If you want more information contact Pam.Turton@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/travel/local-transport-plan-3

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?

n/a

How are you going to measure/check the impact of your proposal?
n/a

B - Environment and climate change	Yes	No

Is your policy/proposal relevant to the following questions?

B7-Waste management - Will it increase recycling and reduce the production of waste?	☐	★

In thinking about this question:

- How will it reduce household waste and consumption?
- How will it increase recycling?
- How will it reduce industrial and construction waste?

If you want more information contact Steven.Russell@portsmouthcc.gov.uk or go to:

https://documents.hants.gov.uk/mineralsandwaste/HampshireMineralsWastePlanADOPTED.pdf

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?

n/a
How are you going to measure/check the impact of your proposal? n/a

C - Regeneration of our city	Yes	No

Is your policy/proposal relevant to the following questions?

C1-Culture and heritage - Will it promote, protect and enhance our culture and heritage?	☐	★

In thinking about this question:

- How will it protect areas of cultural value?
- How will it protect listed buildings?
- How will it encourage events and attractions?
- How will it make Portsmouth a city people want to live in?

If you want more information contact Claire.Looney@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/pln-portsmouth-plan-post-adoption.pdf

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?

n/a

How are you going to measure/check the impact of your proposal?
n/a

C - Regeneration of our city	Yes	No

Is your policy/proposal relevant to the following questions?

C2-Employment and opportunities - Will it promote the development of a skilled workforce?	☐	★

In thinking about this question:

- How will it improve qualifications and skills for local people?
- How will it reduce unemployment?
- How will it create high quality jobs?
- How will it improve earnings?

If you want more information contact Mark.Pembleton@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/cou-regeneration-strategy.pdf

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?

n/a

How are you going to measure/check the impact of your proposal?
n/a

C - Regeneration of our city	Yes	No

Is your policy/proposal relevant to the following questions?

C3 - Economy - Will it encourage businesses to invest in the city, support sustainable growth and regeneration?	☐	★

In thinking about this question:

- How will it encourage the development of key industries?
- How will it improve the local economy?
- How will it create valuable employment opportunities for local people?
- How will it promote employment and growth in the city?

If you want more information contact Mark.Pembleton@portsmouthcc.gov.uk or go to:

https://www.portsmouth.gov.uk/ext/documents-external/cou-regeneration-strategy.pdf

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?

n/a

How are you going to measure/check the impact of your proposal?

n/a

Q8 - Who was involved in the Integrated impact assessment?

Mattthew Gummerson, Head of Strategic Intelligence and Research

This IIA has been approved by:

Contact number:

Date:

Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Date of meeting:	21st September 2022
Subject:	Better Care Fund plan 2022/23
Report by:	Jo York, Managing Director, Health and Care Portsmouth
Wards affected:	All
Key decision:	No
Full Council decision:	No

1. Purpose of report

1.1 The purpose of the report is to update Health and Wellbeing Board members on the Better Care Fund (BCF) for 2022/23 and seek formal Health and Wellbeing Board sign-off for the BCF plan that will be submitted to NHS England and NHS Improvement.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to:

i. Approve the Portsmouth Better Care Fund plan for 2022/23, to be submitted to NHS England and Improvement (NHSE/I) by 26th September 2022.
ii. Note work ongoing to support integrated health and care provision that is funded via the BCF.

3. Background

3.1 NHSE published the Better Care Fund planning requirements for 2022/23 in July 2022. BCF plans are required to be submitted to NHSE/I by 26th September 2022.

3.2 For 2022/23 BCF plans consist of:

i. A narrative plan
ii. A BCF planning template including planned expenditure, confirmation that national conditions are met, ambitions for national metrics and additional contributions to BCF section 75 agreements.
iii. Capacity and demand plan (this will not be subject to assurance)

3.3 Use of BCF funding streams is jointly agreed by the Integrated Care Board (ICB) and City Council, via the BCF and Health and Care Portsmouth

Commissioning Partnership Management Group, which is comprised of the relevant officers from both organisations and oversees the Section 75 agreements.

3.4 Local areas were not required to submit BCF plans in 2020/21 due to system pressures of the Covid-19 pandemic. In 2021/22 BCF plans focused on continuity of integrated health and care, supporting recovery from the pandemic and building on partnership working across Health and Care Portsmouth to benefit people across the city.

3.5 The BCF plan for 2022/23 continues to support the well-established principles of the refreshed Portsmouth Blueprint to deliver better outcomes for our population. Our vision is for everyone in Portsmouth to be supported to live healthy and independent lives for as long as possible, with health, social care and support integrated around individual needs at the right time and in the right place.

4. Reasons for recommendations

4.1 The Better Care Fund policy framework indicates the national conditions that BCF plans must meet:

i. A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board.
ii. NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution.
iii. Invest in NHS commissioned out-of-hospital services.
iv. Implementing the BCF policy objectives.

4.2 The plan reflects well established joint commissioning and partnership working arrangements that continue with the transition from Clinical Commissioning Groups to Integrated Care Boards and Health and Wellbeing Board members are asked to sign off the attached 2022/23 Portsmouth BCF plan.

5. Integrated impact assessment

5.1 An integrated impact assessment is not required as the recommendation does not directly impact on services that are already being delivered. Schemes and services within the BCF are subject to the appropriate ICB or City Council Integrated, Equality or Quality Impact Assessments.

6. Legal implications

6.1 Legal considerations have been taken into account where appropriate for individual schemes and projects within the BCF.

7. Director of Finance's comments

7.1 Financial oversight and approval of BCF expenditure is via the Partnership Management Group, which comprises the relevant members of ICB and City

Council Finance directorates. BCF allocations for 2022/23 are authorised as noted in the planning template.

……
Signed by:

Appendices:

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

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

Title of document	Location

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

……
Signed by:

*{**BELOW FOR VERSION INFO**}*

1. *Narrative Plan (Word doc) – FINAL 090922*
2. *Summary tab info from Excel planning template – FINAL 090922*

Portsmouth

Better Care Fund 2022-23

Narrative Plan

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

Cover

Health and Wellbeing Board
Portsmouth

1a. Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils
NHS Hampshire & Isle of Wight Integrated Care Board, Portsmouth City Council, Portsmouth Hospitals University Trust, Solent NHS Trust, Southern Health NHS Foundation Trust, Portsmouth Primary Care Alliance, Social Care providers including, Housing Renewals Team, Healthwatch, and Voluntary, Community and Social Enterprise groups across the city.

1b. How have you gone about involving these stakeholders?

Work continues with alongside the development of the Portsmouth Health and Wellbeing Strategy 2022-2030, and Portsmouth's City Vision for 2040. Stakeholder engagement takes place through regular forums and working groups, such as the Dom Care Provider Forum that meets every 6 weeks and the Care Home Managers forum that meet monthly.

During an online event hosted by Hampshire and Isle of Wight (HIOW) ICB the 6 partner members of Health and Care Portsmouth (NHS Hampshire and Isle of Wight Integrated Care Board, Portsmouth City Council, Portsmouth Hospitals University NHS Trust, Portsmouth Primary Care Alliance, Solent NHS Trust and HIVE Portsmouth) came together to discuss the challenges arising from the pandemic and the opportunities that the ICB and Integrated Care System offers, and the need to refresh and agree priorities for the city in the Health and Care Portsmouth Blueprint.

2. Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

This plan describes how Health and Care Portsmouth and Portsmouth City Council, along with other key partners in the city, will work together to further strengthen the place based health and care integration across the wider hospital footprint and the Hampshire and Isle of Wight (HIOW) geography of the new Integrated Care System (ICS), to ensure the successful development of an ICS for our region that is able to fulfil all the ambitions set out in the White Paper. We will work closely, understanding local needs and designing services to meet them in line with the issues and challenges identified as part of the city's Health and Wellbeing strategy, and the Blueprint for Health and Care in Portsmouth, which identifies significant health inequalities, but also the strengths that exist when we come together to improve and support the health and wellbeing of our residents.

Partners agreed key commitments and principles for Health and Care Portsmouth last year as part of the Blueprint refresh and five place-based priority areas were identified:

1. Health improvement – focusing on addressing health inequalities and improving outcomes.
2. Children's services (0-25) – The overarching strategic aims/objectives of commissioning under this scheme specification are to deliver on the priorities identified in the Children's Trust Strategic Plan.
3. Vulnerable adults – we want to:
    - Reduce harm caused by substance misuse including alcohol misuse.
    - Reduce suicide and self-harm in the city by delivering the outcomes in the Suicide Prevention Plan.
    - Implement a comprehensive Adult Mental Health Strategy to:

    - Improve wellbeing through increased access to community-based support.
    - Strengthen primary and community mental health service provision.
    - Timely access to secondary care provision.
    - Improved crisis service response.
  - Implementation of a clear dementia pathway, including strengthened support for carers, integration with physical health services and a delirium pathway.
  - Implement Homelessness and Rough Sleeping Strategy.
  - Deliver on Health and Wellbeing Strategy priorities in the Safer Portsmouth Plan.
  - Alleviate causes and effects of poverty in Portsmouth, as expressed in the Anti-Poverty Strategy.
4. Primary and community services integration – The Better care Fund is organised around three strategic themes:
  - **Early intervention and self-care** - improving healthy life expectancy and reducing dependency on health and care services through upgrading prevention, early intervention, and self-care, with effective prevention and management of long-term conditions in the community provided by joined up services. By developing and improving a range of low-level preventative services people can be supported to make choices to meet their individual needs and remain safe, healthy, and independent for as long as possible.
  - **Admission avoidance and effective discharge** – Portsmouth City Council and Solent NHS Trust have been working together to support people needing help to leave the Hospital. In Portsmouth, social workers, nurses, physiotherapists, occupational therapists, and other professionals are working together with people in hospital to understand their immediate needs. Once ready to be discharged, they can leave hospital in a timely way, getting the care and support they need. Patients are supported with effective urgent care in the community, and rehabilitation and reablement support to avoid emergency admissions; to ensure no-one stays longer in an acute or community bed longer than they need to and to reduce readmissions.
  - **Proactive care** - planned, pro-active integrated health and care management; focus on single assessment and truly integrated professional teams so people only have to tell their story once with services providing a holistic view of their individual needs.
5. Person centred care planning – continuing health care, and independent sector care purchasing.

A series of smaller sub-groups are being established for each priority area and a further event will take place in September to finalise the Blueprint. It is then anticipated that we will officially launch the new plan in October.

Portsmouth has a dedicated integrated Children's Commissioning Team sitting across Portsmouth City Council and Health and Care Portsmouth working with families and providers to design and deliver effective services and pathways for physical and mental health of children and young people.

Our vision is for everyone in Portsmouth to be enabled to live healthy, safe and independent lives, with care and support that is integrated around the needs of the individual at the right time and in the right setting. We will do things because they matter to local people, we know that they work, and we know that they will make a measurable difference to their lives*.*

A key transformation programme during 2022/2023 is development of the **Portsmouth Integrated Community Programme**, which is informing the future development and design of community bed-based and home-based services to enhance the intermediate care offer across the City and ensure Portsmouth has the right capacity and capability, in the right places.

3. Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

During 2022/23 HIOW ICB (formally Portsmouth CCG) revised its arrangements with Portsmouth City Council in order to extend and further develop the integration and joint working previously in place. This was partly in response to the Health and Care Act (2022), the White Paper; Health and Social Care Integration: joining up care for people, places and populations, published on 9 February 2022, and also from the desire for both health and care to better serve our local population. The White Paper outlines the benefits to staff and patients around better care through the introduction of Integrated Care Systems (ICS) to improve the links between health and social care and references Portsmouth's pioneering approach to integration through Health and Care Portsmouth.

Work was undertaken with Bevan Brittan LLP to ensure that our local governance arrangements, including the Health and Care Portsmouth Place-Based Partnership Board (previously the Joint Commissioning Board) were robust. This included consideration of the agreements that we have in place to enable joint working, including Section 113 and Section 75 agreements. Prior to the dissolution of the CCG an overarching Section 75 was developed which set out the framework for joint working across health and social care within the city. A number of individual schedules were included within the framework, one of which was the revised Better Care Fund – enabling and bringing together a wider range of staffing and financial resource within the Health and Care Portsmouth model in line with the integration agenda in the city. This has now transferred to the Integrated care Board.

This framework also describes and supports a robust programme management and governance approach which has supported delivery of Better Care from the outset and will continue into the future. The Partnership Management Group (PMG) oversees the Better Care Fund schedule of the section 75.

The group is comprised of representatives from the Integrated Care Board and City Council and meets bi-monthly, providing strategic direction on individual schemes and projects, reviewing, and agreeing pooled financial schedules and activity information. The PMG is authorised within the limit of delegated authority of its members (which is received through their respective organisation's own constitution and scheme of delegation)

4. Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning

- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

There is a strong history of partnership working with a clear city vision led by the community to establish an agreed HWB strategy for 2022-2030, Health and Care Portsmouth Blueprint, and operating model, which includes integrated service delivery models and robust integrated commissioning arrangements to address the challenges coming out of the pandemic and need to refresh and agree priorities.

There is the opportunity as part of ICS development to strengthen the partnership arrangements to improve health outcomes and reduce health inequalities both locally and working at scale in the ICS.

Our new commitments within the Portsmouth Blueprint are:

- Our local health services will reflect the diversity of populations and needs in our communities.
- We will build services as locally as possible to reflect the needs of the community but recognise that it will make sense for some things to be led at a different scale.
- We will always design services from the perspective of the person using them, and make these as seamless as possible, joining up functions and organisations for better experiences and outcomes for service users.
- We will remove barriers to accessing services so that everyone can get the help and support they need.
- We will involve people in designing services for them and those they care for.
- We will make sure that we have a well-led, well-organised and well-supported workforce that we empower to work across organisational boundaries to improve the experiences and outcomes for service users.
- We will be honest about what we can and cannot do and explain why.
- We will work with people in their communities to develop the relationships and opportunities they need to stay healthy, independent, and active in the places they live.

We bring together important functions that allow our organisations to deliver more effective community based front-line services and preventative strategies; this includes HR, Estates, IT, and other technical support services.

We establish a new constitutional way of working to enable statutory functions of public bodies in the City to act as one and to improve local people's involvement and influence in health and care in the city. This includes establishing a single commissioning function at the level of the current Health & Wellbeing Board with delegated authority for the totality of health (NHS) and social care budgets.

We establish improved and integrated ways of delivering health and care services for the City. This will be achieved through a range of ways including the formal integration of some services. For local people this will mean they do not have to experience multiple assessments, will be offered choices about how they are treated

and opportunities to explain what is most important to them, with referral in a straightforward way to the services they need.

- We simplify the current configuration of urgent, emergency and out of hours services, making what is offered out of hours and weekends consistent with the service offered in-hours on weekdays so that people have clear choices regardless of the day or time.
- We focus on building capacity and resources at a local level and in communities in the City to enable them to commission and deliver services at a locality level within a framework set by the city-wide Health & Wellbeing Board.

We also agreed some **key principles** for how all health and care partners would work together in the city:

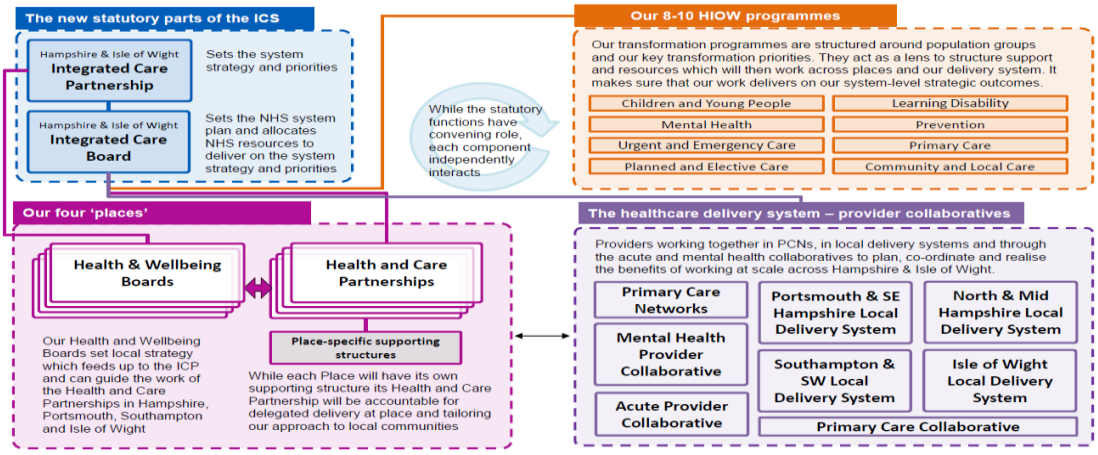
- **Outcomes** - improving outcomes for Portsmouth people will be at the heart of place-based working.
- **Equality** – Our place-based working will seek to shape service delivery to reduce inequalities in the city.
- **Evidence** – Place-based working will be informed by the needs of local communities and evidence of what works.
- **Integration** – Place-based working will integrate service delivery around the needs of individuals and families.
- **Prevention** - Prevention and early intervention services will reduce dependency on public service delivery.
- **Participation** - Residents will be active participants in the co-production of services.
- **Accountability** - Resource allocation decisions will be transparent, contestable, and locally accountable.
- **Value for money** - Decisions will be driven by the goal to achieve optimum quality, value for money and outcomes.
- **Partnerships** - Strong and effective partnership is key to place-based working.

Why integrated care systems?

Hampshire and Isle of Wight

How NHS England and Improvement explains the purpose and benefits of Integrated Care Systems

How each aspect of our system functions



Our System Capabilities: priorities for 2022/23

NHS Hampshire and Isle of Wight

With different behaviours, ways of working and support we will be able to deliver the change in outcomes we aspire to as an Integrated Care System.

Key capability	Description
Adapting how we work	Looking at the values, behaviours, skillset, support and organisational design necessary to create very different ways of working within and as part of the system.
Strategy	Building our system strategy which is inclusive of our partners and appropriately ambitious for our future direction.
Clinical leadership	Fostering a widespread culture of clinical leadership, growing a strong clinical voice at every level of the system, providing active support to emerging clinical leaders.
Population health management	Embedding population health management into our system decision making and culture, driving a focus on outcomes and evidence-based practice.
Engagement	Developing a framework and upskilling our teams to engage broadly in the system with all system partners, citizens and patients and with neighbouring systems and the region
Delegation of resources	Our approach to the delegation of finances and resources to support the delivery of our four core aims and ensuring effective delivery as a system.

Portsmouth has a population of over 172,000 adults over the age of 18. Services covered by this Scheme Specification are available to all adults who live within the geographical area covered by the Council and HIOW ICB (Portsmouth Place Users)

The patient cohorts to be supported are:

- Service Users with long term conditions.
- Service Users with diagnosis of dementia.
- Service Users requiring end of life care.
- Service Users with health and social care circumstances adversely affecting their physical and mental wellbeing.
- Service Users over 75 year who will have a GP check and will receive care co-ordination and intervention as appropriate.

Service Users will be identified using risk stratification based on current and predicted use of health and care service.

Health & Care Portsmouth partners share a number of aspirations:

- Personalisation of care and support – including domiciliary care intervention and review, end of life care planning, future care planning, and Continuing Healthcare assessments.
- Improving health and well-being and strengthening our communities using an asset building approach – including partnerships with the VCSE sector, HIVE, community helpdesk and community development.
- Strengthening primary and community care services – including integrated intermediate care to avoid hospital admissions and links with Primary Care Networks.
- Improving access to acute/secondary or specialist services – including system resilience, urgent and elective care pathways and the Collaboration of Urgent, Elective and Diagnostic (CUED) Care Programme Group.
- Improving access to mental health services at all stages of the pathway; well-being, access to community support, primary mental health services, secondary care and planned and crisis services.

These aspirations are intertwined with the principles of Portsmouth's Better Care funded schemes and projects.

We have established enablers for partnerships across the City including:

- Health & Care Portsmouth Commissioning - Integrated Commissioning Service provided by the City Council and ICB.
- Portsmouth Rehabilitation & Reablement Team – service provided by Solent NHS Trust and City Council, funded via the Better Care Fund.
- Senior Responsible Officer for Hospital Discharge & Flow - City Council and Solent NHS Trust provided.
- Continuing Health Care – City Council and ICB provided.
- Adult Mental Health – City Council and Solent NHS Trust provided.
- Integrated Learning Disability Service - City Council and Solent NHS Trust provided.
- Quality Team - City Council and ICB provided.
- Designated Setting – City Council provided.
- Common Record System across Primary Care, Solent NHS Trust, and Adult Social Care.
- Safety and cost-saving in the home – Home Energy Assistance top up grant and Home Improvement Loan.

Portsmouth aims to deliver several community transformational plans this financial year. The aim of these plans is to:

- Enhance the intermediate care offer across the City and ensure Portsmouth has the right capacity and capability, in the right places.
- Continue the development of the Urgent Community Response service.
- Deliver the national ambition for both virtual care and virtual health.

Inter-related workstreams of the programme are:

Urgent Community Response (UCR)

The Portsmouth UCR service provides admission avoidance and was developed and delivered in line with national guidance and expectation in financial Year 2021

to 2022. This was achieved through the amalgamation and enhancement of elements of the Solent NHS Trust Community Nursing and Portsmouth Rehabilitation & Reablement Team (PRRT) to form a single UCR service. The plan for financial year 2022 to 2023 is to continue to monitor and develop the service in line with the latest iteration of NHS England's guidance released in March 2022 Community health services two-hour urgent community response standard. The aim of the UCR is to provide an urgent community crisis response service within two hours, to people in their usual place of residence with an urgent care need, to provide the care they need to optimise independence and avoid preventable escalation of care to non-home settings including the Emergency Department, care home and hospital, where the person is safe to remain at their usual place of residence. The service predominately offers an assessment and short-term intervention(s) (typically lasting up to 48 hours) and where appropriate onward pathways to Virtual Wards, Community Nursing, Portsmouth Rehabilitation and Reablement Team (PRRT), Voluntary, Community & Social Enterprise (VCSE) and other Health & Care professionals.

Community Rehabilitation and Reablement review and reconfiguration
The Portsmouth Rehabilitation and Reablement Team (PRRT) is a well-established service in Portsmouth that provides admission avoidance and supports discharge from acute care into pathway one. The plan is to undertake a review of the service to determine the best strategic fit within the local Portsmouth health and care system. The need for this review is due to developments of the Urgent Community Response Service, Virtual Wards, and the national hospital discharge guidance for home first.

Bed based intermediate care model
The local intermediate care offer has been revised across the city to enable the realisation of the vision to:

Enable people to receive the right level and type of health and care services in their own home and community wherever possible, enabling them to remain well and independent for as long as possible by maximising their recovery, managing their long-term conditions, and avoiding unnecessary hospital admissions.

Solent NHS Trust and Portsmouth City Council are working in a more integrated way to utilise the bed stock across the city and are adopting the national directive to fully embed 'a Discharge to Assess' and 'Home First' approach.

Data analysis of the current bedded provision for rehabilitation and D2A shows that reprovisioning the bed stock will allow for a more efficient utilisation of rehab beds.

There was also a need to determine a sustainable operating model moving forward that complies with the Government requirements for D2A and home first which optimises people's independence and is able to flex based on individuals needs and demand. This model would also include the development of a full 7 day a week therapy service to support the maintenance of the 18-day length of stay.

In June 2022 there was agreement to develop a blended health and social care model for the Southsea Unit which would have 20 discharge to assess beds and 10 rehabilitation beds and additional surge capacity of an additional 10 beds.

The staffing of the unit would be with a blend of health and social care staff under a section 75 agreement with Solent NHS Trust being the lead provider. Social Care staff will transfer to Solent NHS Trust under a TUPE arrangement with a

collaboration agreement being drawn up with all partners (PCC, Solent NHS Trust and the ICB)

Virtual Care Delivery Programme

The virtual care programme main aim is to support admission avoidance and discharge from acute care. Portsmouth is working in collaboration with the South East Hampshire locality on a Virtual Wards and Virtual Care Delivery Programme that will deliver a sustainable transformational change with the golden thread of digital enablement, providing better connected, more personalised care in people's homes, including care homes.

Virtual wards support patients who would otherwise be in hospital, to receive the acute care, remote monitoring, and treatment they need in their own home or usual place of residence. Virtual wards provide acute clinical care at home for a short duration (up to 14 days) as an alternative to care in hospital. Patients admitted to a virtual ward have their care reviewed daily by a consultant practitioner (including a nurse or Allied Health Professional (AHP) consultant) or suitably trained GP, via a digital platform that allows for the remote monitoring of a patient's condition and escalation to a multidisciplinary team.

Virtual Wards are suitable for a range of conditions that can be safely and effectively managed and monitored at home, or at a person's usual place of residence, including people with respiratory problems and COVID-19 (Covid@Home), heart failure or acute exacerbations of a frailty-related condition. Central to the approach is services working towards providing a model that is patient centred, and in which home is an option for care. This is part of the shared decision-making process, in line with personalised care principle.

Virtual wards will be fully technology-enabled (the management of patients via a digital platform) to optimise care of patients, support communication and enable the effective management of a patient's condition. Where relevant, patients may measure agreed vital signs and enter data into an app or website. In some cases, they wear a device that continuously monitors and reports vital signs. Clinical teams can see individual measurements for the patients they are responsible for via a dashboard. The platforms ensure that the team is alerted when any patient moves outside agreed parameters, allowing them to take appropriate action.

The key aims of this area of work are to:

- Design, implement and evaluate the expansion of virtual health models across the Portsmouth and South East Hampshire system
- Improve patient outcomes and experience.
- Improve flow and capacity, provide system resilience, and reduce hospital bed pressures.
- Be developed across systems and provider collaboratives, based on partnership between secondary, community, primary and mental health services. Consideration will also be given to partnerships with the independent sector where this will help grow capacity

VCSE Wellbeing Collective

Through the Better Care Fund several contracts for the provision of Home from Hospital and Admission Avoidance are delivered by the VCSE sector and have been commissioned in the traditional format for several years. We are seeking to change

the way that we work with the VCSE and move away from a commissioning model based on competing for contracts to one of collaboration and partnership working. The development process started in September 2021 with delivery of the VCSE Wellbeing Collective model from November 2021.

In line with the Health and Social Care Bill, "Integration and Innovation" (February 2021) this is a partnership approach with three VCSE organisations (HIVE Portsmouth, British Red Cross, and The Salvation Army) to strengthen links between health and social care and the VCSE sector in the city and to support people collaboratively to remain living independently and prevent hospital admissions. From the first 8-months of delivery (Nov 2021 – June 2022) the Collective received an average of 45 referrals per month. Referrals were mainly for; urgent food provision, ongoing shopping support, welfare, environment safety, mobility support and reablement. The Collective is in the process of establishing a Single Point of Access into the service to support the developing model.

Anticipatory Care Plan

Portsmouth as part of the Hampshire & Isle of Wight Integrated Care Board, has identified proactive case management as a key priority for this Winter to support admission avoidance. This will help accelerate the forthcoming anticipatory care Primary Care Networks Directly Enhanced Service, while building on current Primary Care Networks delivery models relating to Health Inequalities and Personalised Care. The BCF infrastructure will provide the additional enablers and levers to further integrated working in our places and neighbourhoods.

Portsmouth Provider Partnership (P3)

The City has a thriving provider alliance arrangement through P3 (previously the MCP) comprising of Health and Care Portsmouth, PPCA, Solent NHS Trust, PCC, HIVE Portsmouth, PHU Trust, Healthwatch Portsmouth, and Primary Care Networks within the city who are are committed to working together to integrate primary, community, social care and voluntary services in Portsmouth City. This has been and continues to be an important vehicle to improve provision of community care within Portsmouth. Transformational activities have progressed well since the establishment of the partnership. The P3 Programme will be a key building block in the foundation of the HIOW Integrated Care System (ICS) and the Portsmouth & South East Hants Integrated Care Partnership (ICP) The P3 programme continues to be the enabler to delivering the outcomes set out in the Portsmouth Health and Care Blueprint.

5. Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy 2022/23 objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embe a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

The current requirements remain largely unchanged in that once a person no longer meets the clinical criteria to require inpatient care in an NHS setting (CTR), they will be discharged home the same day as becoming medically optimised (or within 24 hours), and any further assessment required (including CHC consideration) will be carried out within a community setting (D2A).

To deliver this requirement, the Portsmouth Community Assessment team manages all step-up and step-down care for Portsmouth City residents, including interim placements and onward care arrangements. This multidisciplinary team works in partnership with the Integrated Discharge Service (IDS) at Portsmouth Hospital University Trust (PHU) to facilitate hospital discharge and consists of staff from Portsmouth City Council (PCC), and Solent NHS Trust.

This then enables people to have their longer-term needs assessed in the community outside the acute environment. This means that there are less lost bed days, better utilisation of capacity to assess and meet people's needs, and a sharing of resources to where they are needed rather than based on organisational boundaries.

The local intermediate care offer has been revised across the city with Solent NHS Trust and Portsmouth City Council working in a more integrated way to utilise the

bed stock across the city by adopting the national directive to fully embed 'a Discharge to Assess' and 'Home First' approach.

Data analysis of the current bedded provision for rehabilitation and D2A shows that reprovisioning the bed stock will allow for a more efficient utilisation of rehab beds. This model also allows for the development of a full 7 day a week therapy service to support the maintenance of the 18-day length of stay.

We have a strong integrated rehabilitation and reablement team and a Community Independence Service that, along with other VCS provided services, aims to support people back home and prevent avoidable readmissions whilst optimising people's potential to remain living healthy and happy lives. The plan is to undertake a review of the service to determine the best strategic fit within the local Portsmouth health and care system.

The Trusted Assessor role continues to be funded by Portsmouth BCF and helps support early discharge of people in hospital to nursing and residential homes – carrying out and co-ordinating needs-led assessments and providing effective discharge planning for patients and their carers.

Portsmouth and South East Hants are working as system partners to ensure that robust metrics and systems are in place to ensure that the LOS and discharge profiles within the acute and community trust are effective and deliver flow within the health and care arena.

Partners in Portsmouth and South East Hampshire worked closely throughout the winter to manage and limit the pressure on the NHS and the impact of that on local residents. Health and care providers worked together on a campaign to reduce demand at Portsmouth Hospital University NHS Trust's Emergency Department at Queen Alexandra Hospital, increasing timeliness in daily discharges from hospital, and encouraging people to self-care at home where possible

Targets are reviewed and set daily to ensure that they include the admission avoidance impact.

There are daily system meetings in place to review the current position regards the system pressures, this is held with all system partners and is reportable 3 x weekly meetings are in place with senior leads and Chief Operating Officers and is reported to CEO on a weekly basis.

6. Supporting unpaid carers.

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Carers support in Portsmouth is well established with excellent cross organisational relationships across health and care organisations at an operational level. The

challenge of being a small Unitary Authority with limited capacity combined with the pressures presented by the pandemic has meant that strategic leadership remains an ongoing challenge.

BCF funds are focused on the operational delivery of carers support including the provision of breaks and ensuring as seamless an experience as possible for carers across the health and social care system.

Admission avoidance
The Carers Service in Portsmouth is part of Adult Social Care and supports all adult carers, usually via a Carers Assessment to access support. The team take an early intervention and prevention approach seeking to build on strengths, use community assets and prevent more complex needs developing.

Assessments start at first contact, are proportionate and scalable depending on the level of need and how the caring role progresses. The assessment and support planning process has been developed based on the principle of getting as close to perfect as possible for the carer and the person they are supporting, it meets the requirements of the NHSE 'different conversations' guidance and delivers both the legal requirements of the Care Act and the spirit of it. The service can offer joint assessments for the carer and the person they support providing a single assessment and named worker where the care and support needs are not complex. The Carers Service does not have sufficient qualified staff to support complex cases but will work with qualified colleagues across adult social care to deliver a joined up approach.

Data around admission avoidance has not been available locally, admissions due to carer breakdown are not routinely recorded so any data available is not reliable. However, the Carers Service works proactively with carers and those they support to avoid crisis point being reached and will work with colleagues elsewhere in the system to avoid admissions where possible.

Common things carers want help with are:
- Help to get a break
- Information, advice and gaining useful knowledge
- Emotional support, problem solving and risk management
- Planning for an emergency

The breaks offer includes non-chargeable one-off payment, replacement care equivalent to 6 hours p/w sitting service and chargeable access to 2 respite beds.

The Carers Service works from the Carers Centre which is a community hub for a range of carer activity including groups, training, cooking activities and events, most of which are run by partners from a variety of organisations across the city. Examples include public health funded cookery sessions, carers peer support activities, young carer activities, training sessions and specialist clinics.

7. Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?
The purpose of the DFG is to provide funding to individuals living in owner occupied and privately rented properties, to help them make changes to their living environment. DFGs are an essential tool in enabling people to remain independent in their own homes and can delay the need to move into supported living or residential care settings, reducing the need for care packages. For all of these clients, Housing Services work closely with Occupational Therapists from both health and social care under a section 113. We have amended our processes to simplify them and enhance client service. During 2019-20, Portsmouth agreed with recommendations for the flexible use of the DFG allocation. This enabled Health and Care Portsmouth and Private Sector Housing to test new ways of working and operating structures to benefit residents requiring adaptations at home. In July 2020 with the success of a pilot scheme, changes were agreed by the BCF board on a permanent basis, with a further addition of exempting all DFG's from the means testing. In November 2021 Portsmouth City Councils Private Sector Housing Financial Assistance Policy 2021 was adopted. This revised Policy included the implementation of the agreed changes to become permanent as follows:- - Remove Means Testing to all DFG's - Increase the Grant limit (from £30,000 to £40,000) - For grants in excess of £40,000 a Home Improvement Loan will be offered - Make DFGs available to shared lives carers and special guardianship cases. Flexible use of DFG was agreed due to the waiting list that had amassed due to limitations on inspections during the COVID-19 Pandemic, this is now being addressed and the underspend (approximately £500,000) was retained and balance carried forward into 2022/23. Feedback on the progress will be provided at relevant stages throughout the year. In May we held approximately 122 clients on our DFG waiting list. Whilst all efforts have been made to reduce this number, we did receive a high number of referrals in April, May and June. Typically, we can expect appx 26 referrals per month. In April, May and June we received approximately 42 per month, which has had an impact on ability to reduce the waiting list, which remains a similar number. This high number of referrals is not anticipated to be maintained and we expect in the upcoming months to receive closer to 26 per month. The timeframe clients are waiting has reduced down to approximately 4 months. Health, Care and Private Sector Housing teams continue to link to ensure the most effective utilisation of DFG. Proposals and project updates are discussed regularly at the PMG and initiatives this year include: • Research and development of digital service provision within the Telecare Project. Portsmouth City Council has an established in-house Telecare and home safety service (Safe at Home) supporting residents of all ages to stay

safe and live independently in their own homes across the city with a range of detectors and sensors. The entire telecare platform is being reviewed to ensure we provide a robust and reliable service for existing and future customers.

The project continues to support our vulnerable residents with the digital switchover to live safely and independently in their own homes. The Safe at Home service now operates on fully digitalised equipment for new and future customers and the team have already supported over 200 existing customers with analogue to digital switchovers enabling a robust and reliable service for those who have already undergone the changes in the city. With the full digital upgrade for existing customers to be completed by end of 2022.

With the new service launch and web, the in-house Safe at Home service within Housing continues to work closely with internal and external partners including health and social care. Technology cannot only help understand customer's needs but also be an additional option available to practitioners to support independent living and reduces pressures on their own services.

The DFG also helps to support PCC equipment purchases for the community equipment store, helping provide adaptations for people in the community and being discharged from hospital to maintain their independence at home.

8. Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- Changes to local priorities related to health inequalities and equality, including as a result of the Covid-19 pandemic
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

Alongside the development of the Portsmouth Health and Wellbeing strategy 2022-2030 and Portsmouth City Vision for 2020, partners came together to discuss the significant challenges facing the city which are contributing to Portsmouth's health inequalities. This includes the cost-of-living crisis, demand and capacity pressures across the health and care system, residents struggling to access key services, workforce challenges, financial challenges and more.

In 2021, we worked with partners locally to consider how the Blueprint would need to develop for the future and our new commitments include:

- Our local health services will reflect the diversity of populations and needs in our communities
- We will remove barriers to accessing services so that everyone can get the help and support they need

We also agreed some **key principles** for how all health and care partners would work together in the city, including *Equality* - our place-based working will seek to shape service delivery to reduce inequalities in the City. The development of the ICS presents an opportunity to strengthen partnership arrangements to improve health outcomes and reduce health inequalities both locally and working at scale.

Aspirations to truly tackle health inequalities are woven throughout the NHS Long Term Plan (2019) and the Covid-19 pandemic has exacerbated issues for those who were already disadvantaged. The NHS operating plan for 2021/22 includes a significant focus on tackling health inequalities, aiming for equitable access, excellent experience, and optimal outcomes, as well as increasing access to Primary Care services as a priority.

The charity CRISIS reported that homeless people are almost 40 times more likely not to be registered with a GP and five times more likely to have difficulty getting onto or staying on a GP's list than the general public. Homeless people are probably amongst the most impacted by the inverse care law for both physical and mental health as their significant needs are often unmet, resulting in an over use of emergency and inpatient provision.

Portsmouth is establishing a Health Inclusion Service with Brunel PCN leading the work in collaboration with P3 partners, which provides a team dedicated to supporting people who are or have been homeless and/or those who struggle to access mainstream health services due to the chaotic nature of their lifestyles. The Primary Care Team will offer a transitional service for individuals, with an aspiration to manage any on-going needs through mainstream health and care services where possible. The team will have a co-located base with the mental health and substance misuse team, but also provide outreach into the existing support services, hostels and the street as necessary.

Some examples of our approach to supporting a reduction in health inequalities following the Core20PLUS5 principals:

- **Pulmonary Rehab** – this service has recently been adapted to make it more accessible and now offers a wide range of interventions including remote and face to face groups, liaising with Practice Nurses to try and identify the most appropriate referrals for long-term COPD management.
- **Breathlessness Hub** – this service has recently been set up as a pilot to support respiratory problems by providing breathlessness assessment, diagnostics, and management in a community setting.
- **Early cancer diagnosis / Chronic respiratory disease** – Currently Portsmouth's early lung cancer diagnosis rate is 38% (Stage 1 or 2), in April 2022 we started delivering the Targeted Lung Health Check (TLHC) programme with a targeted population of 24,000 people, the aim is to increase our early diagnosis to 75%. To date we have identified that 10% of the checked cohort have undiagnosed COPD, these patients have been referred to primary

care for treatment. In addition, 21 people have had cancers identified and are being treated by our acute hospital.

- **CVD/Hypertension** – We have successfully delivered BP at home monitoring project with 700 BP monitors delivered to Portsmouth practices for dissemination to their patients. Also the introduction of other CVD schemes such as pharmacy BP monitoring ICB working jointly with LA Public Health Wellbeing Service who are providing a CVD preventative programme of work.

Inequality of access and outcome:

- **Health:** Life expectancy for men and women in Portsmouth is significantly lower than the England average; and it is 7.8 years lower for men in the most deprived areas of the city than in the least deprived. Rates of under-75 mortality rate from cardiovascular diseases, cancer, respiratory diseases and liver disease are worse than the England average. In school year 6 (at the end of primary school) 21.5% of children are classified as obese.

- **Index of Multiple Deprivation (IMD):** Portsmouth (along with Southampton) ranks as significantly more deprived than any other district within Hampshire and Isle of Wight. Of 317 LA districts in England, Portsmouth is the 57th most deprived by the average rank of each LSOA, the 59th most deprived by average score of LSOA, and 72nd most deprived by the proportion of its LSOAs that are in the most deprived 10% nationally. With only 2 LSOAs in the least deprived 10% nationally, and 15 in the most deprived 10%, Portsmouth has pockets of affluence rather than pockets of deprivation.

- **Educational Attainment** - In many key measures of educational attainment, Portsmouth is ranked lower than other cities.

- **Skills -** Educational outcomes have implications for achievement at further and higher education. The most recent statistics show that the proportion of young people not in education, employment or training has risen to 5.2%. Many higher paid and higher skilled jobs are occupied by employees commuting into Portsmouth and not by residents. Resident salaries are lower than the national average despite city workplace wages being higher - this indicates the lower skills level of the local workforce.

The Covid-19 pandemic has had a disproportionate impact on many who already face disadvantage and discrimination, highlighting some of the health and wider inequalities that persist in our society. The impact of the virus has been particularly detrimental on people living in areas of high deprivation, on people from Black, Asian and Minority Ethnic Communities (BAME), on older people, those with a learning disability, and others with protected characteristics.

The pandemic has shown the importance of reorientating our efforts to address the broad outcomes that drive good health, recognising that the distribution of income and wealth matter in reducing health inequality. In Portsmouth, we have begun to address this through our use of the ONS Health Index as a measure of progress,

aiming to support a longer-term focus to our policy and investment decisions aimed at improving the health and wellbeing of our residents and communities.

Data from the ONS Health Index for Portsmouth in 2018 showed that health was worse than the England average in 2015, and that the city's relative position has decreased in the years since. Portsmouth's position has worsened in relation to health outcomes and wider determinants and improved in relation to health-related behaviours. Portsmouth is not an outlier in terms of its overall score – the City sits within a pattern in which more deprived areas have less healthy populations.

Since 2015, organisations involved in Health and Care Portsmouth have combined their knowledge and expertise to improve support for vulnerable people in the community across a range of different services including health visiting, school nursing and learning disability support.

The HWB strategy has been refreshed for 2022-2030 and takes a different approach where we have really tried to understand what about Portsmouth are the significant impacts on health and wellbeing, and what we can do as a system to bring about some key changes.

We have identified five issues which we describe as the "causes of the causes" – the underlying factors in our city that lead to some of the issues which in turn influence health and wellbeing. Rather than look at individual services and responses, we are looking at how we create the conditions for good health and wellbeing in Portsmouth around the following themes:

- Poverty
- Educational Attainment
- Positive Relationships
- Active Travel and Air Quality
- Housing

As a system, we collectively aim to meet the needs of all our communities through a combination of universal and targeted services and approaches; some of the activities to help mitigate health inequalities include:

- Working with Portsmouth City Council and Primary Care Networks to make COVID-19 vaccinations accessible to those groups who have lower uptake, such as our black communities, travelling community and rough sleepers.
- We are part of the HIOW ICB engagement work around online and video consultations and using technology to support healthcare.
- Increased engagement with communities that are underrepresented and disadvantaged.
- Work continues across Health and Care Portsmouth to develop support services to lessen inequalities for Autistic residents. Appropriate targeted support is being developed working in co-production with the community.
- HIVE Portsmouth works with the ICB, Local Authority and Solent NHS Trust to engage with and support our residents. Throughout the pandemic, as a locally based support service, HIVE Portsmouth has been able to identify changing needs and been agile responding to the specific needs of the city

and vulnerable groups. Many people and families in the city do not have access to computers or tablets. HIVE has established a digital loans library to enable self-support and access to online health and wellbeing support, as well as reduce social isolation. HIVE is connected with 56 diverse (BAME and Faith) groups across the City.

The Supported Intensive Recovery Service

This BCF funded service supports hospital discharge for a vulnerable cohort of patients as they are discharged from hospital. This is unique to Portsmouth and has been provided for a number of years as part of the wider Public Health contract for an Integrated Drug & Alcohol Recovery, Supported Housing, and Homeless Support Service linking with other key agencies in the city to improve access to accommodation and support services. The service aims to support homeless people to access accommodation following a discharge from hospital; to improve access to accommodation and support services for those who have a dual diagnosis and provides intensive support with housing and all DWP benefit issues (including assessments). The service works in partnership with external services such as the Substance misuse Recovery Hub, ED, and Alcohol Specialist Nurse Service at the acute hospital, homeless day services, local authority housing departments, Two Saints and other supporting services to try to reduce re-admissions to hospital.

Portsmouth pledges to address inequalities for our people, patients and communities with real purpose and action, developing a strategy in partnership with our people and patients in conjunction with data from the NHS staff survey, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard, Gender Pay Gap, and Model Employer targets.

The Covid-19 pandemic shifted the landscape globally and influenced every aspect of our lives and the way the NHS operates, in response to these changes and the publication of the NHS People Plan, and People Promise we have we reviewed our strategy and recognised the need to strengthen our position on EDI to ensure it is aligned to the new national NHS equality agenda and will create a culture that is positive, compassionate, and inclusive.

We continue to be committed to the Portsmouth City Council Equality and Diversity strategy 2019-2022 and continue to promote Portsmouth as an employer of choice, providing all members of staff with a positive, inclusive work experience where they will feel valued and are given the opportunity to reach their full potential, ensuring that EDI is a focus. This will include strengthening the EDI training offer for managers and staff to increase awareness and provide knowledge, mentoring programmes, and making sure that employment and opportunities for promotion are accessible to everyone, policies and recruitment materials are representative and build upon the Beyond Boundaries positive action programme for ethnic minority.

To work towards intentional inclusion requires deliberate action in addressing individual needs so that inclusion is evident in all we do, this means; actively listening and engaging with staff, patients, and communities, doing more to seek the experience of those that are seldom heard in line with the ambitions set out in Working Towards Intentional Inclusion and NHS England and NHS Improvement's Equality Objectives for 2022/23.

We are committed to making sure that there is equality and inclusion in all that we do, but more specifically:

- How we commission services on behalf of the population we serve.
- How we recruit and support the development of all of our staff.
- How we proactively engage and support everyone who uses our services, especially given the diversity of our population.

Our work in embedding equality into the commissioning of health services is underpinned by regularly engaging with our stakeholders. We believe that engagement with, and drawing on the expertise of, patients, families, carers, residents, service providers and third sector organisations is critical and will ensure that the services we provide are of the highest quality, inclusive to everyone and will provide value for money satisfying the needs of our diverse population.

Embedding equality in the commissioning cycle
The ICB has a centralised view of projects and reporting that is co-ordinated by the Planning and Performance Team. All projects are set up on MS Teams. This includes a project plan which contains a risk register and list of steps to take to ensure good project governance. The process includes completion of and saving

completed Equality Impact Assessments (EIAs) on a project MS Teams Channel.

Monitoring contracts with NHS provider organisations
ICB contracts with provider organisations are monitored at monthly and quarterly clinical quality review meetings with representatives of each provider organisation. Monitoring of provider contracts includes equality metrics. The main providers contracted by the BCF are; Solent NHS Trust, Portsmouth Primary Care Alliance and South Central Ambulance Service NHS Foundation Trust.

Our Equality Objectives
Objective 1 - Ensure the ICB fully understands and fulfils its responsibilities for equality and diversity in order to become a nationally recognised leader on quality, diversity and inclusion. This includes timely Equality Impact Assessments (EIAs) whenever new projects, proposals or policies, commissioning and strategies are being developed.

Objective 2 - Work in partnership with local stakeholders and embed a multiagency approach to the delivery of healthcare services. Address health inequalities in differential access to services and worse health outcomes for identified groups and in localities. For example, the following initiatives seek to address health inequalities working with our statutory and voluntary and community sector partners:

- Our community mental health framework activity engages with residents from across diverse groups to ensure that mental health services such as Positive Minds, Talking Change and The Harbour are co-produced and reflect the needs of all those who might need to access them. A range of virtual discovery events have been held to get ideas on how best to work together and to discuss what matters most about community mental health service. Sessions have been held for people with lived experience, carers, VCSE organisations and various age groups with more targeted sessions to take place.

- Home care recruitment - campaign developed in partnership with care providers across the city using insight from their staff and clients. The focus of the campaign is to attract new talent to the industry, capitalising on how social care was seen through the pandemic to provide resilience to the vital domiciliary care sector as demand for care at home continues to grow.

- Multi-agency working on the COVID-19 vaccination programme to raise awareness, address concerns and maximised uptake of the vaccine. To address vaccine inequalities the delivery model has included a roving (bus) model, walk in clinics and pop-up clinics in community settings. It has been informed by insight work to understand vaccine hesitancy amongst young people. Engaging with trusted community voices and provided bespoke messaging based on feedback and a range of media have been used. There are also a number of clinics across Hampshire and the Isle of Wight to help patients suffering from Long Covid.

Objective 3 - Improve access to healthcare for everyone routinely and when they need medical help fast but it is not a life-threatening situation. Achieve year on year improvement in bringing primary, community and adult social care together with specialists from local hospitals and third sector organisations as a single extended primary care team.

We continue to work with our GP members and statutory and voluntary and community sector organisations to remove traditional boundaries between the different organisations that provide health and social care. For example, in their role to tackle neighbourhood health inequalities, we are supporting identification of equality leads for each Primary Care Network in the city and using a population health management approach to develop data and insights into particular populations experiencing inequalities, as well as community assets, to help design and develop interventions and inform engagement. This approach will be supported across Portsmouth and the HIOW region.

Objective 4 - Engage with diverse communities and consult with them when undertaking equality impact assessments and other commissioning activities. There will be a particular focus on groups and in localities that face specific inequalities in health and health outcomes. Our assessment of equality impact on our commissioning projects and plans includes consultation and engagement with patients and members of the public. Patient experience data also informs individual projects and plans. Our EIA template includes questions specifically aimed at addressing inequalities in health and health outcomes.

Objective 5 - Strengthen commissioning and partnership working so that the communities we serve feel informed and supported to be as involved as they wish to be in decisions about their care. We have worked with stakeholders to deliver programmes including a new Adult Social Care Strategy which places co-production, choice and control over care and working with the community at the heart of services for adults in Portsmouth. The Strategy includes the creation of a monthly co-production working group with colleagues across Hampshire and the Isle of Wight. We have also developed *Supporting carers* – an eight-week programme of activities for carers to help them get out and about again after lockdown, and

promotion of Employers for Carers - advice for employers on supporting staff who are carers.

Objective 6 - Work with all levels of staff to ensure the CCG has a representative and supported workforce and inclusive leadership. Build on current work to strengthen staff partnership arrangements.

Shared local outcomes, shared local leadership and aligned financial goals is the way we have been working in Portsmouth. The encouragement to invest in our joint workforce and build on our use of intelligence and technology to improve lives is welcome and we look forward to developing the place of Portsmouth as part of our Integrated Care System.

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Portsmouth

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,059,689	£2,059,689	£0
Minimum NHS Contribution	£16,814,564	£16,814,564	£0
iBCF	£8,616,489	£8,616,489	£0
Additional LA Contribution	£2,881,000	£2,881,000	£0
Additional ICB Contribution	£6,243,436	£6,243,436	£0
Total	**£36,615,178**	**£36,615,178**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£4,786,503
Planned spend	£10,513,564

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£7,030,477
Planned spend	£7,617,000

Scheme Types

Assistive Technologies and Equipment	£0	(0.0%)
Care Act Implementation Related Duties	£487,000	(1.3%)
Carers Services	£946,000	(2.6%)
Community Based Schemes	£8,190,000	(22.4%)
DFG Related Schemes	£2,059,689	(5.6%)
Enablers for Integration	£578,000	(1.6%)
High Impact Change Model for Managing Transfer of Care	£773,000	(2.1%)
Home Care or Domiciliary Care	£887,000	(2.4%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£4,519,000	(12.3%)
Bed based intermediate Care Services	£5,826,000	(15.9%)
Reablement in a persons own home	£4,350,000	(11.9%)

Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£273,000	(0.7%)
Residential Placements	£7,726,489	(21.1%)
Other	£0	(0.0%)
Total	**£36,615,178**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Indirectly standardised rate (ISR) of admissions per 100,000 population	435	397	494	417

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	95.5%	95.6%	95.5%	95.5%

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	622	537

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	86.9%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementing the BCF policy objectives	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

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

Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Subject:	GP Summit
Date of meeting:	21st September 2022
Report by:	Jo York, Managing Director - Portsmouth, HIOW ICB
Wards affected:	All

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1. Requested by: Gerald Vernon-Jackson, Leader of the Council

2. Purpose

2.1 To update the Health and Wellbeing Board on the GP Summit event hosted by the Leader of the Council in August.

3. Information Requested

3.1 On 4th August 2022, the Leader of the Council hosted a summit event in the civic offices, attended by a number of colleagues including from the authority, ICB, primary care, Portsmouth Hospitals University Trust, the University and Healthwatch. The purpose of the meeting was to openly explore some of the challenges facing the GP workforce in the city in particular, and think about possible solutions that partners could work together around. Some colleagues were unable to attend, but sent written submissions in advance of the discussion.

3.2 The conversation was very positive, and it was clear from the discussion that the situation in Portsmouth is a result of many factors, a number of which are not in our local control and which have been emergent for some time.

3.3 However, it was clear that there are some things that as a local partnership, could be done to help ease the pressures in the local system, and that the strong Health and Care Portsmouth partnership arrangements that we are fortunate to have in the city will help us achieve some of these.

3.4 There are already a number of workstreams in place to look at how access is improved for patients to the primary care services they need, and the session identified that one of the things we can start doing locally is providing more messaging to residents about the different professionals that can support them with their needs, so that there is wider awareness that people don't always need to see their GP, but will still have their care needs met

3.5 We noted that there are some difficulties with recruitment into the city and there were a range of ideas that emerged around how this could be tackled, including working with PHUT and also looking at how we can support GP trainees who come to Portsmouth and encourage them to continue their careers here.

3.6 The conversation also picked up the work that our University is doing to develop the medical school and support the wider professional workforce and there was great appetite to explore these possibilities, including around supervision which might free up valuable GP time. An invitation has been extended for the University to attend the Health and Wellbeing Board and highlight the developments and opportunity.

3.7 Finally, it was clear that we need to continue to advocate for the voice of primary care to be heard in the wider ICB, and to facilitate networks in the city to enable contributions to be made to their deliberations, and information to flow back out.

3.8 Work is underway to follow up on all of the issues above, and a further session will be scheduled to feedback progress and develop the conversation further.

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Signed by (Director)

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