



NOTICE OF MEETING

HEALTH & WELLBEING BOARD

WEDNESDAY, 23 SEPTEMBER 2026 AT 10.00 AM

**EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL,
PORTSMOUTH**

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

Health & Wellbeing Board Members

Councillors Matthew Winnington (Joint Chair), Nicholas Dorrington, Suzy Horton, Joe Standen and Mary Vallely

Dr Zaid Hirmiz (Joint Chair), Bernie Allen, Helen Atkinson, Roger Batterbury, Sarah Beattie, Andy Biddle, Natalie Brahma-Pearl, Jim Clarke, Sarah Daly, Penny Emerit, David Goosey, James Hill, Paul Markham, Gemma Nichols, Dr Jason Oakley, Suzanne Rankin, Lorna Reavley, Wendy Rees, Alex Rennie, Joanne Shankland, James Stuart, Clark West and Vacancy

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

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

A G E N D A

- 1 Apologies for absence**
- 2 Declarations of interest**
- 3 Minutes of previous meeting on 24 June 2026 (Pages 5 - 12)**

RECOMMENDED that the minutes of the meeting held on 24 June 2026 be approved as a correct record.

4 Ofsted Report - Children's Services

Verbal update

5 CQC Report - Adult Social Care

Verbal update

6 Portsmouth Safeguarding Adults Board: Annual Report 2025/2026
(Pages 13 - 36)

To provide an update on the recent work of the Portsmouth Safeguarding Adults Board (PSAB) in 2025-2026.

7 Director of Public Health Annual Report (Pages 37 - 98)

To note that the Director of Public Health is publishing her statutory Annual Report for 2026.

8 Complex Needs Intervention (Pages 99 - 106)

To provide an update on the Complex Needs Intervention, which is currently nearing the completion of its Roll-In phase, and to seek continued support from the Health and Wellbeing Board.

9 Tackling poverty in Portsmouth update (Pages 107 - 152)

1. To provide information on the current picture of poverty in Portsmouth, continued cost of living pressures, and local welfare support funding.
2. To provide an update to the Board on the tackling poverty priority area of the Health and Wellbeing Strategy and delivery against the Tackling Poverty Action Plan (Appendix 1) as informed by the Public Health Annual Report 2023.

10 Community Safety update (Pages 153 - 250)

To provide an update on the work of the Community Safety focused sub-group of the Health & Wellbeing Board.

11 Approval of the Portsmouth Neighbourhood Health Strategic Plan 2026-2029 (Pages 251 - 448)

To present the Portsmouth Neighbourhood Health Strategic Plan 2026–2029 and seek Health and Wellbeing Board approval of the strategic framework for

neighbourhood health across Portsmouth.

RECOMMENDED that the Health and Wellbeing Board

1. Approve the Portsmouth Neighbourhood Health Strategic Plan 2026–2029, attached at Appendix 1, including:
 - the seven Neighbourhood Health Areas set out within the Plan as the common population geographies for neighbourhood health planning in Portsmouth
 - the initial priorities identified for each of the Neighbourhood Health Areas.
2. Agree the proposed approach to neighbourhood delivery, comprising the neighbourhood organising function, community connection layer and delivery through existing provider and professional arrangements.
3. Confirm that implementation will continue through existing Portsmouth partnership and statutory governance, with Health and Care Portsmouth providing Place leadership and oversight and P3 coordinating neighbourhood delivery, while individual organisations retain their statutory and formal decision-making responsibilities.

12 Integrated Care Partnership Joint Committee update (Pages 449 - 452)

To update the Health and Wellbeing Board on the Integrated Care Partnership Joint Committee Meetings and the ICP Assemblies.

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Agenda Item 3

MEETING of the Health and Wellbeing Board on Wednesday, 24 June 2026 at 10.00 am in the Executive Meeting Room, Guildhall, Portsmouth

Present

Councillor Matthew Winnington, Cabinet Member for Community Wellbeing, Health & Care (Co-chair)

Councillor Nick Dorrington, Cabinet Member for Children, Families & Education

Councillor Joe Standen, Reform UK group

Bernie Allen, Hampshire & Isle of Wight (HIOW) Integrated Care Board (Co-chair)

Helen Atkinson, Director of Public Health, PCC

Roger Batterbury, Healthwatch Portsmouth

Andy Biddle, Director of Adult Social Care PCC

Ian Chalcraft, Associate Director, HIOW Healthcare NHS Foundation Trust

Sarah Daly, Director of Children, Families & Education

Karen Dawes, Office of Police & Crime Commissioner

Zaid Hirmiz, Deputy Chief Medical Officer, NHS HIOW ICB

James Hill, Director of Housing, Neighbourhoods & Building Services

Nikki Jones, Portsmouth Creates

Heather Mitchell, Director of Population Health Equity, HIOW Healthcare

Dr Jason Oakley, University of Portsmouth

Lorna Reavley, The Hive

Ron Shields, Chief Executive, HIOW Health Care

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

Councillor Matthew Winnington, Cabinet Member for Community Wellbeing, Health & Care, opened the meeting. On behalf of the Board he thanked Dr Linda Collie for her contribution as co-chair for many years, and welcomed Bernie Allen, Partnerships Director Portsmouth, Health & Care Portsmouth, as the new interim co-chair. He also thanked Dianne Sherlock of Age UK for her contribution and welcomed Clark West as their new representative; Councillor Joe Standen as the new Reform UK group representative and thanked Councillor Chris Dike, the previous representative, for his contribution; Councillor Suzy Horton, who was now representing the Leader of the council, Councillor Steve Pitt, and thanked him for his contribution.

Apologies for absence were received from Councillor Suzy Horton, Councillor Mary Vallely, Natalie Brahma-Pearl (PCC), Sarah Beattie (Probation Service), Stuart Collett (HIOW Healthcare NHS Foundation Trust), Paul Edwards (Probation Service), David Goosey (Portsmouth Safeguarding Adult Board), James Hill (PCC), Superintendent Paul Markham (Hampshire Police), Gemma Nichols (Portsmouth Creates, represented by Nikki Jones), Alex Rennie (Office of Police & Crime Commissioner, represented by Karen Dawes), Joanne Shankland (City of Portsmouth College).

14. Declarations of Interests (AI 2)

Councillor Winnington declared an interest as he worked for Action Hampshire who had contracts with the Integrated Care Board (ICB).

15. Minutes of previous meeting – 4 March 2026 (AI 3)

RESOLVED that the minutes of the Health and Wellbeing Board held on 4 March 2026 be approved as a correct record.

16. Reforms across Children, Families and Education (AI 4)

Officers from Children, Families & Education (CFE) gave an update on Portsmouth's response to the 2026 children's reforms agenda and highlighted key points. Local Government Reorganisation meant that that considerable work was needed in the next 18 months to deliver CFE's various functions. The multi-agency-working supporting these reforms could only be done by working in partnership.

Hayden Ginns, Assistant Director, outlined the key priorities and strategies along with the three big drivers (trauma, speech and language, neurodiversity), which if addressed early would have a better chance of improving children's lives. The cross-cutting theme of restorative and relational practice linked to one of the Health & Wellbeing Strategy's priorities. He drew attention to BSIL (Best Start in Life Strategy) which had not been to the Health & Wellbeing Board (HWB) before. CFE had met the deadline of 31 March 2026 to publish a strategy to improve developmental outcomes for children between conception and age five. CFE had been set the incredibly tough target of 74.2% children with a good level of development at age five (it had currently achieved 65.5%) but it would improve lifelong outcomes. Partners were working together on how to meet the target with the five Family Hubs co-ordinating support. In neighbourhood health there were lots of conversations on sleep as pathways were not as effective as they could be and ADHD. Portsmouth did good work on autism but there is currently a five-year wait for ADHD diagnosis and support.

Sam Bushby, Deputy Director, Children & Families, noted many government reforms were ones CFE wanted to make anyway. Encouraging support for families support would be at the heart of everything CFE did. The cost of external care placements was a challenge so CFE wanted to ensure better choice as care was best when it was local. Key points were that over the summer CFE would bring together targeted early help and Tier 4 services so there was greater continuity for families. Meeting needs earlier on meant fewer statutory interventions. CFE was doubling the number of Adult Safeguarding workers to support parental need and enable them to better meet the needs of their children. It was looking to strengthen the multi-agency response where risk was outside the home. A dedicated team of practitioners for children with disabilities would start at the end of July. There would be intensive support to help children stay at home, starting from before babies were born. A Support Hub was starting in the autumn to support partners like schools so they could support families. There was significant investment in the therapeutic fostering hub. Work with care experienced young people included leasing and staffing the council's own properties so they could be "tenancy ready" with their own accommodation by age 21. The Youth Justice White Paper had only been published last month but there was a commitment to improving education and a possible move away from institutions like Feltham to smaller units for secure accommodation. The aim was to see children as children first through a trauma-informed lens.

Nathan Caine, Deputy Director, Education, said since the last SEN reforms in 2014 there had been a whole range of unexpected demands on the SEND (special educational needs and disabilities) system. The current system was not fit for the range of needs and the cost of delivery with some LA budgets running at hundreds of millions over their allocations. CFE had had the opportunity to test early thinking of SEND reforms to see what was missing, particularly around early intervention and mainstream inclusion. There had been a significant shift in children with SEND educated away from their local school so CFE welcomed the drive for them to attend local schools with their peers rather than special schools. However, schools needed more investment on two fronts to do this. Investment of £1.6bn was going directly to schools from the Mainstream Inclusion Fund as well as £1.8bn nationally for centrally commissioned "Experts at hand". There was also significant capital investment in inclusion centres. CFE would be running two SEN systems (2014 Act and testing the new system). There was a strong focus on early intervention and much more on coherent policy at national level. Non-statutory inclusion plans would be the same across LAs. CFE needed conversations with the DfE on the proposed school partnerships; schools were keen on local partnerships and sharing resources. The change was happening in advance of legislation and there was the opportunity for consultation.

In response to questions as to how the three big drivers wove through all parts of the plan, officers said they had a strategic home. Neurodiversity was in the SEND strategy; ADHD was moving up the agenda. Speech and language was in BSIL as it was recognised that communication problems affected development. There was an anomaly nationally in that health visitor developmental checks did not align with what nurseries did so it was recognised that work needed to be done. All eight strategies showed the importance of trauma, the response to it and how to develop trauma informed practice. With the strategic approach the drivers could be seen in all work within Children's Social Care.

Healthwatch's report on children and young people and mental health, which was going to the Social, Emotional & Mental Health Board for consideration, highlighted the importance of a single point of access.

Helen Atkinson noted how everyone worked fantastically in partnership; public health felt part of the work with HIOW Healthcare NHS Trust and the ICB. The Department of Health & Social Care (DHSC) had recently done a deep dive in Portsmouth and Southampton as they were sadly seen as the worst performing in the south east for developmental checks. Portsmouth had improved in three months and received a thank you letter from the DHSC, Regional Director of Public Health and the Regional Director of Nursing. It was successful as teams had a "can do, will do" approach to improving. Steve Farrow's (from the NHS Trust) data analysis on missed checks exemplified the success of partnership working.

Councillor Winnington thanked officers for the in-depth report.

RESOLVED that the Health & Wellbeing Board note the report.

17. Nature Positive Portsmouth (AI 5)

Kelly Nash, Corporate Strategy Manager, introduced the report. Nature Positive Portsmouth was funded by the National Lottery Heritage Fund. The project's real benefits were in partnerships, including Southern Water and the University. Work under the university banner was very applicable and had wider benefits as the city moved towards different projects. Felicity Harris, Strategic Lead for Climate Resilience & Natural Environment, was holding an event on developing stronger, connected natural health infrastructure on Tuesday 6 October, which was open to the HWB. After the meeting a link was circulated with a short video.

The HWB agreed that the current heatwave showed why the project was so critical. Councillor Winnington thanked officers for the report and noted the SUDS (Sustainable Urban Drainage Schemes) and Southern Water's new reservoir showed the importance of not wasting water.

RESOLVED that the Health & Wellbeing Board note the report.

18. Community Safety update (AI 6)

Caroline Bell, Corporate Projects Manager, introduced the report on behalf of Superintendent Paul Markham. Although Portsmouth was not high up the order for knife crime it was one out of 27 areas nationally to receive funding under the Knife Crime Concentration Fund, which had replaced the ASB Hotspot Action Fund. Officers were working with the Violent Crime Taskforce to decide where to work, perhaps in the city centre or areas of Southsea. Mentors in Violence Prevention has been offered to schools as part of addressing violence against women and girls. Planning has already started for White Ribbon Day; this year's campaign was "It takes all of us." As part of a pan-Hampshire offer the Hampton Trust has delivered services for perpetrators of domestic abuse since April. The Safe and Connected Community Task and Finish Group gave people resources to have grassroots discussions. It had highlighted a gap for spaces to bring different groups together for dialogue. Credit was due to Sam Graves and her team for the biannual Community Safety survey; the council would be listening to insights from the survey. A more in-depth report would return to the HWB in the autumn. A number of partners had responded to the call for evidence as part of the review of police force structures though it was not due to happen until 2029. In view of the amount of public service reform happening now the HWB, as a stakeholder and statutory group, was asked how they saw delivery of community safety.

Andy Biddle said the work with the Community Safety sub-group was the "glue in the community". He recommended the resources on the White Ribbon website and encouraged the HWB to be mindful of increased domestic violence during the World Cup. Lorna Reavley said the Hive was aware that parts of the VCSE, especially Urbond, did a lot of work on community cohesion so they should be involved in the conversation. Portsmouth Mediation focused on restorative practice.

Councillor Winnington thanked officers for the report and asked them to pass on thanks to the sub-group.

RESOLVED that the Health & Wellbeing Board note the report.

19. Complex Needs Intervention update (AI 7)

Dave Adams, Lead Interventionist, introduced the report, and outlined progress since last summer's report. He put on record thanks to those involved (a "coalition of the willing") as it was a big commitment. The intervention involved nine different services and was nearing the end of its second stage. Phase 1 (Check) studied how the system responded when someone presented with multiple issues. The main finding had been the referral culture with clients often assessed multiple times and still not receiving appropriate support. Clients were treated in silos rather than holistically so that even if someone homeless was offered accommodation they might lose it if they had no support with their other needs. Phase 2 (Redesign) has been very effective so far in helping people supported by the pilot team to need fewer acute services. There would be a presentation of the findings next month with in-depth case studies, costs and performance data.

In response to questions, officers said clients were asked two sets of questions: what have your experiences been and what would you like it to be? The main responses were being heard, telling their story once and treated as a person, not a problem. The system looked different to officers but the crucial point was how it felt to clients. Kelly Nash said the amazing work reinforced the Health & Wellbeing Strategy's work on relationships. Moving forward the lessons banked defined how the HWB in Portsmouth worked.

Councillor Winnington thanked officers for the report. He and Councillor Darren Sanders (Cabinet Member for Housing & Tackling Homelessness) were the main Cabinet sponsors for the intervention so he paid tribute to the team for their work, particularly data sharing, which had been extraordinarily difficult, but had made it possible. Helen Atkinson thanked Mr Adams, Alan Knobel (Public Health Principal) and the team. It was a good example of work not just about neighbourhoods but specific targeted cohorts. There were so many priorities with teams under huge pressure from government targets so if it was decided to work differently it would be a "bigger ask". Mr Adams said much had been learnt during the experimental pilot model. To be sustainable in the future services would need to think long and hard as the model would have to stand up in the longer term.

Councillor Winnington recommended attending the presentation. Everyone should try to make the model work as it saved money, time and effort. There could be benefits for other areas like the prison system or hospitals. In the end making differences to people's lives was what mattered.

RESOLVED that the Health & Wellbeing Board note the report.

20. Health & Wellbeing Boards and neighbourhood health (detailed proposals) (AI 8)

Bernie Allen, Partnerships Director Portsmouth, Health & Care Portsmouth, NHS Hampshire & Isle of Wight and Programme Lead for the National Neighbourhood Health Integration Programme (NNHIP), introduced the report. National policy had caught up with Portsmouth; a key element for the HWB was that it was explicitly positioned as place based leaders for neighbourhood health planning. It was particularly relevant to the HWB as it was already starting from a

strong position. Neighbourhood health was judged on how outcomes improved; commissioning arrangements should support not drive. Key commissioners recognised the role of local authorities in areas like housing. There would be significant ground work ahead of work in September to bring neighbourhood plans to the HWB for approval. Community engagement done by the Hive would define six to seven health neighbourhoods. They were working on a proportionate evidence framework with the existing priorities as the blueprint and incorporating existing work. The NNHIP was six months into implementation with Portsea and Paulsgrove targeted first; the emphasis was on meeting people and not shiny new buildings. Ms Allen asked that the HWB agree to maintain the momentum until the more substantial update in September.

Lorna Reavley noted that the proposed help desk at QA Hospital was not open yet but it was hoped it would operate from September. Recruitment was taking place and there were discussions with QA on where to house it.

Councillor Winnington thanked officers for the very comprehensive report. Although the Spark was near Fratton Park but it was a community centre for everyone in Portsmouth. Portsea and Paulsgrove had particular needs and learning from the pilots could be shared elsewhere.

RESOLVED that the Health & Wellbeing Board

- 1. Note the current national context for neighbourhood health planning, including the publication of national neighbourhood health policy and “next steps” instructions (March/April 2026), and the implications this has for local planning and sequencing.**
- 2. Note progress to date in Portsmouth towards integrated neighbourhood health planning since March 2026, including neighbourhood engagement activity, development of an outcomes and evidence base approach, alignment of place priorities, and progress on enabling workstreams (NNHIP, BCF alignment, NHC pipeline and INT development).**
- 3. Agree the continued interim approach for Portsmouth through 2026/27, recognising that finalisation of neighbourhood geographies, locally-defined outcomes/measures and the draft neighbourhood health plan package will be brought back as part of the planned September HWB report.**
- 4. Confirm that, under existing delegations, the Health and Care Partnership will continue to coordinate work on behalf of the HWB, working with established place-based partnerships including the Portsmouth Provider Partnership (P3), and will bring a further report to the HWB in September 2026 setting out the next stage of neighbourhood health proposals for Portsmouth.**

21. Better Care Fund Framework 2026-2027 update (AI 9)

Bernie Allen, Partnerships Director Portsmouth, Health & Care Portsmouth, NHS HIOW and Programme Lead for the NNHIP, introduced the report. Although about £53m was invested it was for aligning existing mechanisms and delivering statutory functions and could not be distributed at will. 2026/2027 was a transition year with a continued focus on measurable improvement and less reliance on professional services. The schemes listed in the appendix formed

the basis of the application submitted to NHS England; some of the funding was aligned into neighbourhood health.

Councillor Winnington thanked officers for the report. As Portsmouth was likely to be part of a larger authority its ways of working could be used as an example. Relationships should be maintained and not get diluted. He thanked the BCF as it worked incredibly hard with NHS partners for the people of Portsmouth.

RESOLVED that the Health & Wellbeing Board

- 1. Note the role of the Better Care Fund as a key mechanism for integrated working between the NHS and Local Authority, supporting improved population outcomes system flow and efficiency.**
- 2. Note the 2026/27 BCF as a transition year towards a more outcomes-focused model, with an increased emphasis on delivery against national metrics and demonstratable improvement.**
- 3. Endorse the use of Chair's Action to approve the submission of the 2026/27 Better Care Fund Plan to NHS England on behalf of the Board, in order to meet national reporting deadlines.**
- 4. Approve the deployment of the Portsmouth Better Care Fund pooled budget (£53 million) through the detailed schemes set out in Appendix 1, supporting prevention, hospital discharge, recovery, and long-term independence for Portsmouth residents.**
- 5. Note that BCF-funded schemes are subject to in-year monitoring of finance, activity and outcomes, with performance reviewed through partnership governance arrangements and issues escalated where delivery is not on trajectory.**

22. Integrated Care Partnership (ICP) update (AI 10)

Matt Johnstone, Head of Strategy, ICB, introduced the report. The main update from the recent ICP Joint Committee was that all partners felt there was a real benefit to it. Despite patchy ICB membership and attendance there was renewed commitment to work closer with the ICP. It was a question of how to share messages between the ICP, the ICB and the joint committees. There was an opportunity to consider the connection between the HWB and the ICP and align them. The ICP's priorities on neighbourhood working understood that there was a real local element such as what Portsmouth did well and what were the opportunities for delivery at scale. The ICP's assemblies attracted about 80 people. The theme of the next one on 8 July was anchor employers supporting people into meaningful work. Large employers had a role not only in supporting people with health needs in their own organisations but in supporting other organisations get people into and stay in work. For example, people with musculoskeletal conditions and mental health could struggle to get employment so the NHS as an anchor employer had a responsibility to get them into employment.

Sarah Daly was not aware of the next assembly but it was relevant in view of NEETS (not in education, employment or training). As to how events were publicised, Mr Johnstone said the ICP could provide regular updates on its assemblies and joint committees. The Chair asked the ICP to promote events through all the HWBs. Events could also be communicated through Health & Care Portsmouth, Portsmouth Provider Partnership and delivery groups.

As a member of the ICP Helen Atkinson apologised that Sarah Daly did not know about the assembly. She asked how organisations dealt with system and place so effort was not duplicated. The HWB was a statutory board with clear functions. The ICP was now not statutory so was the perfect place to bring system leaders together. She asked how the ICP and the new Combined Authority would communicate effectively with the HWBs, who were all different, and to use system leadership. Some organisations used the system to dabble in place. Mr Johnstone agreed and asked how the two-way communication between the HWB and the ICP could flow better. Learning from what was done well and what could be used at scale could go to the ICP; system-wide discussions could be brought back to the HWB. It was always a challenge between place and system.

Councillor Winnington noted how powerful examples were. The HWBs across HIOW could learn from each other. At its core the ICP was a joint committee of the four HWBs. There was discussion about opening up the ICP more. Big businesses could be included to help them support employees with physical and mental health. The HWB would keep the ICB's assemblies up to date.

RESOLVED that the Health & Wellbeing Board note the report.

23. Proposed dates for 2027 meetings (AI 11)

The HWB agreed the dates of meetings in 2027 as 10 March, 23 June, 22 September, 8 December (all Wednesdays at 10 am). The remaining dates in 2026 are 23 September and 9 December.

24. Any other business

Councillor Winnington thanked Ron Shields and wished him the best as it was his last meeting today. He had been fantastic and engaged. Mr Shields noted that from his experience of other HWBs there was always tension between place and system. In Portsmouth's HWB the clarity of focus, the clear commitment and passion of officers, and breadth of the agenda came through item after item, which he did not always see with other HWBs. It had been a pleasure to work the HWB.

The HWB congratulated Helen Atkinson for being awarded the MBE for services to public health in the King's Birthday Honours.

The meeting concluded at 11.41 am.

Councillor Matthew Winnington and Bernie Allen (Chair)

Agenda Item 6

Official

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:	Portsmouth Safeguarding Adults Board: Annual Report 2025-26
Date of meeting:	23 September 2026
Report by:	Portsmouth Safeguarding Adults Board Independent Chair
Wards affected:	All

1. **Requested by** Portsmouth Safeguarding Adults Board Independent Chair
2. **Purpose**
 - 2.1 To provide an update on the recent work of the Portsmouth Safeguarding Adults Board (PSAB) in 2025-26.
3. **Information Requested**
 - 3.1 The Care Act 2014 requires Safeguarding Adults Boards to publish a report on their activities each year (Appendix A).
 - 3.2 The PSAB's strategic priorities are:
 1. Hear and champion the voice of the service user and front-line practitioners
 2. Challenge stigma, marginalisation and unconscious bias
 3. Ensure safeguarding practice is done well across agencies and between agencies
 4. Support the effective identification, assessment and coordinated management of risk.
 - 3.3 Key achievements in the year included:
 - Continuing to develop the programme of community group visits.
 - Revising our Learning and Development Guidance for Safeguarding Adults and starting a piece of work to look at how our partners measure and report to the PSAB on their safeguarding training.
 - Reviewing the Safeguarding Concerns Guidance and associated Multi-Agency Tools and holding a Spotlight on Safeguarding Concerns learning event.
 - Holding an adult safeguarding conference focussing on legal literacy in relation to the Mental Capacity Act and Mental Health Act.



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)

- Setting up a new Multi-Agency Risk Management Framework (MARM) Champions Network to bring together staff with expertise in the MARM framework and support them to provide advice, guidance, and shadowing opportunities for others.
- Published new Multi-Agency Domestic Abuse Guidance and a new Domestic Abuse Awareness Animation.
- Carried out our annual multi-agency audit on the quality of safeguarding referrals submitted to the local authority adult safeguarding team and the quality of decision-making about these referrals.
- Looked in detail at data on Neglect and Acts of Omission, which is the most common type of abuse or neglect in safeguarding concerns raised in Portsmouth.

3.4 The Care Act 2014 states that a Safeguarding Adults Review (SAR) must take place when there is reasonable cause for concern about how the Safeguarding Adults Board, members of it, or others, worked together to safeguard an adult with care and support needs, and death or serious harm arose from abuse or neglect. The Care Act also gives Safeguarding Adults Boards the discretionary power to review cases where these criteria are not met.

3.5 The Board published one Safeguarding Adults Review in 2025-26: 'Anne', the findings of which are outlined in the full report. The Board accepted the findings of the review and developed a multi-agency action plan to address the recommendations. The plan is being monitored by the quality assurance subgroup.

3.6 There were 21 new SAR referrals received in 2025-26. A SAR has been commissioned for one of these cases and the review will be published in 2026-27. The Board continued to work on two further SARs relating to individuals, and a thematic SAR relating to several cases where self-neglect in the person's own home was considered to have been a factor in their death. The remaining cases referred did not meet the criteria for a mandatory SAR, and it was not considered that a discretionary SAR was required.

.....
Signed by (Director)

Appendices:

Appendix A: PSAB Annual Report 2025-26

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

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

Title of document	Location

Portsmouth Safeguarding Adults Board Annual Report



2025 - 2026

Statement from the Independent Chair



It is again a privilege to present the Portsmouth Safeguarding Adults Board (PSAB) Annual Report for 2025 to 2026. This report reflects the continued commitment of partners across our city to make Portsmouth a place where adults at risk of harm are safe, supported and empowered.

This year the Board has continued to work against the four priorities in our Strategic Plan for 2023 to 2028. We have made progress on hearing the voices of people with lived experience and frontline practitioners, on challenging stigma and bias, on strengthening multi-agency practice and on improving how risk is identified and managed. This report sets out what we have done in each of these areas but more still needs to be done to improve safeguarding overall.

A central part of the Board's work this year has been learning from the Anne Safeguarding Adults Review, published in September 2025. Anne was an 82-year-old woman living with vascular dementia who was cared for by her partner. Her case raised important questions about the value of understanding a person's background, the difficulty of assessing coercion and control within a caring relationship and the need for better information sharing between agencies. The Board accepted the findings and has developed a multi-agency action plan, including work on dementia awareness, advocacy and support for unpaid carers.

We have also continued to strengthen how the partnership manages risk which does not meet the criteria for statutory safeguarding. The new Multi-Agency Risk Management (MARM) Champions Network held its first meeting in June 2025 and has grown to more than thirty champions across agencies including the police, health, housing and social care. Their work is already improving how MARM meetings run and how confident practitioners feel in using the framework.

Our Engagement Subgroup visited nine community groups during the year, including Solent Mind, the Paulsgrove Men's Group and the Veterans Outreach Support group. These visits continue to show us that while many residents recognise abuse and neglect when they see it, awareness of how to raise a safeguarding concern remains low. This tells us that safeguarding must be rooted in communities as well as professional practice.

In September 2025 the Board held its annual conference on the interface between the Mental Capacity Act and the Mental Health Act. Well over one hundred people attended from across the partnership and the feedback was very positive.

None of this work happens without the dedication of colleagues across health, social care, housing, the police and the voluntary sector. I want to thank everyone who has contributed to the Board's work this year. Safeguarding depends on people willing to collaborate, reflect and act with compassion, and Portsmouth continues to be fortunate in that regard.

As we look ahead, the lessons from Anne and the voices we have heard from communities across the city remind us that safeguarding is not an abstract process. It is a matter of dignity, safety and human rights for every adult in Portsmouth.

David Goosey
Independent Chair

Our vision

"Working throughout the city with our communities and other partnerships to make Portsmouth a city where adults at risk of harm are safe and empowered to make their own decisions and where safeguarding is everyone's business."

Our strategic priorities

We continued to work on the strategic priorities within our [Strategic Plan for 2023-28](#) and on delivering the actions we had identified for 2025-27.

The PSAB's strategic priorities are:

1. Hear and champion the voice of the service user and front-line practitioners
2. Challenge stigma, marginalisation and unconscious bias
3. Ensure safeguarding practice is done well across agencies and between agencies
4. Support the effective identification, assessment and coordinated management of risk

We have made progress in relation to these priorities by:

- **Continuing to develop the programme of community group visits.** The visits have been used to find out what our communities understand about adult safeguarding, their experiences of abuse or neglect, and to raise awareness.
- **Asking partner agencies to review their mechanisms for seeking feedback** from people who have needed safeguarding.
- **Reviewing data** to help us to understand how well staff take a **family approach** to safeguarding.
- **Revising our [Learning and Development Guidance for Safeguarding Adults](#)** and starting a piece of work to look at how our partners measure and report to the PSAB on their safeguarding training.
- **Starting to review the [Multi-Agency Framework for Managing Risk and Safeguarding People Moving into Adulthood](#).** As part of this review we carried out a staff survey to find out well the framework is working in practice. 31 staff from Portsmouth responded to the survey, with the findings providing a good level of assurance about the framework. Of those who had used it, 80% reported that it was useful.
- **Reviewing the [Safeguarding Concerns Guidance](#) and associated [Multi-Agency Tools](#)** to give staff clear and concise guidance on when to raise a safeguarding concern, when to take other appropriate action, and when to seek further advice. The tools include the types of abuse or neglect listed in the Care and Support Statutory Guidance, as well as contexts such as substance use and homelessness that staff often find challenging.
- **Holding a Spotlight on Safeguarding Concerns learning event** to launch the new guidance, including sessions on the Anne Safeguarding Adults

Review, Domestic Abuse, Homelessness, Pressure Ulcers, Falls, Suicide/Self-Harm, and Medication Incidents.

- **Holding an adult safeguarding conference focussing on legal literacy in relation to the Mental Capacity Act and Mental Health Act**, which brought frontline professionals from different organisations together (see conference report on page 10).
- **Setting up a new Multi-Agency Risk Management Framework (MARM) Champions Network** to bring together staff with expertise in the MARM framework and support them to provide advice, guidance, and shadowing opportunities for others.
- **Commissioning additional MARM training**, including specialist training for Chairs and for Minute-takers.
- **Improving MARM templates** including minutes templates, checklists for chairs, and risk assessments.

MARM Champions Network

The MARM Champions Network for Portsmouth held its first meeting in June 2025,

The Multi-Agency Risk Management (MARM) Framework can be used for adults where there is a high level of risk and where a multi-agency approach would be beneficial, but where the Care Act criteria for a statutory safeguarding enquiry are not met. Learning from Safeguarding Adults Reviews told us that MARM is not being used as widely as it could be, and that often practitioners do not feel confident in using MARM, which is why this network of MARM Champions was set up.

The network has grown to over 30 MARM Champions from different organisations (including Two Saints, Society of St James, Adult Mental Health, Housing Needs Advice and Support, Adult Social Care, Children's Social Care, Police, Stop Domestic Abuse). The MARM Champions are a point of contact to share expertise and updates about MARM, offer shadowing opportunities, share examples of good practice, and provide feedback on learning about MARMs.

Their work so far has included working with adults who have been subject to MARM to review the MARM meeting templates to ensure they support good practice, developing a risk management checklist, and compiling a contact list to make it easier to contact agencies to invite them to a MARM meeting. Each meeting of the network also includes a case study for discussion to highlight good practice in MARM and the positive outcomes that can be achieved by using the framework (see below for an example).

Community group visits programme

The Engagement subgroup visited nine community groups and services during 2025–26, engaging with a broad range of communities, including people accessing mental health support, housing and homelessness services, community associations, veterans' services, and adult education programmes. This included visits to groups such as Solent Mind, the Paulsgrove Men's Group, residents supported by the Society of St James (SSJ), and the Veterans Outreach Support (VOS) group. The visits provided opportunities to raise awareness of adult safeguarding, promote understanding of how to report concerns, and gather feedback on people's experiences of safety, support and local services. The insights gained will help the Board shape future engagement activity and ensure safeguarding messages reach a diverse range of communities across Portsmouth.

Other key achievements in 2025-26

This year, the Board has:

- Published new [Multi-Agency Domestic Abuse Guidance](#) and new [Exploitation and Cuckooing Guidance](#).
- Refreshed the [Multi-Agency Pressure Ulcer Guidance](#), which now includes a flowchart and decision tool, as well as leaflets for patients and carers. We also reviewed and revised the [Multi-Agency Protocol for Falls and Adult Safeguarding](#).
- Published a new [Domestic Abuse Awareness Animation](#). This short, impactful video was originally developed by Bromley Safeguarding Adults Board and has been co-produced with input from local services and individuals with lived experience. It has been adapted for use across our region to raise awareness of domestic abuse, help people recognise the signs, and encourage access to support.
- Published updated versions of our [One Minute Guide to Advocacy](#) and our [One Minute Guide to Care and Support Needs](#). These were updated in response to learning from the ['Anne' Safeguarding Adults Review](#) and the ['Ms K' Safeguarding Adults Review](#).
- Created a new [Pregnancy Plans short guide](#) to support informed, person-centred conversations about pregnancy planning and prevention for people of all genders. This guide was developed in response to the learning from the [Ms K SAR](#), where there was learning that opportunities had been missed to engage with Ms K about her pregnancy plans.
- Published new learning resources for staff on [Cuckooing](#).
- Created a [Modern Slavery toolkit](#) to support professionals working with children, adults and families affected by modern slavery. We also held three learning events to support the launch of the toolkit.

- Carried out our annual **multi-agency audit** on the quality of safeguarding referrals submitted to the local authority adult safeguarding team and the quality of decision-making about these referrals.
- **Looked in detail at data on Neglect and Acts of Omission**, which is the most common type of abuse or neglect in safeguarding concerns raised in Portsmouth. We identified some further areas to work on as a result of this work, including hospital discharge and some assurance work on pressure ulcers and safeguarding, planned for 2026-27.
- **Reviewed data on referrals to the Carers Centre** for Carers Assessments.
- **Asked agencies to present a summary of inspection or internal audit findings relevant to the PSAB's strategic priorities** to the Quality Assurance subgroup.
- **Reviewed the findings from the [Second National Analysis of Safeguarding Adults Reviews](#)** to identify any learning for Portsmouth, and developed an action plan.
- Supported **National Safeguarding Adults Week 2025**. Working jointly with the other 4LSABs and the national campaign delivered by Ann Craft Trust, the PSAB developed and promoted resources on a different key topic each day using our website and social media. We also promoted a programme of learning sessions throughout the week on topics such as Multi-Agency Risk Management, Fire Safety in the Home, and Windows of Opportunity.
- **Attended the Moving Forward flagship annual event** for individuals with learning disabilities and special educational needs (SEND). The PSAB team provided interactive and engaging safeguarding-related activities, helping to prompt discussion with attendees.
- **Supported Portsmouth City Council's Adult Social Care department with their Care Quality Commission inspection** process, including collating information about the PSAB and speaking to inspectors. The outcome of the inspection is expected in 2026-27.
- **Supported the development of a new national training package being created by HM Probation and Prison Service**. This course will be a requirement for thousands of Probation practitioners across the country.
- **Recruited a new part-time member of staff** to focus on PSAB's priority areas of community engagement, communications, and training.
- **Considered the findings of the NHS England Health and Justice South East 'Locked Out': Justice Housing Pathway review report** about homelessness experienced by people released from prison, and the actions being taken in Portsmouth to address the findings.
- **Worked with Housing partners** through our Housing subgroup, on suicide prevention, Community Partnership Information sharing, awareness of the Prevent programme (an early intervention programme to stop people becoming involved in terrorism), and a glossary to support understanding of different roles and responsibilities within housing.



The Moving Forward 2026 event, held at City of Portsmouth College, is an annual information and engagement event for young people with learning disabilities and special educational needs and disabilities (SEND), as well as their families, carers and supporting professionals. With more than 500 booked attendees and additional walk-in visitors, the event provides access to advice, support and local services to help people plan for adulthood and greater independence. The Portsmouth Safeguarding Adults Board supported the event with an interactive stand featuring Easy Read safeguarding resources on the 10 types of abuse. Through a matching activity using images and statements, delivered 35 times throughout the day, attendees were encouraged to discuss safeguarding, ask questions and build their understanding of abuse in an accessible and engaging way.

MARM case study

Client X is a 52-year-old individual with a long history of alcohol dependency and substance use. They live alone in social housing and have problems with cognitive impairment, poor memory, and significant physical health issues, including liver disease and fractures sustained in a road traffic accident. Their home environment was cluttered, posing fire and falls risks, and there was a history of exploitation and self-neglect.

A support worker built trust with Client X over a period of months and supported them to re-engage with health services. Client X was injured while out in the community, which escalated concerns about their vulnerability. A multi-agency meeting was convened under the MARM framework to manage risks collaboratively.

As a result, a property clearance and deep clean were arranged with the housing officer to reduce environmental hazards. Client X was supported to access alcohol detoxification, followed by a ten-week stay in a care home to assess their cognitive functioning while they were not using alcohol. During this period, a mental health assessment was completed, leading to a referral for talking therapies.

Additionally, Client X was referred to sheltered accommodation to ensure a safer and more supportive living environment. The MARM was used successfully to coordinate a multi-agency response which included the Recovery Hub, Fire Service, Housing, and Pharmacy to address Client X's health, safety, and engagement needs. Client X demonstrated progress in maintaining sobriety during the care home stay and is now positioned to benefit from ongoing therapeutic input and a stable living environment.

The work of Board partners in 2025-26 has developed adult safeguarding in Portsmouth and supported our priorities. Here are some examples:

Complex Needs Intervention

People experiencing severe multiple disadvantage or having 'complex needs' means living with several overlapping issues; which for many have been shaped by life-long experiences of poverty, deprivation, trauma, and abuse. Many of the PSAB's Safeguarding Adults Reviews have explored the factors leading to the deaths of adults with complex needs.

In response, Portsmouth City Council has led an intervention, supported by the Health and Wellbeing Board, which has involved staff from different organisations working together to explore how an integrated service offer might improve the outcomes for people with complex needs, and to test this way of working. The team has included members from Probation, Housing Needs, Advice, and Support, Adult Social Care, Queen Alexandra Hospital Alcohol Specialist Nurse Service, Health Inclusion Team, Homeless Drug and Alcohol Team, Stop Domestic Abuse, and Adult Mental Health. The detailed findings from the intervention will be available in 2026-27.

Improving the Quality of Safeguarding Concerns

Following learning from annual multi-agency audits on the quality of safeguarding referrals submitted to the local authority by other agencies, partners were asked by the PSAB to conduct their own audits of the safeguarding concerns they have referred, and to develop action plans to improve the quality of those concerns. Some of the actions being taken forward are:

Hampshire and IOW Fire and Rescue Service: have identified individual and team learning needs through sharing specific feedback on quality; made amendments to Service practice.

Housing Needs, Advice and Support: updating computer systems to enable more detailed data around safeguarding needs and interventions to be recorded; creating training resources including scenarios; improving training; offering shadowing opportunities to upskill staff.

Portsmouth Hospitals University NHS Trust: improving the information available to the workforce on safeguarding concerns; surveying the workforce to identify what would help them most; exploring IT solutions to support the process.

Hampshire and Isle of Wight Healthcare NHS Foundation Trust: safeguarding specialists plan to attend a Mental Health clinical update day; safeguarding specialists are regularly present on mental health inpatient wards to provide advice; good practice examples and top tips available on staff portal; Lunch and Learn sessions offered to all staff.

Hampshire and Isle of Wight Constabulary: have provided training on appropriate referrals to all new joiners; delivered training to Multi-Agency Hub Staff on intelligence sharing; identified a Public Protection Notice specialist for adult referrals.

PSAB Conference and Training Programme

Annual Conference 2025

The PSAB Annual Conference 2025 took place in September at the John Pounds Centre. The theme was 'Safeguarding at the Crossroads: Navigating the Interface between the Mental Capacity Act and the Mental Health Act'.

Our keynote speaker was Professor Keith Brown, who spoke about Consent for Treatment and Executive Function in relation to the **Mental Capacity Act**. Claire Barcham from the Association of Directors of Adult Social Services presented on the use of **professional authority and statutory powers in adult safeguarding**. In the afternoon Jim Dineen explained the 'Right Care Right Person' policy and **police processes around Mental Health and Mental Capacity**, followed by Elliot Wylde from Hampshire and Isle of Wight Healthcare NHS Foundation Trust who gave his

frontline perspectives on the interface between the Mental Capacity Act and the Mental Health Act. Lastly Hannah Taylor from Bevan Brittan LLP explained how **Mental Health law** has evolved and looked at the legal case of 'Jane' in detail.

We also heard from people with lived experience of being subject to the Mental Health Act, and a carer of one of those people who spoke about her experiences when her daughter had been unwell.

Well over 100 people attended from different sectors and professions. The feedback was very positive, with comments including *"Thoroughly enjoyed today!", "Interesting and thought provoking", "I found today so educational and eye opening. I loved being part of it"*.



Photograph of delegates attending the Annual Conference.

PSAB Training Programme

The PSAB's new Workforce Development subgroup meets twice a year to consider a learning needs analysis for the partnership, and to plan and review the PSAB training programme to address the learning needs identified.

Our multi-agency training offer in 2025-26 included:

- Self-neglect and Hoarding
- Chairing Multi-Agency Risk Management meetings
- Understanding the difference between the Multi-Agency Risk Management framework and statutory safeguarding enquiries
- Safeguarding vulnerable dependent drinkers
- 4LSAB Fire Safety Framework update
- Information sharing: Clare's Law and Sarah's Law
- The importance of community partnership information (CPI) sharing
- Modern Slavery toolkit launch

Feedback from attendees of our training sessions included:

Hoarding and self-neglect: *"I can use this info to help my understanding to support my team and ask more probing questions".*

MARM Charing: *"I feel more confident moving forward to complete in the future". "Really informative, great knowledge around legislation".*

Statutory safeguarding vs MARM: *"I will be able to cascade the info learning to staff to help them better assess when to refer to safeguarding".*

Learning from Safeguarding Adults Reviews

The Care Act 2014 states that a Safeguarding Adults Review (SAR) must take place when there is reasonable cause for concern about how the Safeguarding Adults Board, members of it, or others, worked together to safeguard an adult with care and support needs, and death or serious harm arose from abuse or neglect.

The Care Act also gives Safeguarding Adults Boards the discretionary power to review cases where these criteria are not met.

The Board has a SAR subgroup which is multi-agency, with members who have a specialist role or experience in safeguarding adults. The subgroup holds bi-monthly meetings and also meets jointly with the 'Portsmouth Safeguarding Children Partnership Learning from Children and Practice Committee' when there are cases involving both children's and adult services.

Summary of SAR activity during 2025-26

The Board published one Safeguarding Adults Review in 2025-26. This was the 'Anne' SAR and the findings are outlined in the next section. The Board accepted the findings of this review and developed a multi-agency action plan to address the recommendations. The plan is being monitored by the quality assurance subgroup.

There were 21 new SAR referrals received in 2025-26. A SAR has been commissioned for one of these cases and the review will be published in 2026-27.

During the year, the PSAB continued to work on three reviews which were commissioned in 2024-25. Two of these relate to individuals, and the other is a thematic SAR considering several cases where self-neglect in the person's own home was considered to have been a factor in their death. These reviews will be published in 2026-27. Two of the cases referred this year have been included in the thematic review.

The remaining cases referred did not meet the criteria for a mandatory SAR, and it was not considered that a discretionary SAR was required. However, a case learning briefing was developed for one case (Mr L) - see below.

Anne: Safeguarding Adults Review

The Anne SAR was published in September 2025. Anne was an 82-year-old White British woman who was diagnosed with vascular dementia 15 months before her death. Anne was cared for by her partner of 16 years. Concerns were raised by Anne's children about money she had given or lent to her partner and about her partner giving his own medication to Anne. Anne's health deteriorated rapidly a few weeks before her death, leading to a safeguarding concern raised by her son. He was concerned that Anne's partner was giving her unprescribed medication and was neglecting her. Anne's partner admitted to practitioners that he was struggling to care for both Anne and his unwell mother, had physically abused Anne, and had purchased 'sachets' on the dark web to end his life after Anne and his mother died. Anne had unexplained bruising and practitioners noted that the partner did not always follow professional advice about caring for Anne. Anne died unexpectedly, and her partner was arrested on suspicion of murder. However, after a thorough police investigation, evidentially there was no indication that he expedited her death or that there was any coercive or controlling behaviour at that time. Over a year later, during the SAR process, the Coroner returned an open verdict on the cause of Anne's death.

The key findings from the SAR were:

- **Value of Historical/Background Information:** Understanding a person's history is crucial for practitioners to effectively assess and support their current situation. Awareness of a partner's background could have influenced the perception of minor concerns, especially for health and support practitioners.
- **Person-Centred Care:** Ensuring care is directed by the individual's needs and preferences is crucial. Practitioners should engage directly with the care recipient to ensure their voice is heard.
- **Challenges with Dementia:** As dementia progresses, it becomes harder to discern the individual's identity and history, complicating support efforts.
- **Practitioner Involvement:** Lack of early practitioner involvement meant that potential coercion and control by Anne's partner could not be assessed.
- **Capacity and Decision-Making:** as well as mental capacity, dynamics within a relationship can impact decision making.
- **Rapid Disease Progression:** Anne's dementia progressed rapidly, complicating the understanding of her dependency on her partner.
- **Practitioner Perception:** Later-involved practitioners saw a caring partner, unaware of historical relationship dynamics, limiting their ability to reassess the situation.
- **Importance of Information Sharing:** Concerns about financial abuse and over-medication were investigated separately by different agencies. However, the lack of information sharing between these agencies, particularly with the police, led to fragmented understanding and missed opportunities for a comprehensive risk assessment.

- **Need for Multi-Agency Collaboration:** Effective safeguarding requires collaboration among all involved practitioners. A multi-agency approach could have provided a clearer picture of the risks and led to more informed decision-making.
- **Practitioner Curiosity:** Practitioners need to dig deeper when concerns are raised, especially when there is a history of issues. Without a full picture, important details may be overlooked, and assumptions may be made that do not reflect the true situation.
- **Safeguarding Lens:** Viewing care and support needs through a safeguarding lens is crucial. This ensures that all potential risks are considered and addressed appropriately, rather than being seen solely as issues of carer stress. Acts of neglect and omission should be considered in cases of unpaid carers delivering care against advice.
- **Advocacy for Vulnerable Individuals:** When a safeguarding concern involves a primary caregiver, it is essential to seek an independent advocate for the vulnerable individual to ensure their best interests are represented.

The Board accepted the findings of the review, and a multi-agency action plan was developed.

Actions planned or carried out include:

- Promoting information on types of dementia and relaunching Dementia Passports across all provider health and care services.
- Auditing case files to ensure the areas of learning identified in the SAR have been addressed and embedded.
- Review and promoting the 4LSAB One Minute Guide to Advocacy.
- Providing learning opportunities about dementia.
- Creating resources on supporting unpaid carers and carer stress.
- Disseminating the learning from the SAR.

Mr L case learning

The PSAB received a referral for a Safeguarding Adults Review for Mr L. Although this case did not meet the criteria for a mandatory Safeguarding Adults Review, the PSAB considered there was important learning to be established from the case, particularly in relation to domestic abuse practice. Specialist professionals in the field of domestic abuse conducted a domestic abuse-focused learning review to produce a [learning summary](#) to support practitioner reflection. Areas identified included:

- Co-abusive / mutually abusive dynamics.
- Multi-Agency coordination.
- Supporting male victims.
- Proactive referral rather than signposting.
- Working with adults who decline support.

This learning will also feed into the domestic abuse service commissioning review in 2026 to inform service delivery.

Actions taken in response to Ronnie, Kim and Mary Safeguarding Adults Reviews

The Board received action plan closure reports from the Quality Assurance subgroup on the Ronnie SAR (published in 2023), Kim SAR (published in 2023), and Mary SAR (published in 2024). These summarised the actions taken in response to the recommendations, the outcomes, and further work identified. Key points were:

From the Ronnie SAR (view the [full closure report here](#)):

- Housing services have reviewed and developed plans in relation to the supported housing offer in Portsmouth.
- A new Homelessness Strategy 2024-29 has been developed with regard to the learning from SARs.
- Housing services have developed a new policy which includes guidance on the early identification of risk and when to initiate the Multi-Agency Safeguarding Framework.
- There is now increased provision of peer mentors.
- Assurance was sought from partner agencies in relation to unconscious bias and the importance of appropriate use of language.
- An eLearning package in relation to carers assessment has been developed and promoted via the PSAB safeguarding newsletter.

From the Kim SAR (view the [full closure report here](#)):

- Service users at Hope House homeless accommodation now have a card giving key information about them to take with them when they need to go to hospital.
- Care Act training has been provided for staff in the Family Safeguarding Team.
- Drug nurse specialists have been employed within the hospital setting working alongside the alcohol nurse specialists who are supporting maternity services
- There is a new Multi-Agency Safeguarding and Support Team (MASST) in the hospital which is now operating twice a week looking at discharge planning, and patients coming to the Emergency Department are escalated to maternity. A Maternity Outpatient Matron at the hospital has reviewed discharge processes from maternity services.
- A MARM workshop and MARM audit were held. As a result a new MARM Champions network has been set up and an action plan has been created to improve MARM practice.

From the Mary SAR (view the [full closure report here](#)):

- A weekly meeting is now embedded held to discuss 'hard to place' clients - those for whom a housing duty is owed but placement is challenging, or those anticipated to require housing. The meeting aims to develop bespoke solutions for the most appropriate temporary accommodation for the person.

- A review of the Mental Health Act aftercare practice guidance was initiated, and data has been gathered about Portsmouth clients who are subject to aftercare.
- Agencies have raised awareness amongst their staff of escalation routes.

4LSAB Fire Safety Development Group

In addition to the work of the SAR subgroup, the 4LSAB Fire Safety Development Group has continued to review and share learning from serious fire incidents, to ensure that effective inter-agency processes, procedures and preventative practices are in place. The subgroup published a [learning briefing](#) in November 2025 to highlight the learnings established from the 15 fire deaths or near misses reviewed across the 4LSAB area in the preceding year. The subgroup also published the [Fire Safety Development Group Thematic Review 2022-24](#).

Safeguarding activity in Portsmouth

Safeguarding Duty

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

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

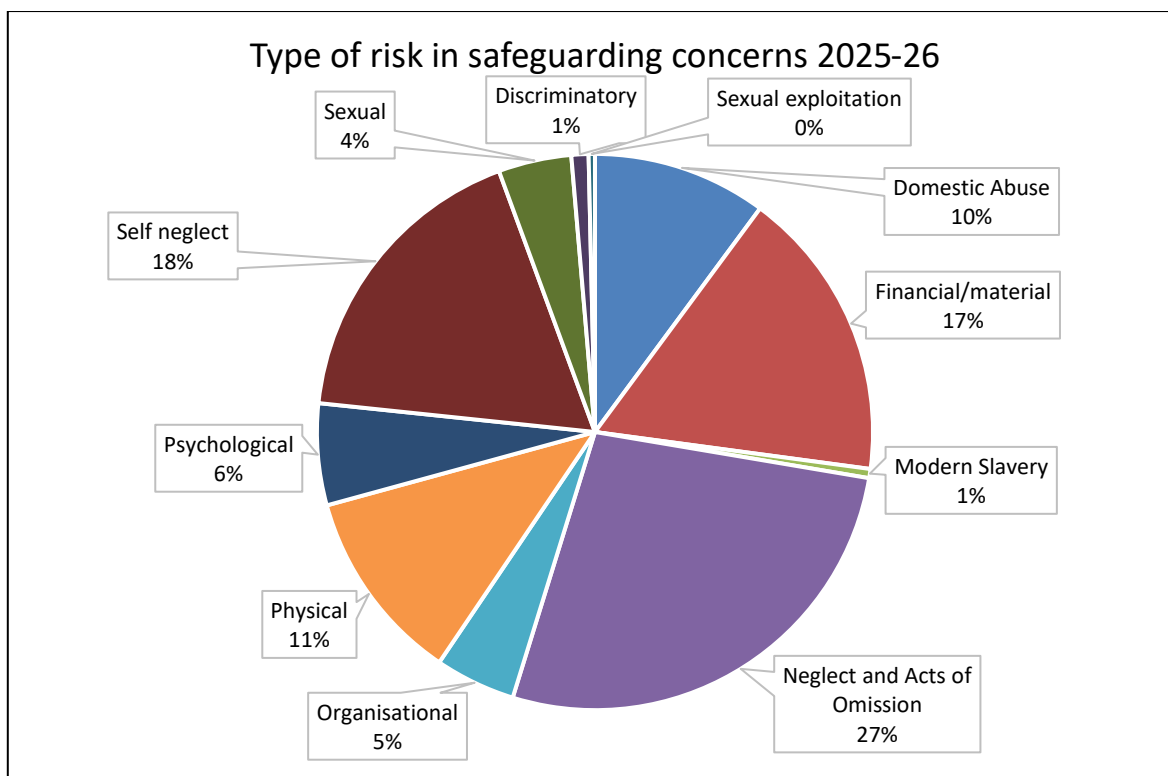
Portsmouth City Council has an adult safeguarding team of social workers who receive a high volume of safeguarding referrals from partner organisations and individuals. They work closely with colleagues in areas such as police, health, housing, and children's safeguarding.

Data collected by the adult safeguarding team gives further information about who has experienced abuse or neglect in Portsmouth, where abuse has taken place, and the types of risk they have experienced. Data is monitored quarterly by the Board's quality assurance subgroup, which looks at changes and trends, and carries out further work if needed.

If an issue about abuse or neglect of an adult at risk is raised with the adult safeguarding team, it is called a safeguarding concern. The adult safeguarding team assesses the concern and takes appropriate action.

There were **3012** concerns raised in 2025-26.

More information about the types of risk in safeguarding concerns is shown below.



If a safeguarding concern meets the criteria from section 42 of the Care Act (see above) a Safeguarding Enquiry will be initiated. The local authority has the power to carry out discretionary enquiries if the criteria are not met.

1662 formal safeguarding enquiries were concluded in 2025-26.

In **89%** of enquiries where risk was identified, action taken led to the risk being reduced or removed.

The Board also receives data regularly from Portsmouth City Council housing services, Portsmouth Hospitals University NHS Trust, Hampshire and Isle of Wight Healthcare NHS Trust (formerly Solent NHS Trust), Hampshire and Isle of Wight Constabulary, and Hampshire and Isle of Wight Fire and Rescue Service.

In 2025-26 Hampshire and Isle of Wight Constabulary reported:

- **934** high risk domestic crimes
- **687** incidents of hate crime of which **57** were disability hate crimes.

There were **0** fire deaths in Portsmouth in 2025-26.

Contact us

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Glossary

4LSAB - The Portsmouth, Southampton, Hampshire and Isle of Wight Safeguarding Adults Boards

CPI - Community Partnership Information. Hampshire and Isle of Wight Constabulary's CPI process gives professionals a safe and direct way to share non-urgent information with police relating to children/adults at risk

ICB - Integrated Care Board. An NHS organisation responsible for developing plans to meet the health needs of the population which includes managing the NHS budget and arranging for the provision of health services within an Integrated Care System (ICS)

ICS - Integrated Care System. Integrated care systems are partnerships of organisations that come together to plan and deliver joined up health and care services

LCPC - Learning from Children & Practice Committee (a committee of the Portsmouth Safeguarding Children Partnership, which also meets jointly with the Safeguarding Adults Review subgroup of the Portsmouth Safeguarding Adults Board)

LSAB - Local Safeguarding Adults Board

MARM - Multi-Agency Risk Management

MCA - Mental Capacity Act 2005. The Act is in place to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment

MSP - Making Safeguarding Personal. A personalised approach that enables safeguarding to be done with, rather than to, people

NHS - National Health Service

PSAB - Portsmouth Safeguarding Adults Board. A multi-agency partnership which oversees and coordinates work to keep adults at risk safe in Portsmouth

PSCP - Portsmouth Safeguarding Children Partnership. A partnership which brings together all the main organisations who work with children and families in Portsmouth, with the aim of ensuring that they work together effectively to keep children safe

SAB - Safeguarding Adults Board

SAR - Safeguarding Adults Review. A multi-agency review process which Safeguarding Adults Boards must carry out to identify learning when an adult at risk dies or is seriously harmed as a result of abuse or neglect, and there are concerns about the way in which organisations worked together to safeguard the adult

Appendix

What is Safeguarding?

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

Who are we?

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

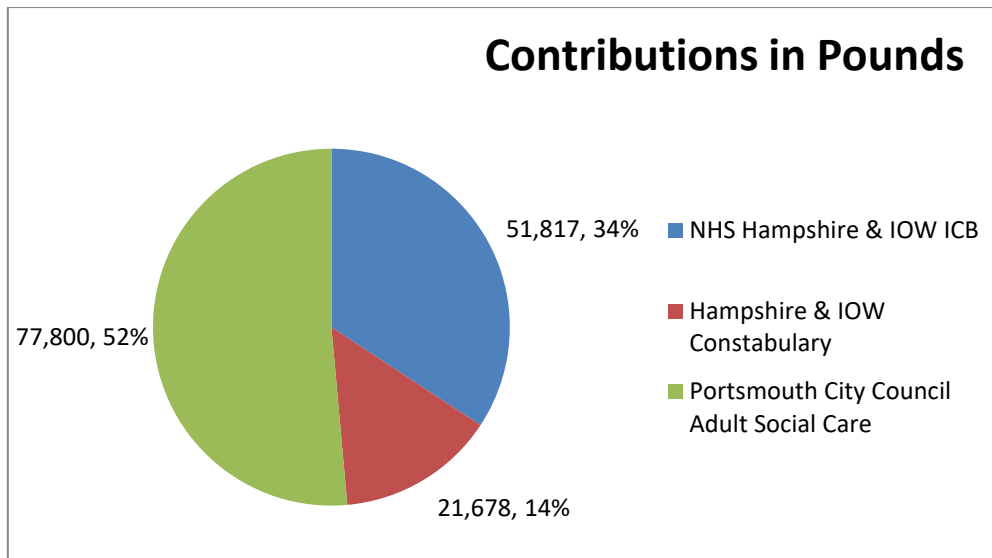
- Adult social care
- Health
- Emergency services
- Probation services
- Housing
- Community organisations.

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

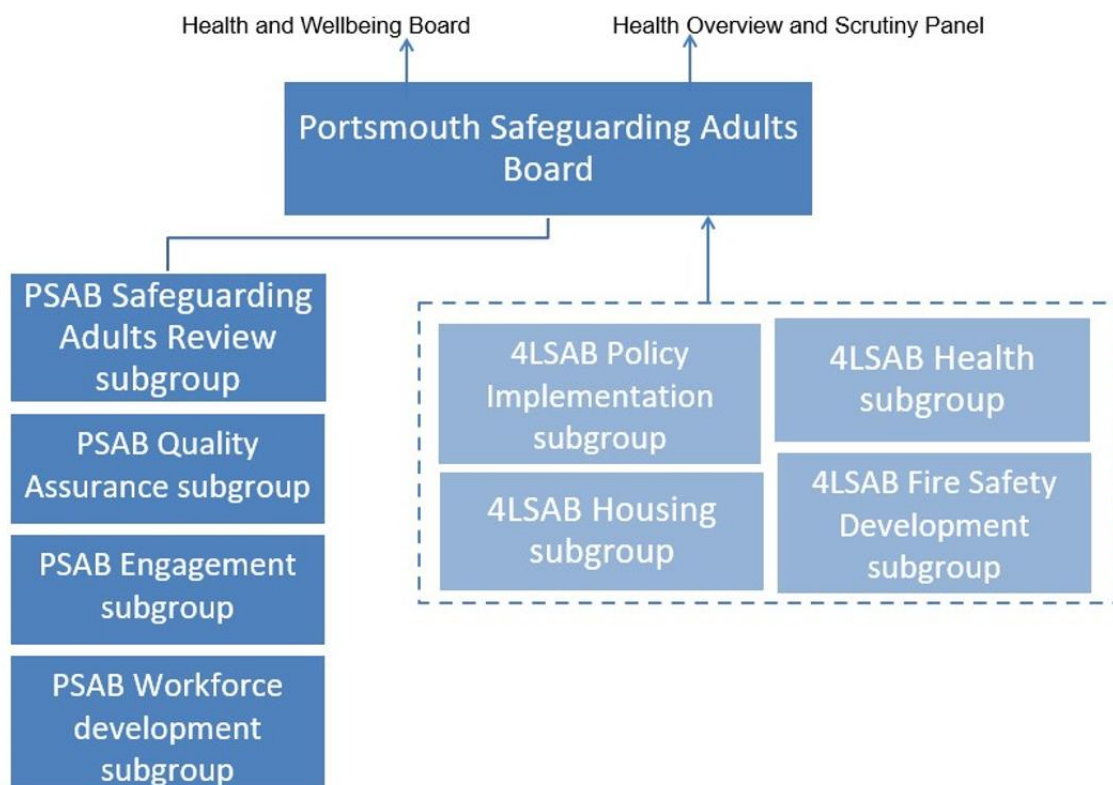
- Offering constructive challenge
- Holding member agencies to account
- Acting as a spokesperson for the Board.

The Board is funded through contributions from its statutory partners (Portsmouth City Council Adult Social Care, NHS Hampshire and Isle of Wight (Integrated Care Board) and Hampshire and Isle of Wight Constabulary).

Partners increased their contributions in 2025-26 to fund an additional part-time member of staff to focus on the priority areas of community engagement, communications, and training. The contributions received in 2025-26 were:



The structure of the Board and its subgroups is shown in the diagram below. In the areas of policy implementation, fire safety, health and housing, we have shared '4LSAB' subgroups with the neighbouring Boards (Hampshire, Southampton and the Isle of Wight). This helps ensure that we are working in a joined-up and coordinated way with our partners across the region on common priorities.



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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)

Title of meeting:	Health and Wellbeing Board
Subject:	Public Health Annual Report 2026
Date of meeting:	23 rd September 2026
Report by:	Emily Brown and Sophie Fry on behalf of Helen Atkinson, Director of Public Health
Cabinet Member:	Councillor Matthew Winnington
Wards affected:	All

1. Requested by Councillor Matthew Winnington, Cabinet Member for Community Wellbeing, Health & Care

2. Purpose

To note that the Director of Public Health is publishing her statutory Annual Report for 2026. This year the report focuses on 100 years of public health in Portsmouth, 1926 – 2026, in line with the Portsmouth City Centenary celebrations.

3. Information Requested

This year's annual public health report (APHR) focuses on the health of our population over the last 100 years. Portsmouth is celebrating 100 years as a city throughout 2026 and we have looked at how health has changed over this time. The report shows us some of the major progress made over this time from fewer children dying young, adults living longer, the introduction of vaccination, antibiotics and the creation of the NHS. This progress reflects a century of progress in public health, housing, sanitation, healthcare and medical innovation. Conditions that once caused widespread illness and early death, particularly among children, are now often preventable or treatable. However, the report also raises an important question – who has benefited most from that progress, and who is still being left behind?

Like other major cities, the history of Portsmouth demonstrates that life expectancy is closely linked to the living conditions mentioned above. The report explores our residents' life expectancy and contributing factors from 1926 to 2026; including overcrowded housing and infectious disease, through war and rebuilding, to today's challenge of helping everyone to live longer, healthier lives. However, despite substantial improvements over the last century, life expectancy at birth in Portsmouth continues to lag behind the England average for both males and females.



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)

.....
Signed by (Director)

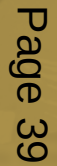
Appendices:

Appendix A: 100 years of public health in Portsmouth, 1926 – 2026 - The Public Health Annual Report 2026

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



100 years of public health in Portsmouth 1926 – 2026

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Foreword by Helen Atkinson, Director of Public Health for Portsmouth

I am very pleased to present this year's annual public health report (APHR) which focuses on the health of our population over the last 100 years. Portsmouth is celebrating 100 years as a city throughout 2026 and we thought it would be an opportunity to look at how health has changed over this time.

The report shows us some of the major progress made over this time from fewer children dying young, adults living longer, the introduction of vaccination, antibiotics and the creation of the NHS. This progress reflects a century of progress in public health, housing, sanitation, healthcare and medical innovation. Conditions that once caused widespread illness and early death, particularly among children, are now often preventable or treatable.

However the report also raises an important question – who has benefited most from that progress, and who is still being left behind?

Like other major cities, the history of Portsmouth demonstrates that life

expectancy is closely linked to the living conditions mentioned above. The report explores our residents' life expectancy and contributing factors from 1926 to 2026; including overcrowded housing and infectious disease, through war and rebuilding, to today's challenge of helping everyone to live longer, healthier lives. Life expectancy has increased substantially over the past century. In the mid-1920s, life expectancy at birth in England was around 58 years for males and 62 years for females and was likely to have been similar in Portsmouth. However, despite substantial improvements over the last century, life expectancy at birth in Portsmouth continued to lag behind the England average for both males and females in 2024. While overall progress has been remarkable, this enduring gap shows us the importance of tackling the wider social, economic and environmental factors that continue to influence health outcomes across the city.

I hope you enjoy reading the report.



Helen Atkinson
Director of Public Health

Setting the scene: 1926 to 2026

Indicator	Portsmouth 1926	Portsmouth 2026	Interpretation
 Total population ¹	246,900	214,300 ↓	Smaller resident population today.
 Households ²	53,279	88,171 ↑	More households despite fewer residents today.
 People per household ³	4.7	2.4 ↓	Much smaller average household size today.
 Population density ⁴	7,675 per km ²	5,307 per km ² ↓	Lower citywide population density.
 Crude birth rate ⁵	18.2 per 1,000 population	9.5 per 1,000 population ↓	The birth rate was much higher a century ago.
 Infant mortality (under 1 year of age) ⁶	54.9 per 1,000 live births	3.4 per 1,000 live births ↓	Far fewer babies die in their first year of life today.
 All cause age-standardised mortality ⁷	1,814 per 100,000	560 per 100,000 ↓	All-age, all cause mortality rates are much lower today.
 Life expectancy at birth ⁸	59.9 years	80.5 years ↑	Babies born in Portsmouth today have a life expectancy around 20 years longer than a century ago.

Note: These changes from 1926 to 2026 in birth rates, infant mortality, all-cause mortality rates and life expectancy at birth are not unique to Portsmouth, but are trends that have largely been reflected nationally as well. They therefore reflect the wider social, economic, healthcare and public health changes that occurred across the country during the past century, rather than improvements specific to Portsmouth.

The Public Health team, then and now

Pictured in the right hand side image are the City of Portsmouth staff of Public Health Department engaged on Civil Defence Main Control Duties 1939-44.

Pictured below are members from the Public Health directorate at Portsmouth City Council in 2026.



Population change

Portsmouth has fewer residents today than it did in the 1920s, but it has many more households. In 1926, the city had an estimated population of 246,900 and 53,279 inhabited houses or households. By 2024, the population was around 214,300, while the number of households had increased to about 88,171. As a result, average household size has almost halved, from 4.7 people per house or household in 1926 to 2.4 people per household today.

Portsmouth has long had a significant military presence. The 1921 Census recorded around 13,400 naval and military personnel, and a further 2,000 service personnel were estimated to be living in the city in 1926. A century later, Portsmouth remains the principal home of the Royal Navy, with recent Ministry of Defence statistics showing almost 8,000 regular serving personnel based locally.⁹

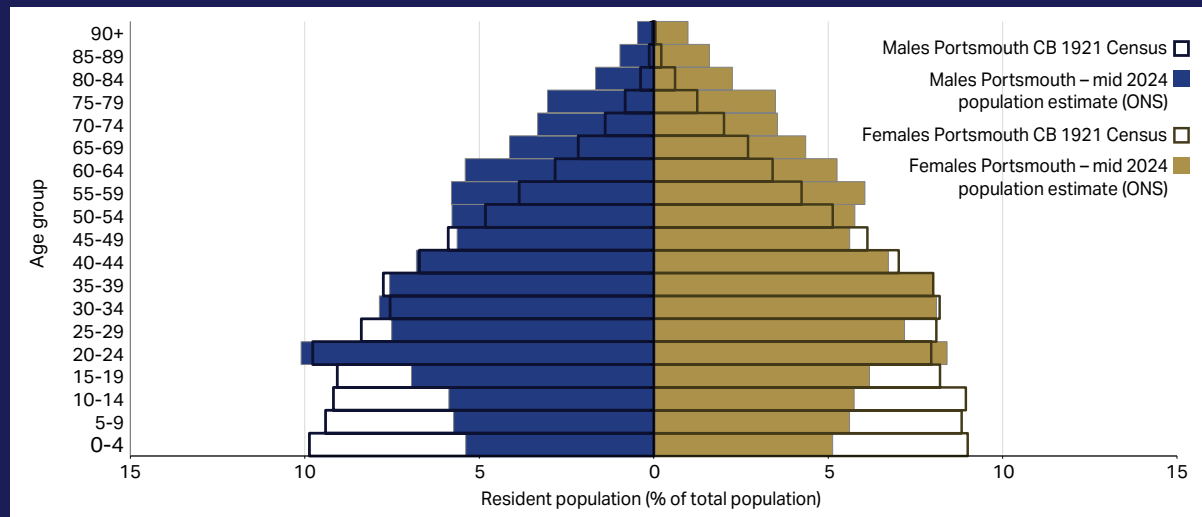
While Portsmouth's population is smaller than it was in 1921, the most notable change has been the way its age structure has shifted over time (Figure 1). Children and young people aged 0 to 19 years were

around 89,600 in 1921, about 36% of the total population, but today the figure is smaller at around 49,900 in 2024, about 23%. People aged 65 years and over were around 14,600 in 1921, about 6%, but today is around 32,000, about 15%. The number aged 85 years and over was around 500 in 1921, but today is about 4,300.¹⁰

The 20 to 24 years age group stands out in the current population structure. This reflects the contemporary higher education population in Portsmouth, with around 26,000 higher education students in 2022/23¹¹ and the 20 to 24 years age group accounting for around 9% of the current resident total. The early-1920s student population was much smaller compared to today.

Figure 1: Chart showing the population structure by 5-year age groups, comparing Portsmouth County Borough 1921 and Portsmouth UA in 2024¹⁰

[Data table](#)



2024 population source: MYE1: Population Estimates by single year of age and sex for local authorities in the UK, mid-2024, Office for National Statistics
© Crown copyright 2025. 1921 population source: Census 1921, Nomis. Office for National Statistics © Crown copyright reserved 2026.

The future population is projected to remain broadly stable in total size, but structurally older. The overall population was projected to be around 215,900 in 2025 and 215,100 in 2047. The older age groups are expected to increase; the 65 years and over

population is projected to increase from about 31,300 in 2022 to 37,000 in 2032 and 40,600 by 2047. The 80 years and over population is projected to increase from about 8,400 to 10,600 and then 14,500.

Table 1: Resident population projections by age group, Portsmouth City, 2022-based 2022 estimate compared to 2032 and 2047 projection¹²

Age group	2022 estimate	2032 projection	2047 projection	Summary
0 to 17 years	41.9k	37.6k	34.6k	Projected decrease of about 17.4% by 2047.
18 to 64 years	136.6k	142.2k	140.7k	Broadly stable, with a peak around 2032.
65+ years	31.3k	37.0k	40.6k	Steady increase to 18.9% by 2047.
80+ years	8.4k	10.6k	14.5k	Projected increase of around 72.1% by 2047.



As the population ages, the number of people aged 80 years and over is projected to increase substantially by 2047. This could mean more people living with multiple long-term conditions, including dementia and frailty, making prevention and healthy ageing increasingly important to help residents live longer, healthier lives – remaining independent for longer and reducing future pressure on health and care services.



1

Life expectancy

1
Life expectancy

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IG AND CARCINOMA PRELIMINARY REPORT

BY
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City of Portsmouth
HEALTH REPORT
For the Year 1926

Place, progress and inequality

Life expectancy has increased substantially over the past century. Babies born in Portsmouth today have a life expectancy around 20 years longer than a century ago. In the mid-1920s, life expectancy at birth in England was around 58 years for males and 62 years for females¹³ and was likely to have been similar in Portsmouth.

The leading causes of death in Portsmouth in 1925 were very different from those seen today. Broncho-pneumonia was the leading cause of death among children aged 1 to 4 years, diphtheria among those aged 5 to 14 years, and pulmonary tuberculosis among people aged 15 to 54 years.¹ Together, these infectious diseases were among the leading causes of mortality across much of childhood and working age.

By contrast, the leading causes of death in recent decades have been very different.

Nationally, in 2015, cancer was the leading cause of death among children and younger adults, while external causes such as accidents, drug misuse, self-harm and suicide account for a substantial proportion of premature mortality. Among older working-age adults, chronic diseases such as coronary heart disease, liver disease and cancer are more prominent.¹⁴ In Portsmouth, analysis of deaths during the six-year period 2014-19 showed a similar pattern. External causes, particularly accidents and suicide, were the leading causes of death among younger adults, while liver disease and coronary heart disease became more prominent in later working age. Among women aged 45-54 years, breast cancer was the leading cause of death.¹⁵

Increased life expectancy reflects improvements in living conditions, public health, housing, sanitation, healthcare and the prevention and treatment of disease.

Many illnesses that once caused early death, particularly in childhood, are now preventable or treatable.

However, despite substantial improvements over the last century, life expectancy at birth in Portsmouth continued to lag behind the England average and remained significantly lower in 2024 – 78.1 years for males and 82.7 years for females, compared with 79.8 and 83.6 years respectively in England.¹⁶

Health inequalities are unfair and avoidable differences in health between people and places. They are shaped by the conditions of daily life: including housing, income, work, education, environment and access to support. This means that where someone lives can still influence how long they live, and how many of those years are spent in good health.



A century ago: housing and early death

A century ago, many people in Portsmouth lived in housing conditions that made it harder to stay healthy. Overcrowding, damp homes, poor ventilation, shared toilets and limited sanitation all increased the risk of

illness spreading quickly between families and neighbours.¹⁷

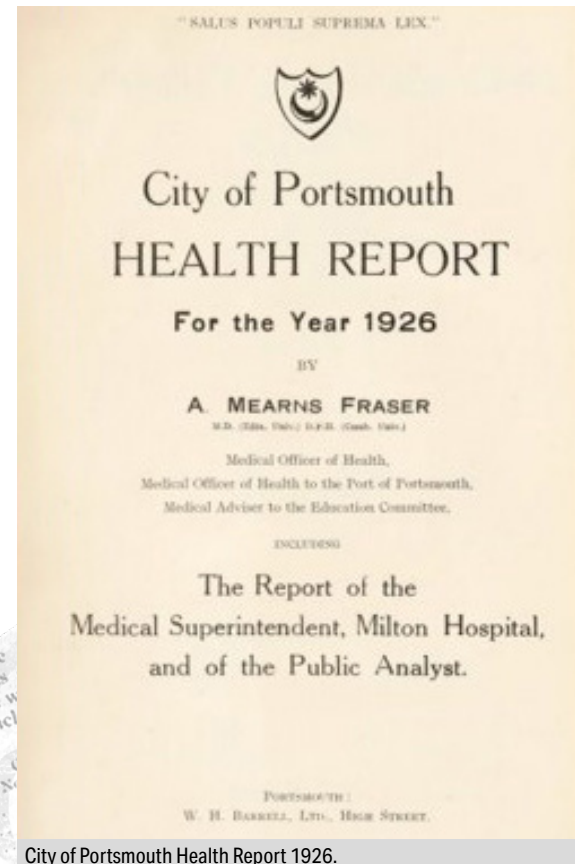
Infectious diseases such as tuberculosis, diphtheria and scarlet fever were common and could be life-threatening, especially for children. Diarrhoeal illness, linked to contaminated water and poor sanitation, was also a major cause of infant death.

Cold and damp homes increased the risk of respiratory illness.¹

This shows how closely health was tied to place. A person's chances of surviving childhood were not only shaped by biology or medical care, but by the home they lived in, the street around them, and the wider conditions of poverty and deprivation.



Hawk Street, Portsea, looking west towards Queen Street 1924.
Available from: <https://www.portsmouth.co.uk/news/nostalgia-portssea-a-population-that-bears-the-hallmark-of-poverty-1070544>



City of Portsmouth Health Report 1926.

24 REPORT OF THE MEDICAL OFFICER OF HEALTH

INFECTIOUS DISEASES.—The following table gives the number of notifiable infectious diseases which occurred in the City during the year. There were no cases of small-pox, cholera, plague, yellow-fever, trench-fever, malaria, relapsing fever, or continued fever.

Disease	Cases Notified	Admitted to Hospital	Total Deaths
Diphtheria	947	924	66
Scarlet Fever	549	489	7
Enteric Fever	14	12	3
Puerperal Fever	8	—	—
Puerperal Pyrexia	7	—	—
Influenzal Pneumonia	28	—	15
Cerebro-spinal Meningitis	2	2	1
Acute Poliomyelitis	4	2	2
Encephalitis Lethargica	9	4	8
Erysipelas	50	—	2
Ophthalmia Neonatorum	34	—	—
Tuberculosis : (a) Pulmonary	M. 170 F. 159 Total 329	101 96 197	97 88 183
(b) Non-Pulmonary	M. 43 F. 35 Total 78	30 37 67	14 24 38

City of Portsmouth Health Report 1926.

Some of these issues like cold and damp housing still matter today. Housing is not just a background issue – it is one of the building blocks of health. Safe, warm, affordable homes help people live longer and healthier lives. Although housing conditions have improved significantly over the last century, the relationship between housing and health remains as important as ever.

"I remember when heating and boilers were introduced. My dad discovered it was too expensive to run though. Everyone was really frugal."

Rose, 61, lived most of her life in Drayton/Farlington.



World War II: destruction, displacement and health

The Second World War was a major turning point for Portsmouth. As a naval city, Portsmouth experienced extensive bombing. Around 6,625 houses were destroyed and more than 80,000 were damaged, creating widespread housing shortages.^{17,18}

The health impacts were immediate and long-lasting. People experienced injury, bereavement, evacuation and separation from family members.¹⁹ Overcrowded shelters, damaged homes and disrupted sanitation increased the risk of infectious disease, particularly respiratory and gastrointestinal illness.²⁰

"The doctor mostly knew me because of bronchitis – it was the illness I remember most from growing up." Tony, Paulsgrove.

Food shortages and rationing also affected nutrition, especially for children, increasing vulnerability to illness and slowing recovery. The emotional impact was significant too, with trauma, loss and uncertainty shaping mental wellbeing for many families.²¹



The aftermath of a bombing raid on Conway Street, Portsmouth 23 December. Available from: https://thedaystory.com/timeline_post/august-1940-may-1941



Damage caused by a bomb. Dunbar Road, Eastney 1942. Available from: <https://portsmouthmuseum.co.uk/collections-stories/80th-anniversary-of-the-blitz/the-portsmouth-bomb-map>

Recovery, public health change and the NHS

The impact of the Second World War on health did not end in 1945. Poor nutrition, overcrowding, disrupted education and the trauma of war continued to affect many families for years afterwards.

"We didn't have a fridge, so food was bought fresh every day. We'd spend all day picking fruit, then Mum turned it into pies for the family." Tony, Paulsgrove.

Children who experienced deprivation during and after the war were at greater risk of poorer health later in life, including heart disease, respiratory illness and other long-term conditions.

For Portsmouth, the war was not only a period of loss. It also became part of the city's transition from crisis and overcrowding towards rebuilding and wider public health improvement.

The war created momentum for major social change. Across Portsmouth, bomb-damaged neighbourhoods were rebuilt and thousands of families moved into new council housing with indoor toilets, running water, improved sanitation, gardens and

more living space. These improvements helped reduce overcrowding, improved living conditions and lowered the risk of infectious disease, creating healthier environments for future generations.

Nationally, the creation of the National Health Service in 1948 transformed access to healthcare. For the first time, healthcare became available to everyone regardless of their ability to pay, improving access to doctors, hospitals, maternity services, vaccinations and preventive care.²²

"Before the NHS you used to pay for the doctors, I remember paying '2 an 6'. One day I dropped it on the way to the doctors with my mum, but they said it was ok and they'd still see my mum." Carole, 86, Buckland.

Combined with advances such as antibiotics, improved medical treatments and better public health measures, these changes helped drive the significant improvements in life expectancy seen in the decades that followed.



Paulsgrove Housing Estate 1948.
Available from: <https://www.britainfromabove.org.uk/image/eaw020629>



Reflection and looking forward

Living longer in Portsmouth – but not equally

People in Portsmouth are living much longer than they did 100 years ago. This is a major public health achievement, reflecting improvements in housing, sanitation, healthcare, living standards and disease prevention.

However, these gains have not been shared equally. Life expectancy in Portsmouth remains below the national average, and there are clear differences between communities within the city. Men and women living in more deprived areas

experience worse health outcomes than those in less deprived areas.

This reflects the continuing impact of poverty and deprivation in our communities. Today, the causes of early death and poor health are more complex than they were in 1926, often linked to poor lifestyle – smoking, poor diet, alcohol use and lack of physical activity – but also still strongly shaped by the conditions people live in: housing quality, income, employment, education, access to services, community cohesion and the wider environment.

The challenge has also changed. It is no longer only about helping people live longer.

It is also about helping people spend more of those years in good health. In 2026 we are focused on reducing the gap in life expectancy between communities by focusing on the wider determinants of health. That means putting health equity at the centre of decisions about housing, neighbourhoods, employment, transport, services and community cohesion.

“Health care felt local – the doctor was just down the road from home and seeing a doctor was much easier back then. Things feel different now.” Celia, 82, Paulsgrove.

2 Sexual and reproductive health

KEY DATES

1917

Portsmouth's Venereal Diseases Treatment Centre established.

1948

Lloyd's Pharmacy pioneered one of Britain's first postal contraceptive services, supplying condoms by mail order.

1967

Family Planning Act 1967 meant local authorities can provide contraceptive advice and supplies through the NHS, inclusive of unmarried women.

**1990s/
EARLY 2000s**

Post-Exposure Prophylaxis (PEP) available.

2025

Opt-out testing for HIV, Hepatitis B and Hepatitis C introduced in the Emergency Department at Queen Alexandra Hospital.

1941

Royal Portsmouth Hospital bombed and the treatment centre was destroyed. Services relocated to St Mary's Hospital.

1961

Contraceptive pill available on NHS (only for married women with children).

1980s

HIV and AIDS emerged in the UK.

2020

Pre-Exposure Prophylaxis (PrEP) available.

Portsmouth's sexual and reproductive health story is closely tied to the city's history. As one of the world's most significant naval cities, Portsmouth has experienced unique public health challenges shaped by military populations, changing demographics and evolving social attitudes. Over the past century, sexual and reproductive health has undergone remarkable transformation. Conditions once associated with serious illness, infertility or death can now often be prevented, treated or effectively managed, while services have expanded from treating disease to promoting sexual wellbeing, reproductive choice and long-term health.

A naval city and the challenge of venereal disease

Portsmouth Naval Base has been at the heart of the city since 1194 and remains the oldest dockyard in the history of the Royal Navy. Like many international ports, Portsmouth developed areas known as 'sailor towns', where sailors arriving ashore would find accommodation, pubs and commercial sex workers.²³ Areas including The Hard and The Point in Old Portsmouth became famous for their nightlife and were sometimes referred to as "The Devil's Acre".²⁴

"Nights out were about dancing and friends, more than drinking. The Navy sent the girls free dance tickets, so Tuesday nights became party nights." Celia, 82, Paulsgrove.

The presence of large numbers of military personnel created significant challenges for controlling sexually transmitted infections (STIs), then known as venereal diseases. Syphilis and gonorrhoea were widespread during the early twentieth century, with particular impact on naval populations. A Royal Navy report published in 1926²⁵ found that venereal disease accounted for almost one third of sickness absence caused by illness and injury amongst naval personnel.

Year.	Average weekly Comple-	Number of cases. Fresh admis-	Rate per 1,000 per annum.	Gonorr- hœa.	Rate per 1,000 per annum.	CLASSIFICATION.				Rate per 1,000 per annum.
						Syphi- lis.	Rate per 1,000 per annum.	Chanc- roids & other V.D.	Rate per 1,000 per annum.	
Last half of 1923	18,244	452	49.54	303	33.21	58	6.35	55	9.97	
Whole of 1924	19,725	703	35.64	522	26.46	95	4.82	86	4.36	
Whole of 1925	20,662	705	34.12	559	27.05	57	2.76	89	4.31	

Incidence of sexually transmitted infections in Portsmouth Naval personnel, 1923-1925.²⁵

From stigma to confidential care

The development of modern sexual health services in Portsmouth emerged from growing concern about rising STI rates following the First World War. In 1917, following national legislation to provide free and confidential treatment, Portsmouth City Council and the Royal Portsmouth Hospital established the city's Venereal Diseases Treatment Centre.

While medical knowledge was advancing, social attitudes often prevented people from accessing information and support. In 1920, Portsmouth's Medical Officer of Health – the equivalent of today's Director of Public Health – Dr. Andrew Mearns Fraser, argued that the prevention of venereal disease was being hindered due to moral and religious concerns: "...the public have been left in ignorance of the methods of prevention of venereal diseases because of a mistaken idea that such knowledge would increase immorality."²⁶

"Most of us knew very little. We were very naive – sex education was just a few diagrams from the PE teacher. When I think about young people learn today, our generation had hardly any information." Celia, 82, Paulsgrove.

Despite these challenges, Portsmouth's service expanded rapidly. By 1920 it was offering eight treatment sessions each week, with dedicated examination rooms, treatment cubicles and inpatient facilities to meet increasing demand. This represented one of the earliest examples of specialist publicly funded sexual healthcare in the city.

40 REPORT OF THE MEDICAL OFFICER OF HEALTH

VENEREAL DISEASE.—Very valuable work has again been carried out during the year at the Venereal Diseases Treatment Centre by Dr. A. Cambell, the Medical Officer in charge, who has prepared the following report :—

ROYAL PORTSMOUTH HOSPITAL.

The Venereal Diseases Treatment Centre established by the Portsmouth City Council has now completed ten years of work. It was opened at an opportune time, as the incidence of venereal disease in the Army, Navy and Air Force was at its height, and there was every reason to fear that on demobilization a large number of men who, owing to the exigencies of military service, could not be regarded as cured in the fullest sense of the word, would be discharged to their homes. When the war was over, the Centre therefore had had ample time for organisation and equipment, in order to deal with the rapidly increasing number of patients.

ATTENDANCES :

(Feb.) 1917	...	...	8,636
1918	...	...	11,144
1919	...	...	19,847
1920	...	...	23,674
1921	...	...	19,115
1922	...	...	15,816
1923	...	...	16,262
1924	...	...	16,022
1925	...	...	17,045
1926	...	...	17,928

Originally the state-aided scheme for free treatment was mainly intended for those suffering with early venereal disease, and a large proportion of patients in the first five years were in the acute infectious stage. Gradually, however, the number of patients suffering from illness directly attributable to venereal disease contracted many years before has increased, so that now they form quite a large percentage of the total number treated.



Dr Andrew Mearns Fraser, pictured in 1934.
Available from: <https://municipaldreams.wordpress.com/2020/04/21/council-housing-in-portsmouth-part-i>

Medical Officer of Health report showing attendances at Portsmouth's Venereal Diseases Treatment Centre. Available from: [Report 1926] / Medical Officer of Health, Portsmouth Borough. Wellcome Collection <https://wellcomecollection.org/works/ny493aak/items?canvas=3>

The service faced further challenges during the Second World War. On 10 January 1941, the Royal Portsmouth Hospital suffered a direct hit during an air raid, and the treatment centre was destroyed. Services relocated to St Mary's Hospital, where sexual health services continue to operate today. A 1949 handbook promoted the clinic whilst reassuring patients that treatment was "absolutely confidential".²⁷ The emphasis placed on confidentiality reflects the stigma surrounding sexual health at the time and the importance of creating services people felt able to access.

Today, Portsmouth Sexual Health Service provides considerably more than treatment alone. Alongside clinical care, residents can access online STI testing, condoms by post, contraception services, outreach programmes and education, reflecting a broader focus on prevention and wellbeing.

From restriction to reproductive choice

Few developments illustrate changing attitudes to health, equality and personal choice more clearly than contraception.

In the early twentieth century, access to contraception was heavily restricted by

social, religious and medical beliefs. Family planning advice was often unavailable to those who needed it most, with access strongly influenced by marital status and financial circumstances. Women experiencing the greatest burden of poor health, poverty and repeated pregnancies frequently had the fewest opportunities to obtain reliable information or support.

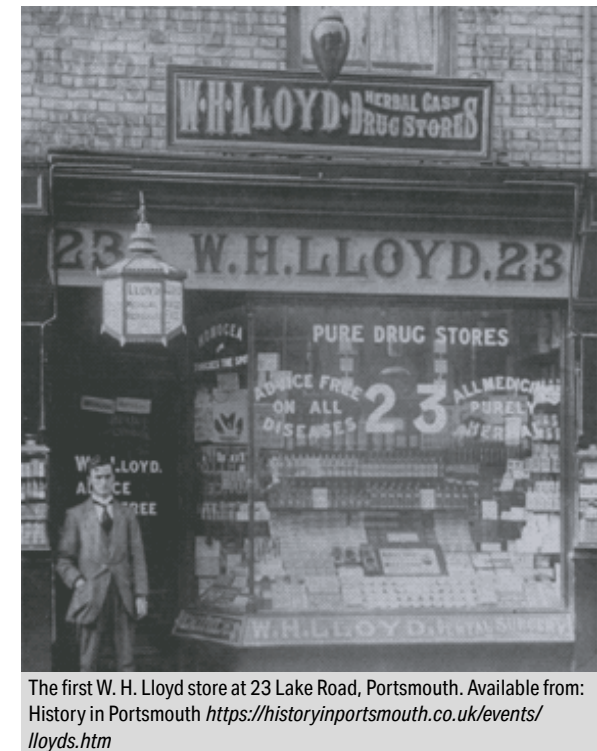
The opening of Britain's first birth control clinic by Marie Stopes in 1921 marked an important turning point, helping establish contraception as a healthcare issue rather than simply a moral or social concern.²⁸

Portsmouth also played a role in improving access. In 1948, Lloyd's Pharmacy pioneered one of Britain's first postal contraceptive services, supplying condoms by mail order in plain packaging to maintain discretion. At a time when sexual health products were rarely advertised openly, the popularity of the service demonstrated substantial public demand for family planning support.²⁹

The introduction of the contraceptive pill during the 1960s transformed reproductive healthcare. Although initially available only to married women, access gradually expanded following the Family Planning Act 1967,

which enabled local authorities to provide contraceptive advice and supplies through the NHS, including for unmarried women.

Today, Portsmouth residents can access a wide range of free contraceptive options through GP practices, pharmacies and sexual health services. Contraception is increasingly recognised not only for preventing pregnancy but also for supporting women's health through the management of conditions such as heavy



The first W. H. Lloyd store at 23 Lake Road, Portsmouth. Available from: History in Portsmouth <https://historyinportsmouth.co.uk/events/lloyds.htm>

menstrual bleeding, menstrual disorders and symptoms associated with perimenopause. Over the last century, contraception has evolved from a restricted and controversial subject into an important part of modern healthcare.

“Had to learn from my sister and families didn’t really talk about it.”

Brenda, Portsea (on sex and periods being taboo topics).

Data relating to STIs, contraception and HIV for Portsmouth can be found on our website: <https://www.portsmouth.gov.uk/services/health-and-wellbeing/joint-strategic-needs-assessment/adults-health-and-wellbeing-jsna-report/#sh>

HIV: a public health success story

When HIV emerged during the early 1980s, it was associated with fear, misunderstanding and significant stigma. With no effective treatment available, a diagnosis often carried devastating consequences for individuals and families.

Over the following decades, advances in science, medicine and public health

transformed HIV from a life-limiting condition into one that can be effectively managed. Today, people diagnosed early and receiving treatment can expect to live long, healthy lives. Prevention has also been transformed through the availability of Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP), medicines that significantly reduce the risk of acquiring HIV.

One of the most significant developments has been the recognition that people living with HIV who achieve and maintain an undetectable viral load cannot pass HIV on to sexual partners, a principle known as Undetectable = Untransmittable (U=U). This has transformed both HIV prevention and efforts to reduce stigma.

Portsmouth Sexual Health Service continues to play an important role in HIV prevention, diagnosis and care for residents. The service provides rapid assessment for newly diagnosed patients, lifelong treatment and monitoring, psychological and peer support, specialist pharmacy advice, sexual health care and support for those affected by HIV.

In March 2025, opt-out testing for HIV, Hepatitis B and Hepatitis C was introduced in the Emergency Department at Queen Alexandra Hospital. Patients aged 18 years

and over who require a blood test are routinely tested unless they choose not to be, helping identify infections earlier and improving access to treatment.

Reflection and looking forward

The sexual and reproductive health services available in Portsmouth today are markedly different to what was available 100 years ago. Yet the underlying goal remains the same: preventing ill health, improving wellbeing and ensuring that people have access to the information and support they need.

From controlling venereal disease amongst sailors to expanding contraceptive choice and transforming HIV care, the history of sexual and reproductive health in Portsmouth reflects a century of scientific progress, changing social attitudes and public health innovation. It is ultimately a story of moving from secrecy and restriction towards prevention, choice and better health for all.



Watch the video
Video description
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3

Substance use and recovery

KEY DATES

1920, 1923, 1925, 1932, 1951

Dangerous Drugs Acts, controlled supply and possession while doctors continued prescribing within the 'British System'.

1939

Local resident Will Bell's drawing of pubs and breweries captured the density of Portsmouth's pub landscape.

1971

Misuse of Drugs Act – became the cornerstone of UK drug law, introducing Classes A, B and C and offences for possession, supply and production.

1990s

National drug strategies – 'Tackling drugs together' introduced a cross-government focus on crime, prevention and treatment, with Drug Action Teams and greater recognition of deprivation.

2020s

Public health narrative – the Dame Carol Black review and "From Harm to Hope" strategy renewed focus on treatment, recovery, reducing demand, stigma and harm.

Continued on next page

1926

The Portsmouth Medical Officer report recorded liver disease deaths but made no reference to dedicated alcohol or drug treatment, specialist substance use services or recovery support. 1926 Rolleston report – recognised addiction as a medical condition and allowed doctors to prescribe heroin or morphine for treatment.

1961-1967

Rising heroin use and concerns about over-prescribing led to stronger controls on drugs.

LATE 1980s-1990s

Harm reduction – HIV/AIDS drove needle exchange, outreach and a stronger public health focus alongside enforcement.

2013

Portsmouth Recovery Hub became a central part of the local treatment system.

KEY DATES

2023

Portsmouth completed a women's substance misuse needs assessment to identify barriers to treatment.

2024-25

The number of pubs in Portsmouth was estimated to have fallen to around 114, reflecting changing drinking patterns and the movement of alcohol harm into less visible settings.

2026/27

Planned next steps include developing referral pathways for fibrosis testing, embedding structured recovery check-ups after planned treatment exits, and strengthening early toxicology sharing arrangements across the wider region.

2024

Project W opened as a women-only, trauma-informed safe space, providing integrated recovery, health, domestic abuse, peer and wellbeing support. Portsmouth signed the charter to become an inclusive Recovery City.

2026

Portsmouth completed its Drug and Alcohol Related Death self-assessment and action plan, identifying priorities including non-fatal overdose reporting, recovery check-ups, early liver disease detection and stronger toxicology intelligence.

2026/27

Developing a multi-agency access service supporting people with compounding intersecting needs such as substance use, homelessness and mental health and trauma.

Portsmouth's current challenge

Substance use has always reflected the wider conditions in which people live, but the challenges facing Portsmouth today are more visible, more complex than they were a century ago. Portsmouth continues to experience some of the highest rates of drug-related deaths in the country, with alcohol and drug-related mortality around twice the national average. Behind these figures are people, families and communities affected by poverty, trauma, homelessness, poor physical and mental health, and barriers to timely support.

The reasons are not simple. Substance use harms are a "wicked issue": shaped by deprivation, access to healthcare, the availability and potency of drugs, and the way different disadvantages can accumulate over a person's life. Portsmouth has a high number of people using opiates, and the local picture is increasingly

affected by changes in the illegal drug market. Synthetic opioids, fake or diverted medicines, high-potency cannabis products, ketamine and polysubstance use all create greater and less predictable risks, particularly for people already experiencing exclusion or poor health.

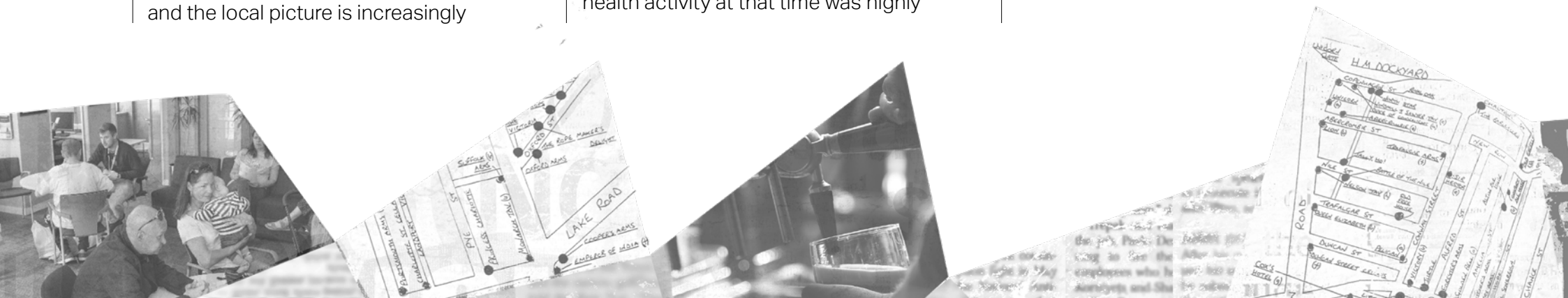
This changing risk environment means that prevention, treatment and recovery support need to be flexible, assertive and relationship-based. It also means that reducing harm cannot sit within one service alone: it requires public health, housing, primary care, mental health, criminal justice, voluntary and community services, and people with lived experience to work together.

Looking back: what was visible in 1926?

The 1926 Portsmouth Medical Officer report¹ tells a very different story. Public health activity at that time was highly

developed in relation to infectious disease, maternal and child health, sanitation and housing conditions. However, there is no clear evidence of alcohol or drug treatment, recovery support or specialist substance use services. Alcohol-related harm is only indirectly visible through mortality data such as cirrhosis (liver damage), and substance use was not yet framed as a public health priority.

This absence matters. It reminds us that what society chooses to measure, name and respond to changes over time. A century ago, any support that existed for people experiencing alcohol or drug harms was likely to be informal, voluntary or punitive, rather than medical, trauma-informed or recovery-focused. The contrast with today's system highlights the progress made.

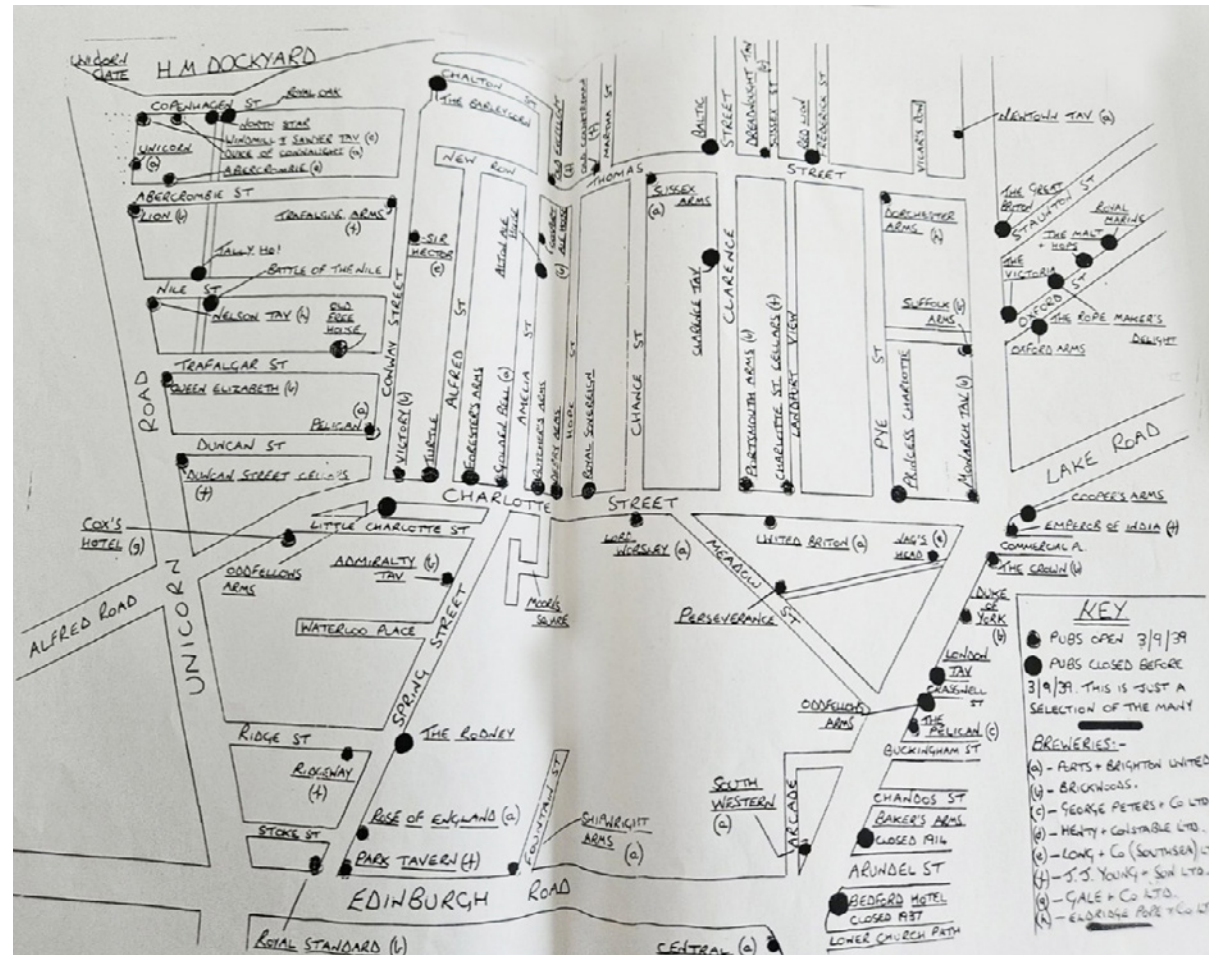


From pub culture to hidden harm

Portsmouth's identity has long been shaped by its dockyard, naval history and dense network of public houses. For much of the last century, pubs were part of the social fabric of many neighbourhoods, particularly around the city centre and communities connected to the dockyard. Local resident Will Bell's drawing of pubs and breweries around Charlotte Street, open as of 3 September 1939, captures how visible and concentrated this drinking culture once was.

That landscape has changed significantly. Pub numbers declined steadily after the Second World War, with closures accelerating from the 1990s onwards due to redevelopment, economic pressures and changing social habits. Around ten years ago Portsmouth was estimated to have around 140 pubs; by 2024–25 this had fallen to around 114.³⁰

“The pubs were the heart of the community. You could smoke in pubs... People would go there to drink and socialise. People would finish work and head to the pub instead of going straight home, and the drink driving policy didn't seem like a thing.” Chris, 68.



Drawing by local resident Will Bell depicting the pubs and breweries around Charlotte Street in 1939.
Available from: <https://www.facebook.com/groups/1429837203969076/posts/4066413663644737>

The decline of pubs can appear at first to suggest a decline in alcohol harm. In reality, the pattern is more complex. In 1926, alcohol consumption was more often associated with weaker beer and public house drinking. Today, people have access to a broader range of wines, spirits and high-strength products, and alcohol is widely available through off-licensed premises and supermarkets.

Alcohol-related harm has not disappeared; in some cases, it has become less visible, with people able to consume alcohol behind closed doors. This reinforces the importance of looking beyond what is obvious in the built environment and understanding the wider commercial, social and health inequalities that shape how harm is experienced.

Portsmouth had significantly higher rates than England in 2024 for the following alcohol-related indicators³¹:

- Alcohol-related mortality.
- Mortality from chronic liver disease.
- Hospital admissions for alcohol-specific conditions.



How support has changed

From specialist treatment to harm reduction

In the early 20th century addiction was recognised as a health condition, treatment was largely individualised and GP-led with heroin prescribed to stabilise dependent patients where appropriate, this was known as the 'British medical system'.

From the 1960s onwards, rising heroin use led to increasing national concern and the development of specialist drug dependency services. The Misuse of Drugs Act 1971 consolidated drug legislation and classification, while specialist NHS services and prescribing models emerged alongside criminal justice approaches. This period

marked the beginning of a more formal treatment response, but support was often specialist, clinic-based and separated from wider community healthcare.

The public health turning point

The HIV/AIDS epidemic in the 1980s changed the public health response. Harm reduction approaches, including needle and syringe programmes, methadone maintenance and low-threshold outreach, expanded rapidly. The focus began to shift from abstinence alone towards safety, stability, engagement and preventing avoidable deaths. This was a crucial moment in recognising that keeping people alive and connected to support is a foundation for recovery.

Expansion, recovery and renewed investment

During the 1990s and 2000s, drug treatment expanded through national targets, voluntary and community sector provision, and closer links with criminal justice. The concept of recovery became more prominent, with a growing emphasis on housing, employment, community connection and rebuilding lives. At the same time, later reductions in funding and workforce capacity contributed to a more fragmented system nationally, at a time when drug-related deaths were rising.

Inclusion health and trauma-informed practice

The current period is one of both urgency and renewal. Recent investment has strengthened treatment, harm reduction and outreach. Services increasingly recognise the importance of inclusion health, trauma-informed practice and health inequalities. This is especially important for people experiencing homelessness, contact with the criminal justice system, poor mental health, domestic abuse, or other forms of multiple disadvantage.

Portsmouth's current provision

Portsmouth's response has developed into a city-wide, multi-agency treatment and recovery system. Public health, housing, criminal justice, NHS partners, voluntary and community sector organisations, and people with lived experience all contribute to a shared aim: reducing harm, improving access, and supporting people to build safer, healthier lives.

The Portsmouth Recovery Hub, established in 2013, became a central feature of this local system. It offers a one-stop, non-judgemental access point for drug and alcohol treatment, alongside clinical prescribing, psychosocial interventions and group-based support. The local system increasingly recognises that recovery is rarely linear. People may move in and out of treatment and benefit from long-term, flexible relationships rather than a single episode of care.



The Recovery Hub, Elm Grove.

4

Tobacco control

KEY DATES

1939-1945 Cigarettes included in military rations during WW2.	1954 Follow up study showed a higher mortality in smokers compared to non-smokers.	1974 First national publication of smoking rates; an estimated 44% of population smoke.	2007 Smokefree legislation introduced.	2024 Portsmouth smokefree alliance created.
1950 Doll and Bradford Hill published landmark UK study linking smoking to lung cancer.	1965 Cigarettes banned from being advertised on TV. Taxation on cigarettes also began to increase.	1984 National No Smoking Day launched.	2015 The Portsmouth Wellbeing Service is launched. Public Health England concludes e-cigarettes are substantially less harmful than smoking and can support quitting.	2026 Tobacco and Vapes Bill gained Royal Assent, aiming for a smokefree generation.

Over the last 100 years, there has been a dramatic shift in how people understand and respond to smoking. In 1926, tobacco use was commonplace and the health risks largely unknown. Despite smoking remaining the leading preventable cause of illness, premature death and a major contributor to health inequalities, Portsmouth has made significant progress in line with national trends. Smoking prevalence has fallen markedly over recent decades, and residents now have access to a broad range of evidence-based support to help them quit.

The following highlights the discoveries, policies and local action that have driven progress and continue to shape our ambition for a smokefree Portsmouth.

Normalisation: 1920s-40s

Cigarette smoking is widely normalised across the city, including workplaces and the Armed Forces; no health warnings or restrictions and certain campaigns were endorsed by medical professionals to encourage people to use certain brands of cigarettes.

During the Second World War, with Portsmouth's long naval history, cigarettes were included in military rations and promoted for morale and stress relief.

"I started smoking at 13 and getting through 20 cigarettes a day. Lots of people smoked in Paulsgrove back then, it was what everyone did. I wish I'd never touched a cigarette, now I've got heart problems and COPD."

Tony, Paulsgrove.

Scientific breakthrough: 1950s-1960s

A landmark UK study was published by Doll & Bradford Hill in 1950, linking smoking and carcinoma of the lung, which stated that smoking was an important cause of lung cancer.³²

The advertisement is a full-page spread. The top half features a large portrait of a middle-aged man with grey hair, wearing a white shirt and a dark tie, holding a lit cigarette. To his left is a yellow text box with the following text: "He's one of the busiest men in town. While his door may say *Office Hours 2 to 4*, he's actually on call 24 hours a day. The doctor is a scientist, a diplomat, and a friendly sympathetic human being all in one, no matter how long and hard his schedule." Below the portrait, the headline reads: "According to a recent Nationwide survey: **MORE DOCTORS SMOKE CAMELS THAN ANY OTHER CIGARETTE**". Below the headline, there is a small paragraph: "DOCTORS in every branch of medicine—113,597 in all—were queried in this nationwide study of cigarette preference. Three leading research organizations made the survey. The gist of the query was—What cigarette do you smoke, Doctor? The brand named most was Camel! The rich, full flavor and cool mildness of Camel's superb blend of costlier tobaccos seem to have the same appeal to the smoking tastes of doctors as to millions of other smokers. If you are a Camel smoker, this preference among doctors will hardly surprise you. If you're not—well, try Camels now." To the right of this text is a small illustration of a Camel cigarette pack. Below the pack is a woman's face, with a red box highlighting her mouth area. To the right of her face is the text: "Your 'T-Zone' Will Tell You... T for Taste... T for Throat... that's your proving ground for any cigarette. See if Camels don't suit your 'T-Zone' to a 'T.'" At the bottom left, the word "CAMELS" is written in large, bold letters, followed by "Costlier Tobaccos" in a smaller font.

1946 advertisement.³³

BRITISH MEDICAL JOURNAL

LONDON SATURDAY SEPTEMBER 30 1950

SMOKING AND CARCINOMA OF THE LUNG

PRELIMINARY REPORT

BY

RICHARD DOLL, M.D., M.R.C.P.*Member of the Statistical Research Unit of the Medical Research Council*

AND

A. BRADFORD HILL, Ph.D., D.Sc.*Professor of Medical Statistics, London School of Hygiene and Tropical Medicine; Honorary Director of the Statistical Research Unit of the Medical Research Council*

Headline in the British Medical Journal, 1952. Available from: <http://www.epi.umn.edu/cvdepi/document/a-study-of-the-aetiology-of-carcinoma-of-the-lung>

This evidence started to help shift smoking from a normal personal habit to a recognised cause of preventable illness and death. This created the argument for smokefree policies and stop-smoking support.

This was followed up with a 1954 study, which sent out over 34,000 questionnaires to male British physicians, to record details of their smoking habits. It showed a higher mortality in smokers, compared to non-smokers, and concluded that lung cancer could not be attributed to pollution exposure.³⁴

Just as research helped transform our understanding of smoking and led to policies that improved population health, research continues to play a vital role in tackling today's health inequalities. Through our Health Determinants Research Collaboration (HDRC), we are strengthening how evidence, learning and community insight inform decisions across Portsmouth.

Regulation and shift in public opinion: 1960s-1990s

Throughout the late 20th century, some controls on tobacco were introduced, but many remained voluntary. In 1965, cigarettes were banned from being advertised on television and taxation on cigarettes slowly began to increase.

In 1974, the first national publication of smoking rates showed an estimated 44% of the population smoked.³⁵

Public opinion began to shift and in 1984 National No Smoking Day was launched to encourage smokers to quit smoking.

During the 1980s and 1990s, evidence accumulated showing the substantial cost of smoking related diseases to the NHS and wider economy, including:

- The costs of treating smoking related cancers, heart disease and respiratory illness.
- Productivity losses from sickness and premature mortality.
- The financial burden on public services in the city.

Smokefree environments and stop smoking support: 2000-2015

In the early 2000s legislation on tobacco really began to change.

The introduction of smokefree legislation in 2007 meant smoking was no longer permitted in pubs, restaurants, workplaces and enclosed public spaces, reducing exposure to second-hand smoke for residents and workers. The legislation marked a major shift in social norms, helping make smoking less visible and less acceptable, while supporting more smokers to consider quitting.



Front Page from The Daily Mail, 2004. Available from: <https://www.dailymail.com/news/article-13791941/how-britain-looked-2007-smoking-ban.html>

The estimated smoking prevalence in Portsmouth was 24.7% in 2011 and down to 21.5% in 2014, however the rates differed for some population groups.³⁶

- **Smoking at time of giving birth:** 17.9% in 2011 and 15.9% in 2014.
- **Routine and manual workers:** 35% and down to 29.9% in 2014.
- **Adults with long-term mental health conditions:** 40.1% in 2013/2014.

The Portsmouth Wellbeing Service was launched in October 2015, with the

mission of helping those who live or work in Portsmouth to stop smoking, drink less alcohol and get to a healthy weight.

The service works across some of the most deprived areas of the city and can provide free stop smoking products to residents such as nicotine replacement therapy and stop smoking medications.

In 2015, the Public Health England evidence review concluded that e-cigarettes are substantially less harmful than smoking and can support quitting.³⁷



Public health message stressing the relative safety of e-cigarettes. Available from: <https://www.bbc.co.uk/news/health-66852503>

Growth of Portsmouth stop smoking support and declining smoking rates: 2016-2025

Stop smoking support increased throughout the city with the Wellbeing Service being the main provider, supporting people in-person and via telephone. Local pharmacies were also commissioned to provide support to residents as well as Tobacco Dependency Advisors being recruited to work within our hospitals.

Our local stop smoking campaigns progressed to include sharing the annual national Stoptober campaign to local stop smoking campaigns – a contrast to the advertisements promoting smoking seen in 1926.

In 2025 Portsmouth Wellbeing Service celebrated its 10-year anniversary, having supported over 10,000 quit attempts with residents.³⁸

"What began as one-to-one client sessions only has now grown into a multifaceted support system, including drop-in clinics, group interventions, and telephone support ensuring we meet the diverse needs of our community. We have supported thousands of individuals in making sustainable lifestyle changes. We don't just help people quit smoking, lose weight, or reduce alcohol consumption anymore, we offer a holistic experience that helps clients explore and address underlying factors contributing to unhealthy or risky behaviours."

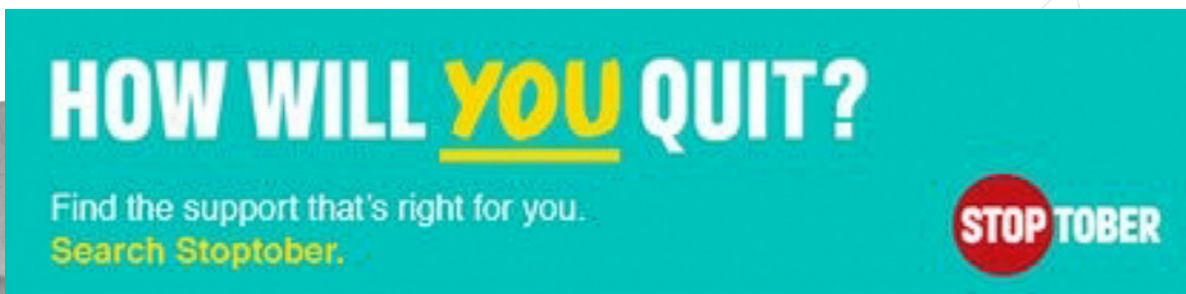
Sophie, Senior Practitioner, Wellbeing Service.



Above: Portsmouth City Council Wellbeing Service stop smoking campaign poster.

Far left: Stoptober campaign banner.

Left: Stoptober promotional poster for the NHS John Jenkins drop-in clinic.



Overall, smoking rates are reducing but remain high in certain population groups (shown below).

Table 2: Portsmouth smoking prevalence 2016 and 2025³⁶

Smoking prevalence	2016		2025	
	Portsmouth	England	Portsmouth	England
Adult population	20.1%	15.5%	10.5%	10.4%
Smoking at time of giving birth	13.2%	11.0%	6.8%	6.1%
Routine and manual workers	25.3%	26.5%	19.3%	19.2%
Adults with long-term mental health conditions	37.1%	33.0%	28.7%	24.0%

Reflection and looking forward

Over the last century, smoking has shifted from being widely accepted to being recognised as a major preventable cause of illness and inequality. National legislation is going further in protecting future generations from the harms of smoking. Fewer Portsmouth residents now smoke, and support to quit is more available than ever.

Wider tobacco control and smokefree generation: 2026 onwards

Stop smoking support – As well as the services providing support across the city, residents now also have access to digital support via the smokefree app.

Youth vaping – A Needs Assessment with young people throughout the city was completed. 171 young people provided the public health team with feedback and recommendations on what we can do to protect them from the harms of vaping. This included training trusted adults and creating a peer-led education programme.

Trading Standards – Public Health undertake partnership work with the Council's Trading Standards team to tackle illicit tobacco, illegal vapes and underage sales continues. The team supports national initiatives such as Operation Viper and uses local intelligence to remove large quantities of illegal products from Portsmouth retailers.

Smokefree Alliance – The Portsmouth Smokefree Alliance moves into its second year. The Alliance brings together partners from local government, NHS services, pharmacies, education and VCSE organisations to deliver the **Portsmouth Tobacco Control Plan**,³⁹ with future priorities focused on reducing smoking related health inequalities, supporting more people to quit, preventing youth smoking and vaping, tackling illicit tobacco and vapes, and strengthening system-wide collaboration.

Tobacco and Vapes bill – The Tobacco and Vapes Bill gained Royal Assent on the 29 April 2026. This landmark bill will introduce measures to create a smokefree generation, including making it illegal to sell tobacco to anyone born on or after 1 January 2009, it will also strengthen restrictions on vape sales and marketing, as well as introducing new enforcement powers and a retailer licensing team.

"I started smoking at 15, you could buy cigarettes in fives, and children could collect them from the shop with a note from their parents. Looking back, it's hard to believe children could walk into a shop and buy cigarettes!" Celia, 82, Paulsgrove.

5

Dental health

KEY DATES

1926

Dental care depended on ability to pay; decay, tooth loss and extractions were common, while school dental services were emerging.

1980s-2000s

Fluoride toothpaste, brushing and public health messaging reduced decay, with dentistry focusing more on prevention, saving teeth and tackling sugar, diet and inequality.

1948

Free NHS dental care reduced the wealth divide, but tooth decay and unmet need remained high as care shifted towards treatment and restoration.

2026

Poor oral health is largely preventable, but deprivation and access inequalities persist despite stronger prevention and targeted programmes.

Portsmouth is 'desert' as despoiled city to WATCO

IG AND CARCINOMA PRELIMINARY REPORT

RICHARD DOLL, M.D., M.R.C.P.

A. BRADFORD HILL, Ph.D., D.Sc.

London School of Hygiene and Tropical Medicine, Honorary Research Unit of the Medical Research Council

City of Portsmouth
HEALTH REPORT
For the Year 1926

From extraction to prevention

In the past 100 years there have been many positive changes around dentistry including prevention and treatment options.

In the 1920's specific dental data was limited and is difficult to obtain, but wider neighbourhood health inequalities were already visible as set out in the 1926 Medical Officer of Health report.

Population-level data on dental health only became routinely available in the late 1990s, when dental records became digitalised. However, from generic written reports we can confidently say dental health was poor 100 years ago and has been improving, due to:

- **Advancement in the dental profession** – Dentist Act 1921 formalised training and registration, aided further by the creation of General Dental Service and frameworks under the NHS in 1948.
- **Improved knowledge on preventative approaches** – i.e. regularly toothbrushing, fluoride toothpaste (instead of salt powder), impact of dietary behaviours, fillings instead of teeth removal etc.

Royal Navy dentists: keeping the fleet mission-ready at sea

As a proud navy city, ensuring the health and wellbeing of serving personnel is key to keeping crews healthy, deployable and mission-ready. One area that has changed considerably in the last 100 years is dental health.⁴⁰

- **Basic care** – 100 years ago rotten teeth and scurvy were common, with poor disinfection of instruments just as dangerous to sailors' lives. Historically, the ship surgeons carried out basic dental treatment alongside other medical duties.
- **A modern transformation** – a major turning point came in the early 1960s when purpose-designed dental surgeries were first incorporated into Royal Navy ship design. Modern vessels include dedicated dental facilities, from portable units on frigates to fully equipped surgeries and laboratories on HMS Queen Elizabeth.

- **A unique clinical environment** – Royal Navy dentistry has evolved into a specialist service with treatment delivered aboard warships, often at sea and in challenging conditions, requiring specialist skills and adaptable equipment, to help maintain operational readiness, ensuring sailors are fit to deploy anywhere in the world.



Toothpulling, a frequently performed dental procedure, was frequently staged in comedic performance, ca. 1892. National Library of Medicine #101393641. Available from: <https://medicineonscreen.nlm.nih.gov/2015/02/05/come-with-me-into-the-visual-instruction-room>

Has oral health and dentistry really changed?

Yes:

Dental health in 1926 = poor	Dental health in 2026 = superior, but room for improvement
- o Tooth decay was widespread, and natural teeth for life was unusual. - o Dental hygiene education was emerging, but not yet widespread or standardised. - o Many people delayed care until pain became severe and then tooth removal was common. NHS didn't arrive until 1948. - o Dentistry was often reactive, painful, and focused on removing the problem – tooth extractions – rather than saving teeth.	- o Although tooth decay is still common, advances in prevention and treatment mean most people keep the majority of their teeth for life. - o Major improvements in oral health promotion, with regular brushing, fluoride and dietary messaging central to campaigns. Preventing tooth decay is the focus. - o NHS dental services are available across the UK, with many treatments free or subsidised, resulting in wider engagement with dental services and earlier treatment. - o Dentistry is a recognized profession within health, with national systems and guidelines. Advanced treatments save teeth, with extractions often a last resort.

In 100 years, we moved from extraction-focused care to prevention and tooth-saving treatment.

No:

Supervised toothbrushing

The school 'Toothbrush Drill' in the 1920s has been replaced by 'supervised toothbrushing' in 2025. We currently have 32 early year settings and schools participating in our Portsmouth 'supervised toothbrushing' programme delivered by the University of Portsmouth Dental Academy and the NHS Specialist Dental Team from the local Community Health Trust.



Toothbrush Drill at a school in England circa 1920. Available from: <https://wellcomecollection.org/works/y79uekby>

These are similar interventions, with the emphasis of preventing poor oral health/tooth decay in children.

"Dentist came in to school every 6 months and you would get toothpaste in a tin and get a toothbrush, used to make it last."

Carole, Brenda and Jan, Portsea Hub.

More schools to be asked to supervise toothbrushing



BBC News Headline March 2025. Available from: <https://www.bbc.co.uk/news/articles/cn8r4vx4j38o>

Inequalities – socio-economic status

In 1926 the inequalities between rich and poor were in terms of ability (funds) to access dentists, however today, despite free NHS access for all, we see similar issues.

Poor oral health/tooth decay is more prevalent within our more deprived communities, with diet and access to dentists two key factors. Children living in deprived areas are three times more likely to need dental extractions in hospital.⁴¹

Analyses (published in 2023) carried out by the University of Portsmouth, involving data relating to local school aged children, highlights significant oral health inequalities that still exist in Portsmouth⁴²:

- 5,860 appointments analysed aged 0-17 years, 2018-2022.
- Nearly 3 x rise in child emergency dental pain appointments between 2018 and 2022.
- 24% of 2022 emergency pain appointments were under 18 year olds.

Limited access to NHS dentists and cost of treatment can be barriers, leading to self-appointed dental care like we'd have seen 100 years ago i.e. removal of own teeth, as was reported in the news in 2025.⁴³ Alternatively many people are finding they have to travel long distances for an NHS dentist.⁴⁴

"Dental visits felt straightforward back then, but now they seem out of reach for many people." Tony, Paulsgrove.

People pulling own teeth due to lack of urgent NHS dental care in England, watchdog finds

Emergency help should be available, but some being forced to travel 100 miles or go private, says Healthwatch England



Headline from The Guardian 2025. Available from: <https://www.theguardian.com/society/2025/dec/15/people-pulling-own-teeth-due-to-lack-of-urgent-nhs-dental-care-in-england-watchdog-finds>

Portsmouth is branded a 'dental care desert' as desperate family travels from city to WATFORD for NHS treatment

Headline from The News, 2022. Available from: <https://www.portsmouth.co.uk/news/people/portsmouth-is-branded-a-dental-care-desert-as-desperate-family-travels-from-city-to-watford-for-nhs-treatment-3743629>

Reflection and looking forward

We've moved from pulling teeth to preventing disease, but as we look towards the next 100 years, we need to build on the positive preventative approaches already in place and work collaboratively to reduce the gap in oral health outcomes between our most and least deprived communities.

With extensive collaboration between partners across the city, the University of Portsmouth Dental Academy were successful in their bid to become a full dental school.⁴⁵ This secures the future of dentistry locally, increasing capacity, knowledge and skills, building a sustainable workforce to support the oral health challenges faced by Portsmouth residents in the years to come.

Whilst much focus of targeted oral health interventions is with children from deprived communities, at the other end of the scale, modern technological advances i.e. intraoral cameras are being used with our older population living in residential homes, to support earlier treatment and preventative care.⁴⁶



University of Portsmouth Dental Academy



6

Childhood infections

KEY

DATES

VACCINES INTRODUCED

1942

Diphtheria.

1956

Inactivated polio.

1961

Tetanus.

1968

Measles.

1988

MMR.

1950

BCG (TB).

1957

Pertussis.

1962

Live oral polio.

1970

Rubella.

1992

Hib conjugate.

Portsmouth is
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city to WATFO

City of Portsmouth
HEALTH REPORT
For the Year 1926

Infant mortality has long been used as an indicator of the general health of the entire population, reflecting wider social, economic and environmental conditions as well as the quality of healthcare available to mothers and babies.⁴⁷ A century ago in Portsmouth childhood illness, infection and death were sadly a normal part of life.

Infant survival has improved dramatically in Portsmouth, mirroring the national picture over the past century. In 1926, there were 247 infant deaths (under one year of age), equivalent to an infant mortality rate of 54.9 deaths per 1,000 live births. By 2024, this had fallen to just seven infant deaths, with a rate of 3.4 deaths per 1,000 live births.⁴⁸ Relative to its time, Portsmouth performed better than England and Wales in 1926, where the infant mortality rate was 70 deaths per 1,000 live births. Today (2022-24), Portsmouth's rate remains statistically similar to the England average of 4.2 deaths per 1,000 live births.⁴⁶

Poverty, crowded housing and poor sanitation were major drivers of the spread of infection in 1926. At that time, infant mortality varied substantially across Portsmouth's wards, ranging from 35 deaths per 1,000 births in Buckland to 88 in St. Mary. The highest rates were recorded

in St. Mary, Mile End and Town Hall, while Buckland, St. Simon and North End experienced the lowest rates.¹ The variation between wards highlights the significant health inequalities that existed within the city.

The rate of deaths in infants under one year of age per 1000 births was 103 in babies born to unmarried mothers compared to 52 per 1000 births in married mothers.

At the time, unmarried mothers and their children more likely to have faced a life of poverty and social exclusion. Strong social stigma, limited employment opportunities, inadequate maintenance payments from fathers and restricted welfare provision left many women economically vulnerable.⁴⁹

Apart from prematurity and congenital conditions, which were responsible for 28% of deaths in under 5s (112/395), Table 3 outlines the leading causes of death in this age group.

Table 3: Leading causes of death in 0–5-year-olds in 1926.¹

Disease	Deaths
Broncho-pneumonia	59
Diarrhoea and enteritis	39
Diphtheria	30
Whooping cough	16
Measles	11

Vaccine-preventable diseases: then vs. now

In 1926, 98% of deaths from diphtheria were sadly in children aged under 15 years (65/66 deaths). In fact, 45% of deaths were specifically in children under 5 years old. That year there were 947 cases of diphtheria in Portsmouth and 924 of them were admitted to hospital.

Diphtheria was one of the most feared childhood diseases at the time, often suffocating young children through swelling in their throats. Other now vaccine preventable diseases such as polio left some children with permanent paralysis. Others like measles, scarlet fever and tuberculosis also caused significant ill health

in children and disrupted their families' lives. Many were helpless to prevent this from happening. 10% of deaths from tuberculosis in 1926 were in children under 5.

"...Every house from which a case of diphtheria was notified was visited... nearly every case was isolated in hospital; contacts were kept away from school, and various other measures were taken that seemed likely to control the disease. The spread of diphtheria must be largely due to undetected carriers, and to children with infective nasal discharge..." Dr. A. Mearns Fraser.¹

Today, universal routine childhood immunisations have made many of these diseases rare in Portsmouth and in the UK overall.

What changed?

The decrease in childhood infections over the last 100 years was not achieved by any one intervention or action. Decades of coordinated public health action towards prevention across healthcare, nutrition,

housing, education, sanitation and maternity care has led to fewer childhood infections:

- The rollout of local vaccination campaigns initially and then widely coordinated and provided to the public via the NHS after its creation in 1948. For example, vaccination against Diphtheria was approved by the Health Committee in Portsmouth in 1935 ahead of the national roll out in 1946. Table 4 describes changes in numbers of cases and deaths over the last 100 years.
- Inspection of food and supervision of food handling to prevent contamination and improve hygiene standards and appropriate food handling.
- Improvements in housing and sanitation to limit opportunities for infection transmission.
- Improved access to health visitors and midwives to improve pre and post-natal care for mother and baby.
- Better nutrition to improve children's health e.g. free milk and vitamins to expectant mothers and young children and the provision of meals and milk in schools.
- Better treatment for infectious disease in hospitals.

"School vaccinations were a big event – the whole class queued up and waited their turn. After our BCG vaccinations, we were sent for chest X-rays. Today, would seem extraordinary." Celia, 82, Paulsgrove.

"I was a milk monitor at school (7yrs old), everyone wanted to be a milk monitor. All the children in primary school got given milk, there wasn't much healthy food, so it was a way to make sure you had something good." Carole, 86, Buckland.



Carole at school (far right).

Where are we now?

Childhood deaths from infectious diseases have fallen dramatically since 1926 and many serious infections are now rare because of routine vaccination, improved living conditions and effective healthcare and treatment.

Table 4: Diphtheria cases and deaths in Portsmouth, 1926-2025^{1,50}

Year	Cases	Deaths
1926	947	66
1935	422	39
1947	15	1
1965	0	0
1970	0	0
2025	195*	0

Notifications **NOT cases for *C. diphtheriae* and *C. ulcerans*, two bacteria that cause Diphtheria – there were no cases of diphtheria in Portsmouth in 2025. From January to December 2024, toxigenic corynebacteria were isolated from 12 individuals in England; 2 *Corynebacterium diphtheriae* (*C. diphtheriae*) cases and 10 *Corynebacterium ulcerans* (*C. ulcerans*) cases; there were no deaths.⁵¹*

Infectious diseases have not disappeared completely so prevention remains essential. Measles outbreaks have re-emerged in several parts of England in recent years where vaccination uptake has declined.

These outbreaks show that diseases can quickly return when herd immunity fails.

What is herd immunity?

It is an indirect form of protection that occurs when a large percentage of the population has become immune to infection usually through vaccination or past infection. This prevents the spread of infection.

Portsmouth, like many parts of the United Kingdom, continues to experience inequalities that influence children's health. Some families live in more deprived areas than others and have worse health outcomes associated with infectious disease, compared to those from less deprived areas. Many of these families face different challenges like accessing healthcare and adequate housing.

Vaccination uptake varies between communities due to differences in access and delaying or declining vaccination because of confusing or misleading information about vaccine safety.

Reflection and looking forward

The past 100 years demonstrate what can be achieved when science, public health and communities work together. Diseases that once caused fear across Portsmouth have been prevented through collective public health action. These achievements have saved countless lives and allowed generations of children to grow up healthier than ever before.

This progress should not be taken for granted. Infectious diseases continue to evolve, new health threats emerge, and existing diseases can return if vaccination rates decline. Protecting children requires ongoing commitment from communities, schools, healthcare professionals, local authorities and families.

The World Health Organization (WHO) recommends a target of 95% vaccination coverage to protect vulnerable groups – like newborns, the elderly, and the immunosuppressed – who may not be able to be vaccinated themselves. In 2024-2025, 86.9% of 5-year-olds in Portsmouth received 2 doses of the measles, mumps, rubella (MMR) vaccine; 94.3% received at least one dose. In the same period, 86.6% received the fourth dose of the diphtheria

tetanus polio and pertussis (Dtap/IPV) vaccine booster. Although these levels were higher than the England rate, they did not meet the national target of 95% coverage, and this means that many of our children are not fully protected against these vaccine preventable diseases.

Looking to the future, prevention remains one of the most effective investments in children's health. Maintaining high vaccination uptake, tackling health inequalities, supporting parents with

trusted information and responding quickly to emerging infections will help ensure that future generations enjoy the same protection achieved over the last century.

The rapid spread of misinformation through social media presents a modern public health challenge that did not exist for previous generations. The next 100 years will depend on maintaining a strong commitment to prevention and reducing health inequalities, so every child has the healthiest possible start in life.



7

Air, water, housing and ill health

7

Air, water, housing and ill health

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KEY DATES

1909

Housing and Town Planning Act empowered councils to inspect housing, plan towns and prevent substandard back-to-back homes.

1926

Public Health (Smoke Abatement) Act gave councils stronger powers to tackle smoke pollution.

1956

Clean Air Act introduced smoke control areas following the deadly 1952 Great Smog.

1995

Environment Act introduced local air quality management duties.

2020

Ella Adoo-Kissi-Debrah became the first person in the UK to have air pollution listed as a cause of death.

2022

Building Safety Act reformed high-rise safety following the Grenfell Tower tragedy.

2025

Water (Special Measures) Act strengthened monitoring, fines and enforcement over sewage spills.

1919

Addison Act introduced state-subsidised social housing and boosted council housebuilding.

1945

Water Act laid the foundations for a coordinated national water supply policy.

1974

Control of Pollution Act strengthened pollution controls and the "polluter pays" principle.

2004

Housing Act introduced the HHSRS and mandatory licensing for larger HMOs.

2021

Environment Act set long-term environmental targets and duties to reduce storm overflow impacts.

2025

Awaab's Law Phase 1 set strict timescales for social landlords to investigate and fix damp, mould and emergency hazards.

2026

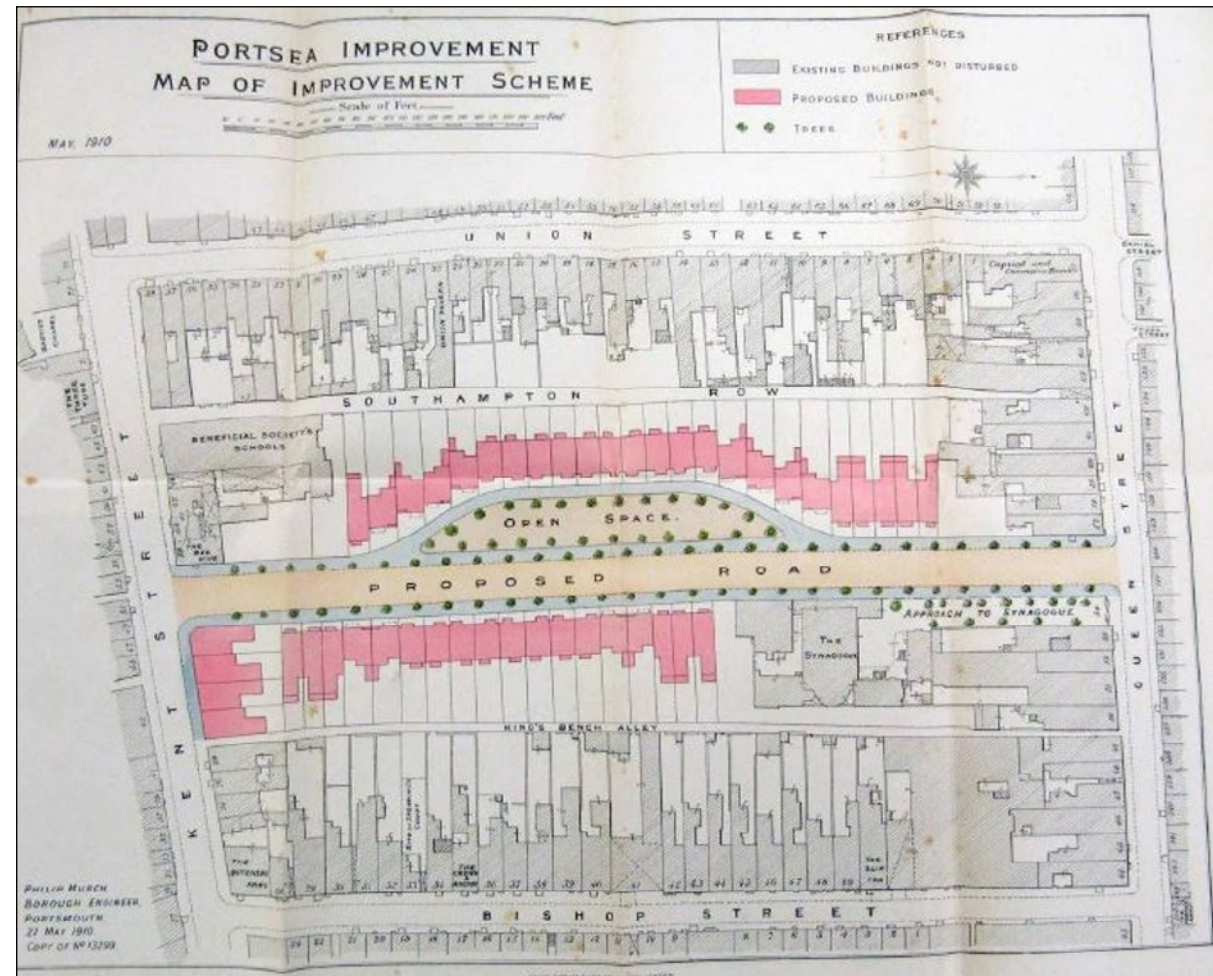
Awaab's Law Phase 2 extended urgent response duties to more social housing hazards.

A lung for the neighbourhood

By 1926, the Medical Officer for Health, Andrew Mearns Fraser had already been in post for 31 years and had established himself as a progressive thinker and public health reformer.

In a 1910 report entitled 'Improvement Scheme for an Unhealthy Area in Portsea', rather than simply calling for slum clearance, he recommended an inner-city town planning scheme not unlike those proposed today, such as the Somers Orchard development.⁵² A notable feature of Mearns Fraser's proposal was a central square 'planted with trees, which shall be a lung for the neighbourhood, and afford a playground for children'.⁵³

This same approach – improving health and wellbeing by working with other parts of the Council (including the Transport, Planning, Housing, and the Climate Resilience and Natural Environment teams) – informs the work of public health today; our focus is on those parts of the city where the need is greatest. Parks and open spaces remain lungs for neighbourhoods, while trees and other green and natural infrastructure can protect against air pollution, soak up excess water during periods of heavy rainfall, and



Portsea Improvement Scheme Map. Available from: <https://municipaldreams.wordpress.com/2020/04/21/council-housing-in-portsmouth-part-i>

help keep the city cool during heatwaves. The Council's **Nature Positive Portsmouth**⁵⁴ programme is one way we are achieving this today.

Air quality 1926

1926 saw the introduction of the Public Health (Smoke Abatement) Act. This updated previous laws from 1875 and 1891 and gave Local Authorities expanded powers to take action against industrial and domestic smoke emissions that were causing "nuisance" to public health.

We don't have local contemporary records of what air quality was like in Portsmouth in 1926, but we can infer that levels of pollution were much higher and more harmful to health than today. Especially in winter, the air would have been filled with coal smoke from both domestic and industrial chimneys; Portsmouth dockyard was thought to be the largest industrial site on earth in the nineteenth century. Inevitably, this will have contributed to significant levels of lung disease in the city, in addition to other risk factors such as high smoking rates, and poor housing conditions.⁵⁵

The Health Report for the Year of 1926 details that there were 376 deaths that year from respiratory diseases (14% of

deaths from all causes), with 349 of those from bronchitis or pneumonia. These were spread across the age range but particularly affected the 0-5 age group and older people.¹ While it's not possible to say categorically that Portsmouth's air quality in 1926 caused these deaths – infectious diseases would also have contributed – we suspect it may have led to many dying earlier than they otherwise might. No less than 29 factories, workshops and workplaces were found to be in 'want of ventilation' during the previous year, with this lack remedied in all cases, showing that a hundred years ago, there was strong local environmental health regulation and enforcement.



Dockyardmen at outmuster crossing tramlines at the Commercial Road Junction with Edinburgh Road, circa 1920s. Available from: <https://www.portsmouth.co.uk/heritage-and-retro/retro/9-photos-of-cyclists-and-their-bicycles-through-the-years-3290283>

Although the city's air quality was afforded greater protection than London owing to offshore winds, in certain weather conditions – a layer of warm air trapping a layer of cold, polluted air – maritime fog will have transformed into a sulphurous smog. These 'pea-soupers' contributed to immediate and long-term respiratory and cardiovascular complications. City smog was eventually tackled through the Clean Air Act in 1956.

Today, about half the air pollution in the city results from road transport. However, car ownership was only beginning to take off in the 1920s and was yet to have a significant impact on air quality, with most people commuting to work by bike, on foot, or making use of electric trams or motorbuses run by Portsmouth Corporation Transport. Photographs from the time show workers leaving the Naval Dockyard en masse on cycles.⁵⁶

"It's all changed so much – you were lucky if you had a car. Most people would take public transport. Most cars were unreliable too."

Rose, 61, lived most of life in Drayton/Farlington.

Air quality 2026

Today we know better than ever that our neighbourhoods need the lungs that green and open spaces provide. When we consulted Portsmouth residents about air pollution in 2025, 73% of respondents were concerned about air pollution, and 69% felt that the air in their own neighbourhoods is particularly polluted some or all the time. 91% wanted us to use trees, hedges and other planting (natural infrastructure) to improve air quality.

Understanding that there is no safe level of air pollution, and that those who are most at risk include children, pregnant women and their unborn babies, older people, people with pre-existing health conditions, and those living in the most deprived areas of the city, we have developed our **Clean Air Strategy 2026 – 2040: Improving Air Quality for a Green and Healthy Future**.⁵⁷

Its mission statement is:

Everyone in Portsmouth should be able to breathe air that does not damage their health and wellbeing. We will:

- Prevent sources of pollution
- Limit exposure to pollution
- Protect the most vulnerable

The action to use natural infrastructure to improve air quality echoes Mearns Fraser a hundred years on, as we strive to further develop the city's green lungs.

Since 2018, the estimated mortality burden associated with long-term exposure to particulate air pollution has decreased in Portsmouth. In 2024, the proportion of deaths attributable to long-term exposure to particulate matter air pollution was below the England average for the first time, accounting for 4.9% of all deaths among those aged 30 years and over in Portsmouth, compared with 5.3% in England. This is an improvement from 2020, when the corresponding figure was 6.9%, around 1.3 percentage points above the England average.

However, we must continue to further improve air quality. Through the Portsmouth Clean Air Pledge, along with our partners in the city, we have committed to a unified and coordinated approach to improve air quality in our city.



Clean Air Strategy and Clean Air Pledge documents.



Clean air pledge signing, January 2026.

Water quality 1926

In the 1920s, Portsmouth's drinking water was of excellent quality, sourced from pure South Downs chalk aquifers and treated at the Farlington filtration works. However, the city's coastal and harbour waters were highly polluted, as untreated municipal sewage and naval waste were frequently discharged directly into tidal creeks and the Solent. Built in 1865 to combat cholera epidemics, the Victorian-engineered Eastney Pumping Station used massive steam-powered beam engines to pump sewage out to sea.⁵⁸ While this kept the streets clear of sewage, the discharge of raw waste into coastal waters remained an ongoing environmental and bathing water quality challenge. In 1926, there were 14 cases of enteric or typhoid fever – a huge reduction from the 1083 cases and 92 deaths in 1900.

Flooding was also an issue in 1926, with substantial coastal flooding that year in Portchester.⁵⁹ Until flood defences were installed later in the twentieth century, areas of the city would regularly flood, particularly parts of Old Portsmouth.⁶⁰



Portsmouth flooding in 1913. Available from: <https://historyinportsmouth.co.uk/events/broad-street-floods.htm>

Water quality 2026

A hundred years on, water quality remains a public health issue. Faecal bacteria (for example *Escheria coli*, *e.coli*) can be harmful to health if ingested from bathing water or shellfish.⁶¹ The Environment Agency monitors water quality, and current classifications for Southsea East and Eastney are considered 'poor' and 'good', respectively.⁶² The source of the faecal bacteria at these bathing waters may be

from several sources, including: agricultural sources, sewage, and other sources including urban runoff, dogs and birds.

Climate change has a range of water quality impacts, including changes to river flow, groundwater recharge and water temperatures. Rainfall patterns will change and winter rainfall will occur in heavy events while summer rainfall will decrease. The trend of more intense rainfall events is expected to continue.

Housing and built environment 1926

In a report to the Town Council in 1909, Mearns Fraser described the slum conditions in which people were living in the 'courts and dwellings' of Portsea:

"... the narrowness, closeness, bad arrangement and bad condition of the streets and houses and groups of houses, together with the want of light, air, ventilation and proper conveniences, and other sanitary defects, are dangerous and injurious to the health of the inhabitants of the buildings in the said area, and that the evils connected with such

houses, streets, courts and alleys and the sanitary defects in the area cannot be effectually remedied otherwise than by an Improvement Scheme for the re-arrangement and reconstruction of the streets and houses within said area."⁶³

Mortality rates in the slums were more than double than the rest of Hampshire, with a third of deaths from tuberculosis.¹⁷ Often, children died before the age of two from gastric and intestinal illnesses. Overcrowding led to the spread of infectious diseases such as tuberculosis and diphtheria.¹⁷

In response to these concerns and stark living conditions, the Garden City Movement had been founded in Britain by Sir Ebenezer Howard. His influential book, *Garden Cities of Tomorrow* (1898) 'promoted self-contained communities, surrounding greenbelts, and carefully balanced areas of homes, industry, and agriculture.' His vision inspired local town planners to develop the 'garden village' estates which emerged around Wymering and Henderson Road in Eastney from the early 1920s.¹⁷ Howard's ideals remain influential to this day.

Mearns Fraser recognised this progress but continued to advocate for better housing for all. His 1926 report states that 'Although this year witnessed a considerable increase in the output of new houses [a total of 682], there still remains a long list of applicants for housing accommodation, many of whom are in urgent need – families of 5,6 and 7 who have at present to live in a couple of furnished rooms.'¹

"I didn't have a bedroom, I slept in the front room on put me up bed. My clothes were kept in a sideboard and every morning my bed was packed away. It became the family's Sunday best room during the day."

Celia, 82, Paulsgrove.



Houses on Medina Road, Wymering, dated 1924. Available from: <https://municipaldreams.wordpress.com/2020/04/21/council-housing-in-portsmouth-part-i>

Housing and built environment 2026

The relationship between housing and health remains clear today. Census 2021 includes a measure of housing deprivation based on whether a household is overcrowded, lives in shared accommodation, or lacks central heating. Using this measure, analysis by the Health Foundation explored the relationship between housing deprivation and life expectancy at birth across middle layer super output areas (MSOAs), neighbourhoods of around 5,000 to 15,000 residents. The findings showed that areas with higher levels of housing deprivation generally experienced lower life expectancy at birth, highlighting the continued importance of good housing as a determinant of health.

Portsmouth and Drayton West (Cosham North) MSA is the least housing deprived area in Portsmouth, ranking within the least deprived 20% of MSAs nationally on the housing deprivation measure. It also has one of the highest life expectancies at birth in the city, at 83.9 years for women and 81.0 years for men. In contrast, South Landport (Fratton West) MSA is the most housing

deprived area in Portsmouth, ranking within the most deprived 10% of MSOAs nationally, and has one of the lowest life expectancies at birth in the city, at 78.7 years for women and 75.1 years for men.⁶⁴

In 2026, we understand that good housing is not just about what our individual homes are like – it’s also about the place we live in, how healthy it is and how safe it feels. Do we have easy access to a wide range of amenities, including doctors, food shops, and leisure centres? Are there good public transport links and active ways of getting around – from where we live, can we easily walk, wheel and cycle around the city? And knowing how they benefit both physical and mental health, our neighbourhoods still need the lungs provided by green and open spaces.

Public Health works with the Housing, Planning, Transport and Climate Resilience & Natural Environment teams to help ensure that we have (and can further develop) both healthy homes and healthy places, which in turn promote healthy communities. The Healthy Streets indicators tool (pictured) is one way of measuring this.⁶⁵

Although fewer people are becoming ill or dying because of poor housing conditions than was the case in 1926, the state of our

housing still has a significant impact on our health and wellbeing. Health can be harmed if homes are too cold in winter or too hot in summer, while increasingly we understand that noise and indoor air pollution can impact on health in the long-term.

In 2024/25, 2,565 households in Portsmouth were assessed as being owed a prevention or relief duty under the

Homelessness Reduction Act. The rate was 28.0 per 1,000 households, significantly higher than England (13.8 per 1,000 households), the South East region (11.2 per 1,000 households) and Southampton (18.7 per 1,000 households). The Portsmouth rate has increased from 19.6 per 1,000 households in 2019/20, suggesting an increasing level of statutory homelessness need within the city.⁶⁶



Healthy Streets Indicator Tool. Available from: <https://www.healthystreets.com/what-is-healthy-streets>

Public Health works with the Council's Housing, Neighbourhoods & Buildings team as well as the local NHS and Voluntary, Community, and Social Enterprise (VCSE) sector to address these issues and ensure that everyone can benefit from good quality, affordable, energy-efficient housing located in safe and healthy places.

Reflection and looking forward

Launched in 2021, the **Imagine Portsmouth**⁶⁷ vision of a healthy, happy and green city in 2040 remains our guiding light. While we have made progress towards this vision in the last five years, there is more to do, and more to come, as we strive to make

our air and water cleaner, and our city more sustainable as well as increasingly resilient to the effects of climate change.

The vision for a healthy and happy city

We do everything we can to enhance wellbeing for everyone in our city by offering the education, care and support that every individual needs for their physical and mental health. All our residents and communities live in good homes where they feel safe, feel like they belong, and can thrive.

The vision for a green city

We have excellent air quality because of our green spaces and sustainable transport, and this means our people live healthy and active lives. We are carbon neutral, use renewable energy and actively work to address climate change. We protect and enhance both our land and maritime environment for future generations.



Artists impression of Somers Orchard.
Available from: <https://www.portsmouth.co.uk/news/politics/council-signs-off-first-phase-of-somers-orchard-redevelopment-5619021>

Supplementary Information



Density, geography and historic boundaries

Portsmouth was already a compact urban area in the 1920s, but the distribution of population within the city was very different. Before 1920, the Borough was largely limited to Portsea Island. In 1920, the boundary was extended northwards to include mainland areas such as what is now Drayton and Farlington, Cosham and Paulsgrove.

Although the Borough boundary had expanded by 1926, much of the population remained concentrated on Portsea Island, particularly in the built-up neighbourhoods

stretching from Stamshaw through central Portsmouth to Southsea. Many mainland areas that now contain large residential communities were comparatively lightly populated at the time.

Overall population density was around 7,675 people per km² in 1926 and today is lower at about 5,307 people per km². The highest ward density in 1926 was about 33,817 people per km² in historic St Mary and today it's about 15,868 people per km² in the most densely populated ward. The lowest ward density in 1926 was around 338 people per km² (Cosham) and today is about 2,450 people per km².

The historic Cosham ward should not be interpreted as equivalent to the modern ward. The 1926 Cosham ward covered a much larger and geographically different area and had a very different population distribution. Direct comparison with today therefore needs caution.⁶⁸

Table 5: Electoral Ward Population Density comparing 1926 to today¹

Density measure	1926	2024	Interpretation
Overall density	7,675/km ²	5,307/km ²	Lower overall city density today.
Highest ward density	33,817/km ²	15,868/km ²	Historic St Mary was far denser than the highest-density ward today.
Lowest ward density	338/km ²	2,450/km ²	Formerly low-density northern mainland areas are now more urbanised.

Overcrowding

Housing conditions have improved substantially since the 1920s. Large households and very high inner-city densities made overcrowding a much more widespread public health concern in the early twentieth century. Today, lower household size and lower overall population density point to major long-term improvement in living conditions and health protection.

However, improvement does not mean that overcrowding has disappeared. Census

2021 data show that some households in Portsmouth still have at least two fewer rooms than required under the Census occupancy standard. Severe overcrowding affected 0.8% of Portsmouth households overall, but the distribution was uneven across the city. The highest rates were found in neighbourhoods within St Thomas, Charles Dickens and Nelson wards (Table 6). Although these wards contained the most affected areas, above-average levels of severe overcrowding were also evident in neighbourhoods across other parts of Portsmouth, including Paulsgrove and Hilsea.

Births

Birth rates in Portsmouth, as in the rest of the country, are substantially lower than they were a century ago. In 1926, there were 4,496 live births in Portsmouth, compared with 2,039 in 2024.¹ The crude birth rate was 18.2 in 1926 to 9.5 per 1,000 population in 2024. This should be treated as a broad indicator rather than a fully comparable fertility measure, because crude birth rates do not adjust for the age and sex structure of the population. Relative to the national picture at the time, Portsmouth’s birth rate in 1926 was slightly higher than the England and Wales rate of 17.8 births per 1,000 population. Today, Portsmouth’s rate is broadly similar to the England average of 9.7 per 1,000 population.⁷⁰

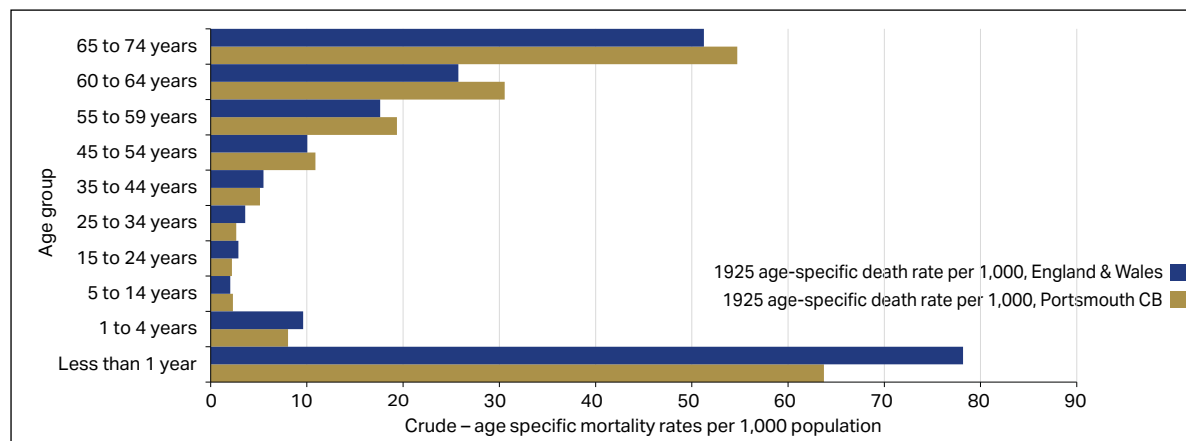
Table 6: Top 5 neighbourhoods (LSOAs) with the highest percentage of households with at least 2 fewer rooms than required ⁶⁹	
Area (Lower super output areas)	Severe overcrowding, Census 2021
Somers Town	4.6%
Landport	3.8%
Sultan Road South	3.7%
Portsmouth Church Road	2.9%
Buckland Kingston Crescent	2.6%
Portsmouth average	0.8%

Age-specific mortality: Portsmouth and England in 1925

Age-specific mortality rates in 1925 were substantially higher than those seen today, particularly in infancy and older age. Figure 2 shows that Portsmouth and England and Wales shared a very similar mortality profile in 1925, with mortality highest in infancy, lowest during childhood and early adulthood, and increasing progressively with age. Figure 3 demonstrates how mortality rates have fallen across every age group over the past century. Mortality rates among children aged 1 to 14 years are now much lower than they were in 1925. Mortality rates at older ages have also declined substantially, although older people continue to experience the highest mortality rates. Together, these figures show that Portsmouth broadly reflected national mortality patterns in 1925 and that the risk of death at all ages is now considerably lower than it was a century ago.⁷¹

Figure 2: Chart showing the age-specific mortality rates per 1,000 population for Portsmouth compared to England in 1925

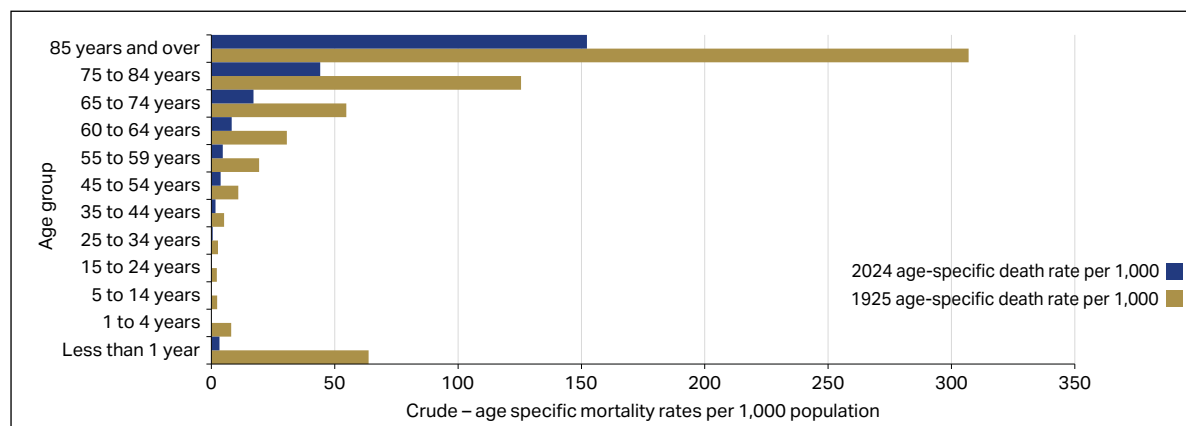
[Data table](#)



1925 sources: Portsmouth 1921 population, Census 2021, Nomis, ONS. Portsmouth 1925 deaths via [Report 1925] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection. Both the population and deaths for England and Wales obtained from Historic Mortality Data Files database, The National Archives. However, only 80+ years was available for E&W so ages 75 years and above cannot be compared to Portsmouth in 1925.

Figure 3: Chart showing the age-specific mortality rates per 1,000 population for Portsmouth CB in 1925 to Portsmouth UA in 2024

[Data table](#)



2024 sources: 2024 population, mid-year estimate, ONS. 2024 deaths by year of registration, Nomis, ONS. Note: Portsmouth number of deaths aged 1-14 years are suppressed due to small numbers.

Life expectancy and inequalities

A baby born in Portsmouth today has a life expectancy around 20 years longer than a century ago. Sex-specific life expectancy estimates are not available for Portsmouth in the 1920s, but it is possible to estimate that life expectancy at birth for Portsmouth residents overall increased from around 59.9 years in 1925⁷² to 80.5 years today.

For England, life expectancy at birth in 1925 was around 57.7 years for males and 62.2 years for females,⁷³ compared with 79.8 and 83.6 years respectively today.¹⁶ While direct sex-specific comparisons with Portsmouth are not possible for Portsmouth in 1925, the estimated life expectancy of 59.9 years for Portsmouth residents overall in 1925, together with the age-specific mortality patterns presented earlier, suggests Portsmouth was broadly similar to the national picture at the time. While life expectancy has increased substantially over the past century in both Portsmouth and England, in 2024, life expectancy at birth in Portsmouth remains below the national average, at 78.1 years for males and 82.7 years for females.¹⁶

Life expectancy also varies considerably within Portsmouth. In 2022-24, life expectancy at

birth for males living in the most deprived 10% of Portsmouth neighbourhoods was 9.4 years lower than for those living in the least deprived 10%, an increase from 8.5 years in 2021-23. For females, the gap was 7.8 years, up from 6.0 years.⁷⁴

Healthy life expectancy could not be estimated for Portsmouth in the 1920s. In 2022-24, healthy life expectancy at birth is 57.5 years for males and 58.2 years for females, both statistically similar to England. Healthy life expectancy estimates the average number of years a person can expect to live in good health, assuming current patterns of health and mortality continue throughout their lifetime.

However, substantial inequalities remain. In 2009-13, the gap in healthy life expectancy between residents living in Portsmouth's most and least deprived areas was estimated at 15.1 years for males and 14.2 years for females.⁷⁵ This means that while people are living longer than a century ago, the number of years spent in good health varies considerably across the city. The overall picture is therefore one of remarkable progress in both length and quality of life since the 1920s, but the benefits have not been shared equally across all communities in Portsmouth.

Table 7: Healthy Life Expectancy

Measure	Historic Portsmouth or England context	Current Portsmouth / current context
Life expectancy at birth, persons	Portsmouth estimate: 59.9 years	Portsmouth: 80.5 years
Life expectancy at birth, males	England 1925: 57.7 years	Portsmouth 2024: 78.1 years; England today: 79.8 years
Life expectancy at birth, females	England 1925: 62.2 years	Portsmouth 2024: 82.7 years; England today: 83.6 years
Healthy life expectancy at birth	Not estimated for Portsmouth in the 1920s	57.5 years for males and 58.2 years for females

References

- 1 1926 source: [Report 1926] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection. '2026' (2024 mid-year estimate) source: Estimates of the population for England and Wales – Office for National Statistics, Office for National Statistics (ONS).
- 2 1926 source: [Report 1926] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection. '2026' (2024) source: 2022-based household projections for local authorities and higher administrative areas within England, Migration category variant, Household projections: 2022-based – Office for National Statistics, Office for National Statistics (ONS).
- 3 1926 source: [Report 1926] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection. '2026' (2024) sources: 2024 mid-year population estimate source: Estimates of the population for England and Wales – Office for National Statistics, Office for National Statistics (ONS). Households in 2024 source: 2022-based household projections for local authorities and higher administrative areas within England, Migration category variant, Household projections: 2022-based – Office for National Statistics, Office for National Statistics (ONS).
- 4 1926 source: Converted from per Acre to km² [Report 1926] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection. '2026' (2024) source: Estimates of the population for England and Wales – Office for National Statistics, Office for National Statistics (ONS).
- 5 1926 source: [Report 1926] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection. '2026' (2024) source: Live births in England and Wales: birth rates down to local authority areas. Office for National Statistics (ONS) via Nomis. Nomis – Official Census and Labour Market Statistics – Nomis – Official Census and Labour Market Statistics (nomisweb.co.uk). ONS Crown Copyright Reserved. Note, both 1926 and 2024 crude birth rates do not take account of the composition of the population, in particular the age and sex distribution, so note caution when comparing between years and areas.
- 6 1926 source: [Report 1926] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection. '2026' (2024) source: Calculated from deaths aged under 1 year and total births in 2024, Nomis, Office for National Statistics (ONS).
- 7 Portsmouth deaths from the Medical Officer of Health Report for Portsmouth Borough, 1925 (Wellcome Collection) and population data from the 1921 Census (Nomis, ONS). The 1925 all-age, all-cause age-standardised mortality rate was estimated using age-specific mortality rates derived from 1925 deaths and 1921 population data, standardised to the 1976 European Standard Population. The 2024 all-age, all-cause age-standardised mortality rate was calculated using age-specific mortality rates derived from deaths registered in 2024 and ONS mid-2024 population estimates (Nomis, ONS), standardised to the 1976 European Standard Population. Historic estimates should be interpreted as approximate due to differences in data sources, age-group classifications and the assumptions required to map historic records to modern standard population age bands.
- 8 1926 source: Approximate life expectancy estimate calculated from 1925 Portsmouth deaths data and 1921 Census population data using standard life table methods. 1925 Portsmouth deaths source: [Report 1925] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection; and Census 1921 population, Nomis, ONS. '2026' (2024) source: Calculated using life expectancy calculator with the final age interval of 85+ (most recent life expectancy calculations use 90+ years as the final interval, but this data was not available in 1926). 2024 mortality data sourced from: Civil Registration Data via Primary Care Mortality Database (PCMD), Copyright ©2024, re-used with the permission of NHS England. All rights reserved. Mid-2024 population data sourced from: Estimates of the population for England and Wales – Office for National Statistics, Office for National Statistics (ONS).
- 9 Source note: Historic population, household and average household size estimates are from the Medical Officer of Health Report for Portsmouth Borough, 1926 (Wellcome Collection <https://wellcomecollection.org/works/ny493aak>). Current population estimates are from ONS mid-year population estimates for 2024, while household estimates are from Census 2021 (Nomis <https://www.nomisweb.co.uk/default.asp>, ONS). Information on UK regular armed forces personnel is from MOD Location Statistics for UK Regular Armed Forces and Civilian Personnel: 2026 <https://www.gov.uk/government/statistics/location-statistics-for-uk-regular-armed-forces-and-civilians-2026>

- 10 1926 source: Census 1921, Nomis <https://www.nomisweb.co.uk/default.asp>, ONS. 2026 source: 2024 mid-year population estimate, Nomis <https://www.nomisweb.co.uk/default.asp>, ONS (Office for National Statistics).
- 11 HESA: <https://www.hesa.ac.uk/data-and-analysis/students/table-1>. Date accessed 24/01/2025 via Portsmouth JSNA.
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Appendix 1

Population structure by 5-year age groups, comparing Portsmouth County Borough 1921 and Portsmouth UA in 2024



Age band	Portsmouth – mid-2024 population estimate (ONS)			Portsmouth CB 1921 Census			% difference between Portsmouth 2024 and Portsmouth 1921		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
0-4	5,779	5,494	11,273	11,939	11,365	23,304	-4.5	-3.9	-4.2
5-9	6,149	6,012	12,161	11,385	11,142	22,527	-3.7	-3.2	-3.4
10-14	6,293	6,150	12,443	11,110	11,297	22,407	-3.3	-3.2	-3.3
15-19	7,444	6,626	14,070	10,978	10,361	21,339	-2.1	-2.0	-2.1
20-24	10,837	9,007	19,844	11,826	10,042	21,868	0.3	0.5	0.4
25-29	8,052	7,697	15,749	10,144	10,228	20,372	-0.9	-0.9	-0.9
30-34	8,433	8,676	17,109	9,143	10,347	19,490	0.3	-0.1	0.1
35-39	8,114	8,559	16,673	9,377	10,112	19,489	-0.2	0.0	-0.1
40-44	7,292	7,204	14,496	8,128	8,866	16,994	0.1	-0.3	-0.1
45-49	6,039	6,014	12,053	7,129	7,734	14,863	-0.3	-0.5	-0.4
50-54	6,197	6,172	12,369	5,837	6,479	12,316	1.0	0.6	0.8
55-59	6,214	6,485	12,699	4,669	5,348	10,017	1.9	1.8	1.9
60-64	5,795	5,627	11,422	3,417	4,305	7,722	2.6	1.8	2.2
65-69	4,429	4,667	9,096	2,617	3,411	6,028	2.0	1.7	1.8
70-74	3,567	3,799	7,366	1,683	2,542	4,225	1.9	1.5	1.7
75-79	3,263	3,736	6,999	991	1,574	2,565	2.2	2.2	2.2
80-84	1,788	2,415	4,203	455	772	1,227	1.3	1.6	1.5
85-89	1,040	1,709	2,749	159	277	436	0.8	1.4	1.1
90+	496	1,051	1,547	33	62	95	0.4	0.9	0.7
All ages	107,221	107,100	214,321	121,020	126,264	247,284			

Appendix 2

Age-specific mortality rates per 1,000 population for Portsmouth compared to England in 1925 [Graph](#)

Age group	1925 age-specific death rate per 1,000, Portsmouth CB	1925 age-specific death rate per 1,000, England & Wales
Less than 1 year	63.72	78.18
1 to 4 years	8.05	9.61
5 to 14 years	2.31	2.04
15 to 24 years	2.22	2.88
25 to 34 years	2.66	3.60
35 to 44 years	5.13	5.50
45 to 54 years	10.89	10.05
55 to 59 years	19.37	17.62
60 to 64 years	30.56	25.75
65 to 74 years	54.72	51.25

Age-specific mortality rates per 1,000 population for Portsmouth CB in 1925 to Portsmouth UA in 2024 [Graph](#)

Age group	2024 age-specific death rate per 1,000, Portsmouth UA	2024 age-specific death rate per 1,000, England & Wales
Less than 1 year	3.27	4.22
1 to 4 years	0.00	0.14
5 to 14 years	0.00	0.08
15 to 24 years	0.15	0.30
25 to 34 years	0.55	0.51
35 to 44 years	1.67	1.18
45 to 54 years	3.77	2.75
55 to 59 years	4.65	4.91
60 to 64 years	8.23	7.18
65 to 74 years	17.07	14.79
75 to 84 years	44.10	39.70
85 years and over	152.23	141.96

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We would also like to thank the residents who shared their experiences and insights, helping to bring Portsmouth's public health story to life.



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Agenda Item 8



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)

Title of meeting:	Health and Wellbeing Board
Subject:	Complex Needs Intervention
Date of meeting:	23 rd September 2026
Report by:	Helen Atkinson, Director of Public Health James Hill, Director of Housing, Neighbourhoods and Buildings
Report Authors:	Dave Adams, Lead Interventionist Alan Knobel, Public Health Principal Rebecca Short, Assistant Interventionist
Wards affected:	All

-
1. **Requested by** Health and Wellbeing Board Chair
 2. **Purpose**
 - 2.1 To provide an update to the Board on the Complex Needs Intervention, which is currently nearing the completion of its Roll-In phase, and to seek continued support from the Health and Wellbeing Board.
 3. **Information Requested**
 - 3.1 The Health and Wellbeing Board previously received updates on the development and implementation of the Complex Needs Intervention. This report provides a further update on the interventions final stage of the Roll-In phase, outlining progress to date, and the arrangements being put in place to support full implementation and service integration.
 4. **Background**
 - 4.1 The Portsmouth Health and Wellbeing Strategy includes an ambition to improve service delivery for adults in the city who are experiencing severe multiple disadvantage and challenges impacting significantly on their welfare and wellbeing. In practice, this tends to mean people who are dealing with, three or more of the following:

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- homelessness
- contact with the criminal justice system
- substance or alcohol misuse
- mental ill-health
- domestic abuse

4.2 People experiencing severe multiple disadvantage or having 'complex needs' means living with several overlapping issues; which for many have been shaped by life-long experiences of poverty, deprivation, trauma, and abuse. These structural inequalities then manifest in different ways and in different combinations, often being compounded by one another. Other issues may also feature:

- experience of sexual violence and/or child sexual abuse;
- involvement in sex work;
- loss of custody of one or more child; and/or
- physical ill-health.

4.3 The June 2025 report to HWB noted a proposal to begin an intervention where staff from the existing Homeless Drug and Alcohol Team (HDAT) would be joined by specialist staff from other key agencies (physical health, mental health, Probation, housing etc) to work together to explore how an integrated service offer might improve the outcomes for people with complex needs, and to test this way of working.

4.4 During the summer of 2025, discussions were held with a range of system partners focussing on the availability of key staff to participate in this work, and ultimately, the following services were represented in the initial intervention team, with each service involved providing a single practitioner:

- HM Probation & Prison Service
- PCC Housing Needs, Advice, and Support (HNAS)
- PCC Adult Social Care
- PCC Supporting Your Future
- Queen Alexandra Hospital Alcohol Specialist Nurse Service
- Health Inclusion Team (via Brunel Practice)
- Homeless Drug and Alcohol Team (Society of St. James)
- Stop Domestic Abuse
- Adult Mental Health (HIOW Healthcare NHS Foundation Trust)

4.5 The team began the intervention process together in September 2025.

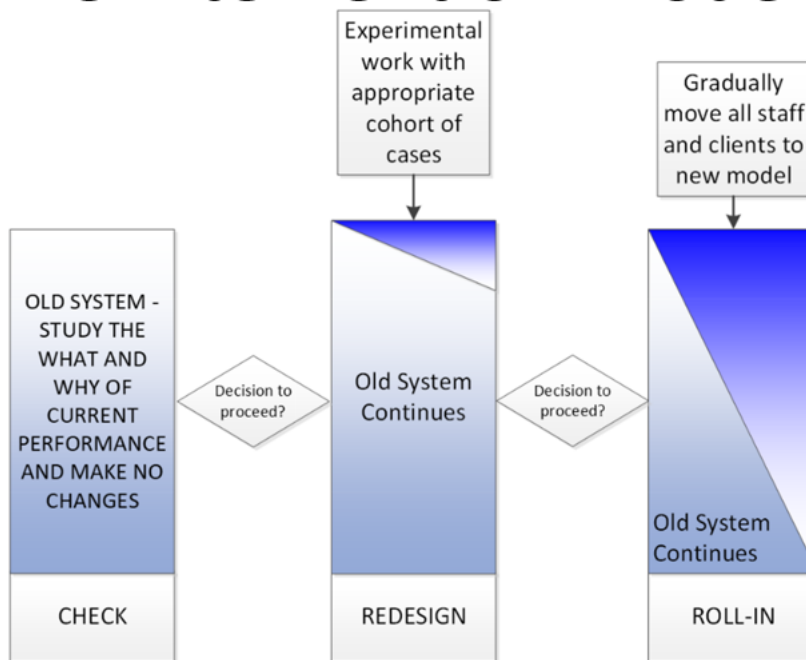
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5 Learning from the Intervention

- 5.1 The intervention model is comprised of three phases, as shown in the diagram below. The work is typically carried out by staff and management with direct experience of working within the system, guided throughout by an interventionist.

The Intervention Model

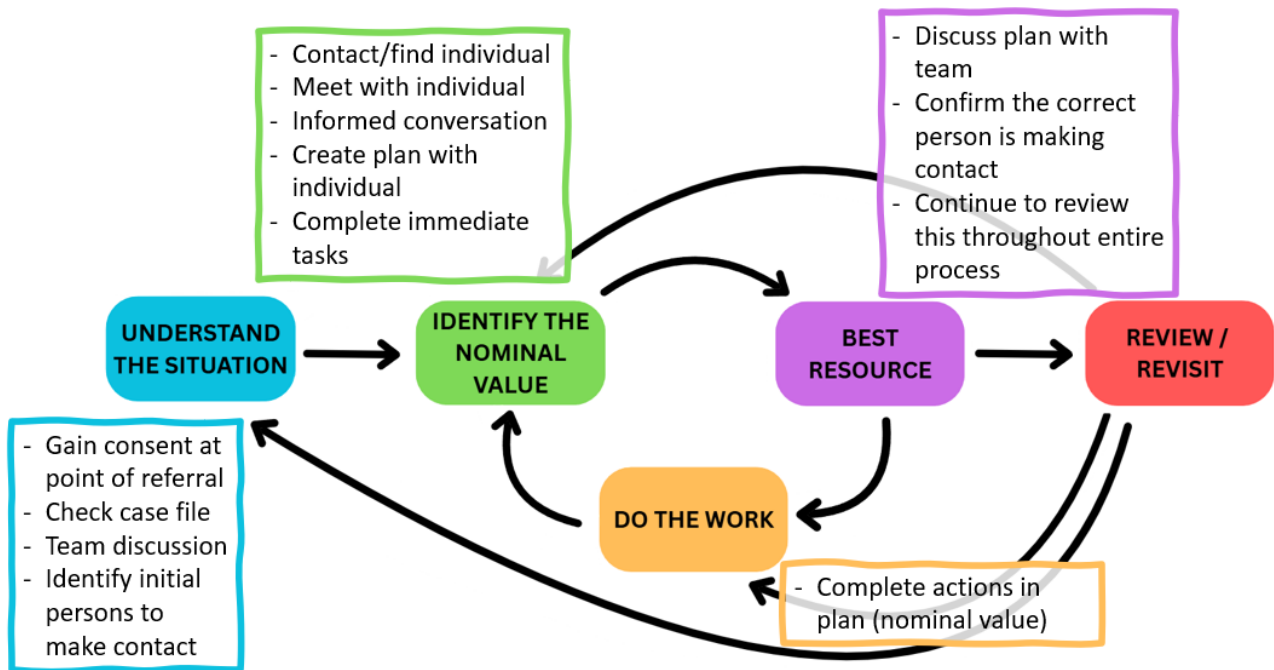


- 5.2 **Learning from Check** - The team spent time in September and October 2025 learning about how the current range of services support adults with multiple complex needs.
- 5.3 The findings from both the team's investigations and the peer-led research were compiled into a detailed presentation delivered to senior leaders in late-October 2025. The findings demonstrated how the system is confusing and difficult to navigate, making it hard for individuals to contact the right services and even harder for them to keep up with support due to significant delays and 'invisible' referrals. At the end of the presentation leaders agreed to move to Redesign.
- 6. Learning from the Redesign**
- 6.1 In the context of the intervention model, a Redesign is a live action-based learning experiment, aimed at improving the effectiveness and efficiency of the system. This particular redesign is obviously considerably more complex than working on a single service, as we are attempting to change the way that several services interact both with the clients and with one another.

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6.2 In December 2025, prior to the start of live casework, the team devised a generic case management process to be followed by all practitioners. This is shown in the diagram below:



6.3 From late-January onwards, the team have been identifying clients who approach services within the existing system and offering them the option to work with the team, which for the purposes of this Redesign has been named the '**Portsmouth Access Team**'. If potential clients are agreed by the team to be suitable, the client is contacted and asked to give formal consent to the work. Once this is in place, the team work in a collaborative, multi-disciplinary model. There are no referrals in this approach; if (for example) the Probation Officer in the team believes that a client needs a social worker, he will simply ask the social worker to accompany him to his next appointment with the client. This simple change means that processes that often take weeks now take minutes, enabling the practitioners to genuinely work as a team around the client.

6.4 In addition to the change in operating model, there is also a marked change in ethos; having learned in Check how often the system would close cases in response to clients 'not engaging' or missing appointments, the team have consciously chosen to adopt a more relational approach. Appointments are at a time and place of the client's choosing wherever possible. Recognising that some of the clients have chaotic lifestyles and all are vulnerable, the team do not close cases in response to missed appointments or client behaviour. This refusal to 'give up' on the clients has helped to build trust and reassure clients that this team really will be different to their previous experience of the system.

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During the Check phase the team created the purpose of the Portsmouth Access Team which is 'Help me get the support that's right for me' which they incorporate in the practices they use to help support their clients. This is reflected in the diagram below which is a visual representation of how the team were thinking and acting to best support the clients they were working with:

Current system		Redesign Approach
Assess client's eligibility	Purpose	Help client
Functional Silos	Structure	Multi-disciplinary team that flexes around client need
Written referrals	Communication	Workers 'pull' help from each other
Silo-based, restricted	Access to information	Shared with client consent
Assess based on laws and policies	Approach to clients	Understand and offer help
Punitive	Response to behaviour problems	Offer <i>more</i> support
Case closures	Response to non-engagement	Assertive Outreach

6.5 The results from both the team's work and customer research were compiled into a presentation delivered to senior leaders in July 2026. In brief, this included:

- Case studies of individuals journeys, including what would likely have happened in the 'normal' system
- All individuals needed the support of 2 or more disciplines, with two thirds needing 3 or more
- Housing, Social Care, Physical health, and Recovery workers were the most common requirements
- There is still difficulty in accessing systems, such as mental health support for people with substance misuse problems and access to accommodation due to past histories
- Individuals are using less resources while with the Portsmouth Access Team and costing these services less, for example reducing hospital admissions and reductions in contact with the criminal justice system
- Advocacy for these clients was key and prevented disengagement
- Work was designed around what the client's nominal value was, which often changed and was done even outside the scope of the practitioner's role

6.6 At the end of the presentation everyone in attendance was asked to agree, based on the learning from the Redesign, that senior leaders across local public services

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commit to establishing the Complex Needs Portsmouth Access Team model as an ongoing service within the local health and care system. It was agreed to continue this service and make it a permanent support model.

7. Next steps

- 7.1 At the time of writing, the team moving towards in the Roll-in stage and are working with the same clients and continuing to offer support.
- 7.2 The recruitment process is in progress to recruit a manager for the team, as well alterations around staffing and additional roles needed. There are discussions around funding and organisational staffing contributions from senior leaders across local public services to establish the **Portsmouth Access Team** model as an ongoing service within the local health and care system.
- 7.3 Part of the learning proved that having a physical location, as well as staff being sat together, is critical for both the practitioners and clients and needs to be established formally.
- 7.4 The changes proposed are structural and cultural and will require participating services' dedication and support, while wicked problems are difficult to navigate it is possible to improve the lives of the individuals in our service.
- 7.4 Health & Wellbeing Board members are welcome to visit the team to learn more about the work underway, its impact, and the emergent model. Contact David.Adams@portsmouthcc.gov.uk to arrange a visit.

.....
Signed by Helen Atkinson, Director of Public Health, Portsmouth City Council and James Hill, Director of Housing, Neighbourhoods and Buildings

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:

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Title of document	Location
Improving outcomes for adults experiencing multiple disadvantage and challenges - next steps - June 2025 Report to HWB	Report to HWB June 2025
Health and Wellbeing Board Complex Needs Intervention Report June 2026	Report to HWB June 2026

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Agenda Item 9



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And

Title of meeting:	Health and Wellbeing Board
Subject:	Tackling poverty in Portsmouth
Date of meeting:	23 rd September 2026
Report by:	James Hill, Director of Housing Neighbourhoods and Building Services
Report Authors:	Katy Ricks, Tackling Poverty Strategic Coordinator
Wards affected:	All

-
1. **Requested by** the Health & Wellbeing Board; annual update on the tackling poverty work.
 2. **Purpose**
 - 2.1. To provide information on the current picture of poverty in Portsmouth, continued cost of living pressures, and local welfare support funding.
 - 2.2. To provide an update to the Board on the tackling poverty priority area of the Health and Wellbeing Strategy¹ and delivery against the Tackling Poverty Action Plan (Appendix 1) as informed by the Public Health Annual Report 2023².
 - 2.3. Portfolio holder and Leader of the City Council, Councillor Pitt, has been updated.
 - 2.4. The Board is asked to note the continued impact of poverty and cost of living pressures in Portsmouth, the progress made in delivering the Tackling Poverty Action Plan 2026–2028, and the transition to the Crisis and Resilience Fund as the city's main local welfare support mechanism.
 - 2.5. The Board and partners are asked to continue to support the work of the Tackling Poverty Partnership.

¹ [health-and-wellbeing-strategy-january-2022-accessible.pdf](#)

² [Public Health Annual Report 2023 - Poverty and the cost of living crisis in Portsmouth – Needs Assessment](#)

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3. Information Requested

- 3.1. The Health and Wellbeing Strategy 2022 - 2030 outlines why tackling poverty underpins health improvement outcomes, building on the work of the Marmot Review³ 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.
- 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 undertaken in line with the Tackling Poverty Action Plan 2026-2028.

3.5. Poverty in Portsmouth

- 3.5.1. Poverty continues to impact on a significant proportion of Portsmouth's residents as evidenced through both nationally published datasets and local data and surveys.
- 3.5.2. National statistics⁴ show that some groups continue to be at greater risk of poverty including larger families with 3 or more children (44%), single parents (43%), Bangladeshi households (53%), Pakistani households (49%), disabled people (28%), informal carers (23%), working-age adults in workless households (53%).
- 3.5.3. Portsmouth experiences high levels of deprivation and is ranked 51st of 153 upper tier local authorities, where 1 is the most deprived in terms of average score across each of the domains of deprivation. Portsmouth has improved since 2019 and was previously ranked 46th⁵.
- 3.5.4. However, the concentration of deprivation has worsened. Portsmouth is now 41st out of 296 local authority areas (was 45th) and 31st out of 153 upper-tier councils (was 35th). Fifteen of Portsmouth's 125 LSOAs (12%) are among the 10% most deprived in England. Just over half are in Charles Dickens ward (8); the others are in Paulsgrove (3), Nelson (2), Fratton (1) and St Thomas (1)⁵.
- 3.5.5. Income deprivation sits at 13.4%⁶ with Portsmouth ranked 80 out of 317 authorities⁷.
- 3.5.6. In Portsmouth, 20.7% (7,911) of children live in relative poverty (live in a household with income that is below 60% of the national median income)

³ [Fair Society Healthy Lives \(The Marmot Review\) - IHE](#)

⁴ [UK Poverty 2026: The essential guide to understanding poverty in the UK | Joseph Rowntree Foundation](#)

⁵ [Index of Multiple Deprivation for Portsmouth | Portsmouth City Council](#)

⁶ [Mapping income deprivation at a local authority level - Office for National Statistics](#)

⁷ [Financial hardship and economic vulnerability in Portsmouth | LG Inform](#)

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before housing costs⁸. Nine of Portsmouth's LSOAs are above 40% with the highest area being Somers Town at 48%⁹.

- 3.5.7. For the latest reported year 2025, 10.9% of households are experiencing fuel poverty (previously 13.2%)⁷. 7,427 households in Portsmouth South (15.5%) and 4,610 households in Portsmouth North (10.7%) are in fuel poverty¹⁰.
- 3.5.8. In the 2025/26 academic year, 37.2% of pupils in Portsmouth are known to be eligible for Free School Meals (FSM)⁷. The attainment gap between FSM and non-FSM pupils continues to persist nationally with FSM pupils roughly 10 months behind at Year 6¹¹.
- 3.5.9. Average weekly earnings in Portsmouth were £701.10 in 2025, £68.40 per week or £3,566.57 per annum lower than England (£769.50)¹².
- 3.5.10. 30,222 people were claiming Universal Credit in Portsmouth in May 2026. The total number of claims has increased by 7.4% compared to May 2025⁷.
- 3.5.11. For the latest month available (Apr 2026) 17,961 (60%) of these claimants were not in employment, whilst 12,118 (40%) were in employment⁷, reflecting the national trend in the increase of working households living in poverty.
- 3.5.12. Local foodbank data for 2025/26 show a moderate decline in foodbank use with 7,250 vouchers fulfilled (7,902 for 2024/25) and 14,400 people fed (17,389 for 2024/25)¹³.
- 3.5.13. Taken together, these indicators show that although some measures have improved, poverty remains concentrated in particular neighbourhoods. Appendix 3 provides poverty heat maps for Portsmouth, appendix 4 provides health pen portraits for Portsmouth's six most deprived Middle Super Output Areas (MSOAs).

3.6. Cost of living pressures for households

- 3.6.1. The Portsmouth Big Survey 2025 identified that the rising cost of living is continuing to have a widespread impact on residents. 76% of residents are 'very' or 'quite' concerned about it in relation to their ability to manage their finances. 44% of residents are less able, or unable to meet the day-to-day costs of living, a slight increase from 2024¹⁴.
- 3.6.2. The increasing price of food shopping (81%) and gas or electricity bills (74%) remain the top reasons for the rise in the cost of living for a third-year running. Higher rents or mortgages appear to have had a slightly greater

⁸ [Fingertips | Department of Health and Social Care](#)

⁹ [Children in Relative Low Income \(BHC\), LSOAs relative to England Map, 2024/25 - CoL - Money Debt and Advice - Power BI](#)

¹⁰ [Local area data: Fuel poverty - House of Commons Library](#)

¹¹ [Chapter 2: Mobility since last year - GOV.UK](#)

¹² [Navigation page - CoL - Money Debt and Advice - Power BI](#)

¹³ [CoL - Food insecurity and poverty - Power BI](#)

¹⁴ [Wave Seven - August-September 2025 - Your City, Your Say survey research](#)

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impact this year (40%). In response to rising costs residents are spending less, using their savings, and using less fuel¹⁴.

- 3.6.3. Office for National Statistics (ONS) data shows that households with the lowest incomes experienced a higher-than-average inflation rate. This is because they spend a larger proportion of their income on essentials like food and energy, which rose particularly quickly between 2021 and 2024 and continue to rise. Of those whose cost of living increased, 94% said it was because food shopping had increased in price, while 68% said it was because fuel prices had increased¹⁵.
- 3.6.4. The Consumer Prices Index (CPI) rose by 2.9% in the 12 months to July 2026, up from 2.6% the previous month¹⁶. Overall price levels increased by approximately 28% over the five-year period from July 2021 to July 2026. Food prices increased by roughly 37.5% over the same period.
- 3.6.5. Inflation ranged from 3.0% and 3.8% between April 2025 and March 2026, up from 2.0% in 2024. However, has slowly been falling in recent months and was 2.9% in July 2026. While inflation is no longer as high, the cumulative effect of rising prices means households face a much higher cost of living than in 2021¹⁵.
- 3.6.6. Average UK house prices rose by 2.0% in the 12 months to June 2026, reaching an average of £272,000, while average UK monthly private rents increased by 3.7% in the 12 months to July 2026 to an average of £1,393 overall¹⁷.
- 3.6.7. The average rent for a two-bedroom property in Portsmouth is £1,134¹⁸, however the maximum housing allowance towards renting a two-bedroom property is £842.70 (£194.47 per week)¹⁹, leaving a £291.30 shortfall.
- 3.6.8. Universal Credit falls short by around £120 every month for a single adult and £205 for a couple of the money people need to afford the essentials²⁰.
- 3.6.9. There are a growing number of households where debt is made up of household bills. In June 2026, average credit card debt stood at £2,809 per household (up from £2,590 in June 2025). The average amount of unsecured debt per UK adult in June 2026 was £4,538²¹.

¹⁵ [High cost of living: Impact on households - House of Commons Library](#)

¹⁶ [Consumer price inflation, UK - Office for National Statistics](#)

¹⁷ [Private rent and house prices, UK - Office for National Statistics](#)

¹⁸ [Housing prices in Portsmouth](#)

¹⁹ [Local Housing Allowance rates | Portsmouth City Council](#)

²⁰ [Guarantee our Essentials: reforming Universal Credit to ensure we can all afford the essentials in hard times | Joseph Rowntree Foundation](#)

²¹ [August 2026 Money Statistics.pptx](#)

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- 3.6.10. The UK energy price cap will increase by 3.6% on October 1, 2026, raising the typical annual dual-fuel bill by £60 to £1,723²².
- 3.6.11. National average water bills for the coming year are forecast to be £603 (a rise of £123 or 26%). This equates to an increase of around £10 a month. Portsmouth Water will see an average increase of 25% (£30 annual increase), and Southern Water a 47% increase (£224 annual increase)²³.
- 3.6.12. Material deprivation and the proportion of working-age adults who cannot afford basic items increased between 2021/22 and 2023/24, then fell between 2023/24 and 2024/25 to 21%. This is a sign that the effects of the period of high cost of living has begun to ease in 2024/25¹⁵.
- 3.6.13. Although some indicators suggest conditions have improved since the height of the cost of living crisis, many Portsmouth residents remain financially vulnerable and continue to require support.
- 3.6.14. The council continues to offer universal support via the Cost of Living Hub and helpline which is available weekdays 9am–5pm (closing at 4.30pm on Fridays)²⁴. The council uses our Cost of Living branding across all forms of Cost of Living support and an updated Cost of Living flyer was issued to all households as part of the information included in this year's council tax bill letters.

3.7. Local welfare funding to tackle poverty and the cost of living

- 3.7.1. Plans for the Crisis and Resilience Fund (CRF) were announced by the UK government in June 2025 as part of the Spending Review 2025²⁵. The fund was introduced to replace the previous Household Support Fund and Discretionary Housing Payments.
- 3.7.2. The DWP issued the CRF guidance to local authorities on 19th December 2025 together with the draft grant conditions²⁶ and provisional allocations²⁷ for financial year 2026/27 which identified that Portsmouth would receive £3,691,344.49. The guidance was embargoed until publication of the scheme's guidance on the government website mid-January 2026.²⁸
- 3.7.3. The UK Government launched the Crisis and Resilience Fund (CRF) on 1 April 2026. Running as a three-year programme until 31 March 2029, the £842 million-a-year fund provides local authorities in England with

²² [Energy price cap will rise by 4% from October 2026 | Ofgem](#)

²³ [Annual average bill changes 2025 -2026 | Water UK](#)

²⁴ [Cost of living hub | Portsmouth City Council](#)

²⁵ [Spending Review 2025 \(HTML\) - GOV.UK](#)

²⁶ [Explanatory note on funding simplification: consolidated grants and draft conditions - GOV.UK](#)

²⁷ [Allocations tables for all consolidated grants from 2026-2027 to 2028-2029 - GOV.UK](#)

²⁸ [Crisis and Resilience Fund \(1 April 2026 to 31 March 2029\) - GOV.UK](#)

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discretionary grant funding to assist low-income households facing unexpected financial shocks alongside long-term resilience building.

- 3.7.4. There are four strands under the new fund:
- Crisis Payments
 - Housing Payments
 - Resilience Services
 - Community Coordination
- 3.7.5. The new fund integrates Discretionary Housing Payments (DHPs) on a phased basis with arrangements largely remaining as current DHP delivery for years one and two, managed by colleagues in Revenues and Benefits. From April 2028, year three, the housing payment strand must be fully integrated within the CRF.²⁹
- 3.7.6. Central to the CRF is its outcomes-based approach. Schemes are expected to deliver:
- reduced experiences of material deprivation
 - reduced need for emergency food parcels
 - increased access to appropriate and quality advice services
 - increased savings
 - reduction in priority debt
 - maximisation of individuals' incomes
 - decreased need for Crisis Payments and Housing Payments
- 3.7.7. Local Authorities have discretion in how they use the fund to build financial resilience in their local area, guided by these outcomes.
- 3.7.8. The CRF marks a shift from reacting to crises to preventing them via longer-term funding which will enable local authorities to provide preventative support to communities while building the local support landscape. CRF is the primary source of local welfare support for local authorities to help vulnerable households struggling with the continued rising costs of living.
- 3.7.9. A report to Cabinet 3rd March 2026 outlined the council's delivery plan for CRF and its use to support residents in financial hardship during 2026/27.
- 3.7.10. The council's Crisis Payment scheme launched end of April 2026 remains open until March 2029. This is a dual-stage scheme, a proposal which was approved by the DWP and noted as innovative. The Fast Track route delivers crisis payments within 48 hours (emergencies) with the Full Review route involving a full assessment of the households' circumstances and underlying

²⁹ [Crisis and Resilience Fund: Guidance for local authorities in England \(1 April 2026 to 31 March 2029\) - GOV.UK](#)

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needs to support a more in-depth level of signposting and wrap-around support, with decisions taking longer than 48 hours.

- 3.7.11. For the period up to 31 August 2026, the council has received 1,012 crisis payment applications and has made 428 awards totalling £139,707. Of the 323 applications that have been declined due to not meeting the scheme's eligibility criteria, most of these are because there is no evidence of a recent crisis therefore applicants are signposted to resilience services.
- 3.7.12. The Housing Payment Allocation within CRF for the first two years is £428,432 with an additional Housing Admin Allocation £68,347.94. As of 2 September 2026, £221,071.78 has been allocated leaving £207,360.22 left to spend.
- 3.7.13. Under the Resilience Services strand the delivery plan committed funding to support our Holiday Activities and Food (HAF) provision to extend places for low-income households who are not in receipt of Free School Meals (FSM) in addition to Switched On Portsmouth to support energy efficiency measures for low-income households. Other council-led initiatives include benefit uptake activities to support vulnerable households to maximise their income, reduce their costs, and resolve debt issues.
- 3.7.14. A CRF grant funding opportunity for the delivery of resilience services was run in May 2026 and 47 applications were received. Following an assessment process 33 grants were awarded £748,392 (90% of which falls within year one of CRF). These grants will support existing provision such as pantries and larders, where they are integrated or co-located with resilience services, in addition to new services and projects.
- 3.7.15. The community coordination strand is being used to fund the council's **Cost of Living Hub and Helpline**. Grant funding is also available to both the voluntary and community sector alongside council services and teams to fund projects which support the objective of creating a more connected local welfare landscape. So far grant funding has been allocated to one initiative.

3.8. Progress against the Tackling Poverty Action Plan

- 3.8.1. The **Health and Wellbeing Strategy 2022-2030**³⁰ outlined three areas for key activity in the short term:
 1. providing immediate support to people in financial hardship;
 2. helping people access the right employability support at the right time;
 3. supporting a community-level response to local needs.

³⁰ [health-and-wellbeing-strategy-january-2022-accessible.pdf](#)

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- 3.8.2. The **Public Health Annual Report 2023**³¹ recommended a focus on four areas for action:
1. To provide adequate financial support for families and services;
 2. To champion policy innovation to maximise available support;
 3. To monitor the long-term health impacts of poverty and the cost-of-living;
 4. To support and empower the workforce so they can support us all.
- 3.8.3. These four areas continue to inform action being taken alongside new tools to support delivery which include:
- The Low Income Family Tracker (LIFT) providing data insights and informing targeted interventions
 - The Money Guiders national training programme supporting frontline staff to provide financial support
- 3.8.4. Work to tackle poverty continues to operate across three levels of intervention:
- Immediate response to those in financial hardship
 - Holistic support to prevent future or recurring crisis
 - Action to understand and address root causes
- 3.8.5. These levels of intervention reflect the policy direction of the new Crisis and Resilience Fund and data-led approach to identifying, understanding, and addressing the underlying causes of poverty.
- 3.8.6. The Tackling Poverty Action Plan has been updated for period 2026-2028 (Appendix 1) following the recommendation made in the annual report presented to the Health and Wellbeing Board in September 2025.
- 3.8.7. This update aligned with the transition from the Household Support Fund to the new Crisis and Resilience Fund and changes in the policy landscape which includes the publication of government's Child Poverty Strategy in December 2025³².
- 3.8.8. A partnership-led review of the action plan took place across 2025, coordinated by the Tackling Poverty Strategic Coordinator. The new Tackling Poverty Action Plan was presented to the Health and Wellbeing Board in March 2026 and sets out four new priority areas with related tasks and action.
- Priority 1: Maximising Household Income
 - Priority 2: Strengthening the Local Safety Net
 - Priority 3: Increasing Opportunities & Improving Wellbeing
 - Priority 4: Using Data to Support Partnership Working

³¹ [Public Health Annual Report 2023 - Poverty and the cost of living crisis in Portsmouth – Needs Assessment](#)

³² [Our Children, Our Future: Tackling Child Poverty](#)

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3.9. Governance and partnership working

- 3.9.1. Monitoring and oversight of the action plan continues to be delivered by the Tackling Poverty Partnership Group (TPPG), a formal sub-group of the Health and Wellbeing Board.
- 3.9.2. Since the 2025 annual update report, The TPPG has been strengthened through;
 - Incorporation of the Cost of Living & Household Support Fund Working Group into the TPPG (January 2026)
 - Strengthening of leadership through the appointment of a second chair (February 2026)
- 3.9.3. The TPPG now acts as the central forum coordinating the transition from HSF to CRF and the city's wider response to the cost of living. This sits alongside the group's role in leading the collaborative approach to address poverty, underpinned by the Tackling Poverty Action Plan.
- 3.9.4. A comprehensive update on delivery against the twelve tasks within the Tackling Poverty Action Plan is provided in appendix 2.
- 3.9.5. The council's work in tackling poverty has been recognised by the Local Government Association in the published April 2026 case study which identifies the multi layered, partnership-driven approach to reducing poverty and strengthening resilience across the city. The case study highlights how the council works with a diverse network of statutory, health, and voluntary sector partners to address poverty in a holistic and sustainable way, recognising that poverty is multidimensional and that effective support requires coordination, data-sharing, and community-based engagement³³.

3.10. Next steps

- 3.10.1. Key actions and areas of focus for the next 12 months are;
 - Implement the Portsmouth Water social tariff data sharing project
 - Continue LIFT-led uptake campaigns including free childcare
 - Utilise LIFT data to target interventions such as prevention of homelessness
 - Review the Money Guiders pilot and roll this out to other organisations and teams
 - Completion of the gambling harms needs assessment
 - Progress the Gambling Harms Awareness and Education Delivery Plan
 - Utilise the Big Portsmouth Survey Wave 8 findings to shape tackling poverty and cost of living activity
 - Review CRF management information and outcomes to inform future delivery

³³ [Tackling Poverty and Building Community Resilience in Portsmouth | Local Government Association](#)

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- Strengthen signposting and referral pathways across CRF funded resilience services
- Develop a Worrying About Money leaflet and online resource for migrants and those with no recourse to public funds
- Continue work to increase food sustainability including working with Felix (formerly FareShare) to distribute 'surplus surplus' food

.....

Signed by James Hill, Director of Housing Neighbourhoods and Building Services

Appendices:

- Appendix 1 - Tackling Poverty Action Plan
- Appendix 2 - Delivery against the Tackling Poverty Action Plan
- Appendix 3 - Poverty heat maps
- Appendix 4 - Health pen portraits

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	health-and-wellbeing-strategy-january-2022-accessible.pdf
Public Health Annual Report 2023: Poverty and the cost of living crisis in Portsmouth - Needs Assessment	Public Health Annual Report 2023 - Poverty and the cost of living crisis in Portsmouth – Needs Assessment
Health and Wellbeing Board 24 th September 2025	Tackling Poverty update.pdf
Cabinet 3 rd March 2026	Supporting residents with cost of living and Crisis Resilience Fund 2026227.pdf
Health and Wellbeing Board 4 th March 2026	Tackling Poverty Action Plan update.pdf



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Appendix 1

Tackling Poverty Action Plan 2026 - 2028

Priority	Task	Action	Outcome measures & metrics
Maximising household income	Increasing uptake of eligible benefits & financial support	- Benefit uptake campaigns (supported by the LIFT platform) & public communications (e.g. breakfast clubs & free childcare) - Free School Meal auto-enrolment - Increasing uptake of social tariffs - Income maximisation & support to sustain social housing tenancies	- Increase in numbers of those in receipt of Pension Credit, Attendance Allowance, etc. - Increase in registrations for Free School Meals - Number of households registered for reduced tariff - Number of intervention sessions with residents, financial impact (£), reduction in evictions
	Equipping the workforce to hold effective financial conversations	- Money Guiders training via MaPS - Making Every Contact Count (MECC) & Poverty and Neglect training via PCC - Greater provision of financial tools and information (benefits calculators, income/ expenditure and local signposting)	- Number of inductions sessions attended, number of modules undertaken - Number of staff attending - Number of times the Portsmouth Better Off Calculator has been used - Number of times the CoL Hub page 'Are you getting the right benefits and payments?' has been visited
Strengthening the local safety net	Accessible information to support residents with increased cost of living	- Cost of living (CoL) online information hub - reviewing, maintaining and updating information - Cost of living helpline - supporting the team to deliver effective support and signposting information	- Number of times the CoL Hub has been viewed - Number of calls to the CoL Helpline - Number of calls to the Switched On Portsmouth helpline & number of referrals made - Number of people attending

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		- Switched On Portsmouth - provision of free energy advice and appropriate referrals into relevant schemes - Community & neighbourhood events (e.g. Bills, Benefits and Biscuit drop-in for Portsmouth Homes tenants)	Feedback from customers and partners
	Increasing access to advice services	- Advice outreach provision in community settings - Recommissioning the Advice Portsmouth service (improving the delivery model and introducing new delivery methods)	- Number of times advice outreach provision is accessed - Successful implementation of new service model and delivery methods
	Provision of resilience services	- Provision of intensive cost of living support for residents (using the 'liberated method') - Increased access to free debt advice, promotion of affordable credit and support to start saving - Wrap-around support & co-location of services - Establishment of community hubs (e.g. HIVE helpdesks and health hubs)	- Number of people referred and supported - Number of locations providing free debt advice, reduced priority debts, reduced arrears - Number of providers delivering wrap-around provision alongside core services - Stronger referral pathways
	Sustainability of the food support network	- Implementation of UK Harvest recommendations (e.g. collaborative purchasing) - Facilitation of Food Support Network meetings & network communication tools - Access to support via the Feeding Britain partnership	- Greater efficiency in sourcing and sharing food across community food aid providers - Reduction of costs - Facilitation of bi-monthly meetings and creation of new WhatsApp group to support members - Access by the network to webinars, training, tools and funding
Increasing opportunities and	Increasing access to employment	Reducing youth unemployment via Aspiration NEET Zero and Youth Hubs	Reduction in the percentage of 16–24-year-olds who are NEET

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improving wellbeing		- Increasing employment opportunities for those with a disability, health condition or complex barriers via Connect to Work - Reducing barriers to work (e.g. childcare and transport)	- Increased levels of employment for targeted groups - Promotion of free and/or affordable childcare and travel
	Developing skills to reduce costs	- Financial literacy workshops (e.g. budgeting, numeracy skills, etc.) - Affordable cooking projects/ sessions - Digital inclusion initiatives including devices, skills, and improved connectivity	- Number of workshops delivered, attendance figures, and learning outcomes - Number of projects/ sessions delivered, attendance figures, and learning outcomes - Number of people engaging or supported, feedback from targeted groups
	Addressing gambling related harms	- Establishment of a gambling harms working group (subgroup of the TPPG) - Completion of the gambling harms needs assessment - Delivery of a gambling harms summit	- Completion of a gambling harms action plan and delivery against this - Increased knowledge of the prevalence and impact of gambling in Portsmouth - Increased awareness of gambling harms, reduced stigma, and greater collaboration to tackle gambling harms
	Improving housing conditions in the Private Rented Sector	- Extended programme of PRS inspections - Networking with the voluntary sector to increase awareness and uptake from residents - Providing education and advice to landlords	- Number of inspections to identify hazards and non-compliance - Attendance at partner meetings and events - Addressing overcrowding, poor management and housing standards
Using data to support	Data sharing projects to target support	Sharing data with water companies to transfer eligible residents onto social tariffs	Number of households registered for reduced tariff following

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partnership working		• Warmth on Prescription project to identify older people with health conditions living in cold homes to make targeted interventions • Increased data sharing with partners using tools such as the Cost of Living dashboard, JSNA, and Low Income Family Tracker (LIFT) platform	• Percentage of identified vulnerable people contacted either by phone, text or letter and increased uptake of Switched On Portsmouth services by target group • Feedback from partners, sharing data via established partnerships & forums
	Community engagement and feedback	• Understand how the cost of living is impacting on residents via the Portsmouth Big Survey • Understand the impact of local welfare provision • Paulsgrove Healthy Living Work and expansion of asset-based community development into other areas (e.g. Portsea) • Co-design and co-production of local support services and the active involvement of those with lived experience	• Results published on PCC website, findings shared with the TPPG • Monitoring and evaluation of the Crisis and Resilience Fund, 6-monthly MI returns to the DWP • Identification of community priorities and delivery against action plan • Involvement of those with lived experience in the funding of CRF services



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Appendix 2

Delivery against the Tackling Poverty Action Plan

1. Maximising household income

a. Increasing uptake of eligible benefits & financial support

- Policy in Practice - LIFT

Portsmouth City Council entered into contract with Policy in Practice and their LIFT (low-income family tracker) data analytics platform in December 2025 for a one-year pilot funded by Household Support Fund. Work to share the core datasets progressed over December to January 2026, with the Portsmouth dashboard becoming available in February 2026. The dashboard has enabled the council to run a series of targeted uptake campaigns.

- Pension credit and attendance allowance campaign

In February a combined pension credit and attendance allowance campaign was run using data from LIFT. 633 letters for pension credit and 593 letters for attendance allowance were sent to residents identified as eligible but not claiming. The letters informed residents how to apply alongside signposting to in-person support via three drop-in support sessions led by Advice Portsmouth. 73 residents went on to claim Pension Credit having an estimated annual impact of £237,813 and a lifetime impact of £2.15 million. 55 households went on to claim attendance allowance having an estimated annual impact of £88,727.

- SSEN priority services register campaign

In July 2026 the council worked with Policy in Practice and Scottish and Southern Electricity Networks (SSEN) on a campaign to increase the number of residents registered for priority services (PSR). Around 5,000 text messages were sent to residents identified as eligible on LIFT, 265 households completed the Better Off Calculator, all of these were told they were eligible for SSEN's free Priority Services and 36 went on to register. 194 households discovered they were missing out on unclaimed benefits to the value of £397,171 a month.

- Healthy Start campaign

Late July 2026 the council ran a Healthy Start campaign using data from LIFT. 714 letters and 326 text messages were sent out to residents. Impact data is expected October with the average household benefit being around £483 per year.



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- Better Off Calculator

The council's contract for LIFT includes use of Policy in Practice's Better Off Calculator (BOC). A public version sits on our Cost of Living Hub and council webpages, and a licenced version is used by money advisors in our Portsmouth Homes Money Advice team and Advice Portsmouth, the council's commissioned advice service delivered by You Trust. Up to the end of August 2026, 624 members of the public completed the BOC which has identified that 456 of these are missing out on benefits that they are entitled to which have a monthly value of £281,865. For the same period, 205 BOCs have been completed by a money adviser, identifying 156 households who are missing out, with a monthly value of £86,234.

- Free School Meal (FSM) auto-enrolment

The council has expanded the Free School Meal (FSM) auto-enrolment project undertaken last year for 2026. The project utilises Council Tax Support data to identify eligible households who have not yet enrolled so that the council can reach out and enrol children on households' behalf (via an opt-out process). The 2026 project is currently in progress. FSM saves households up to £495 a year per child, while schools receive extra Pupil Premium funding of £1,550 for primary pupils and £1,100 for secondary pupils for those meeting targeted criteria. The council is looking to share additional data with Policy in Practice so that future FSM auto-enrolment campaigns can be run via LIFT.

The council also led a communications campaign over the summer to raise awareness of changes to Free School Meal (FSM) eligibility from September 2026. These changes mean that all children from households receiving Universal Credit will be entitled to a free school meal.

- Benefit entitlement awareness raising

The council continues to raise awareness of benefit entitlement through various communication channels including Flagship, HouseTalk (for Portsmouth Homes residents) and our social media accounts. See pages 20-22 of House Talk summer 2026 for an example of this³⁴.

³⁴ [House Talk and Annual Report Summer 2026](#)



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b. Equipping the workforce to hold effective financial conversations

- Money Guiders

In January 2026, the council became a Money Guiders partner with the Money and Pensions Service enabling frontline practitioners from both the council and voluntary and community sector organisations access to free online training, webinars and other resources. In April 2026 the first pilot of the Money Guiders training commenced with the following council teams and VCSE organisations

- Crisis and Resilience Fund team, PCC
- Housing Payment staff within Revenues and Benefits, PCC
- City Helpdesk, PCC
- HomeStart Portsmouth
- Harbour Church (foodbank and community meal provision)
- Society of St James (rough sleeping pathway services)

So far 58 frontline staff have registered for the training and have begun to access the free training modules. An evaluation of the pilot is planned for late 2026.

- Poverty and neglect training

The council continues to deliver a half-day poverty and neglect training course coordinated via the Portsmouth Safeguarding Children's Board. Training is co-delivered by the Tackling Poverty Strategic Coordinator, a lead officer in children's services, the Cost of Living Support Officer, and a representative from the city's foodbank. The training was last delivered in winter 2025 with 25 attendees.

2. Strengthening the local safety net

a. Accessible information to support residents with increased cost of living

- Cost of Living Hub

The Council's Cost of Living Hub continues to provide a one-stop shop for residents to access easy-to-read cost of living help on a range of topics including essential costs, family matters, health and wellbeing, jobs and skills, money, housing, and community. There is also a monthly cost of living blog. In the first quarter of FY 2026/27 there were 19,610 visits to the hub with the most visited pages being low-cost activities, help with essential costs, and gambling harms. The hub continues to be funded using Crisis and Resilience Fund.



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- Cost of Living Helpline

The Council's Cost of Living Helpline supports residents who are either not on-line or would prefer to speak to someone, tackling digital exclusion and other barriers to accessing support. In the first quarter of FY 2026/27 there were 427 calls taken by the helpline. The top three topics were the Cost of Living Hub, food bank vouchers, and the Crisis and Resilience Fund. The Cost of Living Helpline continues to be funded using Crisis and Resilience Fund.

- Switched On Portsmouth helpline

The Household Support Fund and since April 2026 CRF is used to fund support delivered by Switched On Portsmouth's helpline. For the period 1 September 2025 to 31 August 2026 there have been 510 inbound calls and 265 onward referrals. Data for outbound calls is not currently captured (i.e. website referrals and emails) therefore reporting requirements have recently changed to record numbers of cases going forwards.

- Benefits, Bills and Biscuit drop-in events

The Household Support Fund was used to deliver two Benefits, Bills and Biscuit drop-in events facilitated by Portsmouth Homes Money Advice team. These drop-in events focused on money advice and wellbeing and brought together a range of relevant services into one community space. The first event took place in January 2026 in Somerstown and a second in March in Paulsgrove. Across the two events 37 residents were supported with financial advice and support.

- Worrying About Money leaflet and on-line resource

The council has worked with the Independent Food Aid Network (IFAN) to develop a Portsmouth Worrying About Money leaflet. The leaflet helps residents and frontline professionals to easily identify the most appropriate services to support depending on the support need, bringing information about multiple services onto one leaflet which is available both in hard copy and as an online version³⁵. The leaflet was launched at May's Tackling Poverty Partnership Group meeting. The council is working IFAN to develop a similar leaflet for migrants and those with no recourse to public funds.

- CRF community coordination activity

Under the community coordination strand of CRF grant funding has been awarded to Paulsgrove Ark to support distribution of their community newsletter (Grover's Gazette) and to

³⁵ [Worrying about money?](#)



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create and distribute a local services booklet. This builds on the asset-based community development approach taking place within Paulsgrove.

b. Increasing access to advice services

- Advice services - outreach, capacity building and addressing barriers to access

The Household Support Fund (HSF) was used to provide additional funding to You Trust so that the Advice Portsmouth could expand services and deliver additional advice outreach in 11 community settings across the city with the aim of reducing barriers to access. Between April 2025 and March 2026, the outreach provision Portsmouth supported 203 households via 254 instances of support. A high proportion of households who attended the outreach provision had anxiety, depression, or poor mental health, and a higher proportion were older age in comparison to the core service provision. From April 2026, the Crisis and Resilience Fund will continue to provide additional funding to the Advice Portsmouth service for outreach advice with an increase to the funding allocated. The provision will encompass 12 community locations initially, increasing the frequency of support at some locations, with plans to add further locations to this. The first set of CRF management information data is due beginning of October 2026.

HSF funding was also granted to Citizens Advice Solent East (CASE) for the period October 2025 to March 2026 to address an increase in numbers of residents coming through their service requiring generalist advice. The funding enabled CASE to expand their service and support 72 households across 127 instances of support. CASE have also been successful in applying for a CRF resilience service grant to deliver community-based advice services across 9 locations. The first set of CRF management information data is due beginning of October 2026.

The council is in the process of re-tendering the advice service contract which is currently delivered by You Trust as Advice Portsmouth. As part of the tender process a new service specification has been developed which has a primary focus on addressing barriers to access in relation to the delivery model and methods of support. CRF funding will continue to be used to expand delivery in the city until March 2029. The award decision is expected this autumn with the new contract commencing February 2027.

c. Provision of resilience services

- Cost of Living Support Officer

The Council's Public Health team continues to fund a Cost of Living Support Officer (CoLSO) who takes referrals from the Cost of Living helpline and provides support in existing services



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and community settings. The CoLSO supports residents in financial hardship experiencing complex issues adopting a holistic focus and supporting the resident to find and maintain their own solutions. For the period 2025/26 there with 110 referrals to the CoLSO with 94 residents receiving intensive support. In addition, the CoLSO assisted 30 clients within Project W with ongoing support and gave 446 instances of one-off advice. Collectively for this period, 570 unique residents received support with 1,011 supported referrals to PCC services (e.g. Council Tax, Housing Benefits, Household Support Fund, Switched On Portsmouth) and external agencies (e.g. food banks, VCS services, utility hardship funds/support, mental health services). The CoLSO alongside members of the Crisis and Resilience Fund team have attended sessions North End Pantry giving advice on cost of living and support available to reduce costs.

- CRF resilience services grants

The council has awarded 33 grants for the delivery of resilience services under Crisis and Resilience Fund (CRF) totalling £748,392. This encompasses 15 food support organisations (pantries, larders, foodbanks and community meal providers) who work to reduce material deprivation whilst providing wider wrap-around support to address underlying issues, in addition to funding for community cooking sessions to assist residents to cook more affordably and healthily, support for those in the homelessness pathway and in temporary accommodation providing essential items, and targeted services for families, adults accessing mental health services, those accommodated in the private rented sector, and older residents. A brochure is being developed which will list all the grant funded services to aid signposting. The resilience services strand of CRF is also being used to extend Holiday Activity and Food (HAF) provision to low-income and vulnerable households not in receipt of Free School Meals, and to fund Switched On Portsmouth to deliver their freephone energy advice line and provision of free home energy advice visits, small energy saving measures, and broken boiler replacements.

- HIVE community helpdesks

HIVE Portsmouth have established three community helpdesks within the city which offer free information and guidance including signposting to financial support for utility bills and information about where to access free food provision. These are located in Portsmouth Central Library, the John Pounds Centre in Portsea and Paulsgrove Housing Office.



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- Community wellbeing hubs

The council are working with HIVE Portsmouth and wider partners to develop new Community Wellbeing Hubs within the city. The primary objective is to bring care closer to home by delivering services differently. Using an asset-based community development approach three new hubs will be piloted in Portsea, Paulsgrove and Fratton (SPARK community space) and then rolled out to other areas across the city.

d. Sustainability of the food support network

- Food Support Network

The council continues to lead and chair the Food Support Network meetings which take place every quarter and brings together local food banks, pantries, larders and community meal providers. A new community WhatsApp group has also been implemented for the network so that information can be shared and received more easily by partners.

- Feeding Britain Network

The council has also become a partner of the Feeding Britain Network which provides partners in the city with structured support, shared data, and collective policy advocacy to tackle food poverty. Best practice and support are facilitated via a series of webinars, regional partnerships, and working groups on initiatives such as affordable food clubs, holiday hunger programmes and fuel banks. The network also connects members to grant funding opportunities and other resources.

- Food Alliance Steering Group

In 2025, HIVE Portsmouth worked with UK Harvest to undertake an evaluation of food security and sustainability in the city with the aim of developing a cohesive citywide approach. The evaluation identified six interconnected themes; food supply challenges, the value of community support, cultural inclusion and dietary diversity, volunteer and workforce capacity, organisational autonomy and collaboration, and structural inequality and system-level gaps. The outcome of the evaluation resulted in the Nourishing Portsmouth report which set out a series of recommendations focused on these themes. A Food Alliance Steering Group was formed in 2026, led by HIVE Portsmouth, to take forward the recommendations and work to improve food security, promote healthy and sustainable food systems, reduce inequalities, and ensure all residents have dignified access to nutritious, culturally appropriate food.



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3. Increasing opportunities and improving wellbeing

a. Increasing access to employment

- Youth Hubs, NEET Zero Pilot and Youth Guarantee

The DWP Partnership Manager is an active member of the Tackling Poverty Partnership Group, Universal Credit Partnership and the Debt and Benefit Forum and utilises these partnerships to share information about DWP led initiatives. This includes Portsmouth Youth Hub aimed at supporting job-ready 18-24 year olds with more holistic employment support, the NEET Zero Pilot focusing on 16-18 year olds who are not in education, employment or training bringing together DWP, employers and partner organisations such as King's Trust and Enable Ability to provide intensive support and address barriers using flexible support fund resources, training and skills interventions, and the Youth Guarantee Journey Programme which sits alongside the expansion of Youth Hubs nationally providing 16-24 year olds 12 weeks of support and three guaranteed outcomes.

- Connect to Work

Portsmouth was one of the first cities in England to launch Connect to Work, a government-backed work program delivered in partnership with the Department for Work and Pensions (DWP). Connect to Work helps disabled people, those with health conditions and people with complex barriers to employment, to find sustainable work. Those accessing can receive up to 12 months of personalised support. Since the 1st September 2025 there have been 393 referrals/expressions of interest, 181 programme starts and 52 individuals start work.

b. Developing skills to reduce costs

- Affordable cooking projects

HSF was used to fund affordable cooking projects in the city delivered across 8 organisations and teams. For 2025/26, 3,076 sessions were held supporting 742 households. For 2026/27, CRF resilience services grants have been issued to support affordable cooking projects externally delivered by Pompey in the Community, and internally by the council's Independence and Wellbeing Team (IWT), Play Youth and Community (PYC), and the Staying Close team in Childrens Social Care. The first set of CRF management information data is due beginning of October 2026.

- Digital inclusion project

A digital inclusion project was delivered under HSF early 2026 facilitated by Public Health and HIVE Portsmouth. Funding was utilised to expand the number of HIVE digital champions and



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upskill these, to deliver digital drop-ins and one-to-one support, to purchase equipment for community settings, and to provide equipment directly to households where identified. 52 households benefited from this project.

- Financial literacy support

New financial literacy support has also been funded under CRF resilience grants including planned workshops and sessions on topics such as budgeting and debt management led by local advice service providers (You Trust and Citizens Advice South East), and by organisations including Urbond and Age UK.

c. Addressing gambling related harms

- Gambling Harms Working Group

In September 2025, the Tackling Poverty Partnership Group established a dedicated Gambling Harms Working Group to develop a coordinated, partnership-based response to gambling-related harm in Portsmouth. Gambling harm is recognised as both a public health and poverty issue, with evidence highlighting links to debt, financial hardship, homelessness, relationship breakdown, mental ill-health and wider social harms. The Working Group brings together partners from public health, licensing, advice services, housing, poverty reduction, research and treatment services to improve understanding of gambling harms and develop local responses.

- Gambling Harms Awareness and Education Delivery Plan

The working group have developed a Gambling Harms Awareness and Education Delivery Plan to support a whole-system public health approach to preventing gambling harms in Portsmouth. The plan focuses on training for professionals, public health campaigns to reduce stigma, and prevention through targeted education for youth (ages 7-24) and will be delivered in partnership working alongside OHID funded prevention organisations including GamCare, YGam and Citizens Advice Solent East.

- Gambling Harms webpage

The working group also successfully developed a new Gambling Harms webpage on the Cost of Living Hub which was launched and heavily promoted during the 2026 football world cup. Between its launch and end of August 2026 the page received 1,705 views and was the second most viewed page on the hub (excluding the main landing page).



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d. Improving housing conditions in the Private Rented Sector

- Private Housing Sector (PRS) partnership work

Officers from the council's Private Housing Sector (PRS) team have joined the Tackling Poverty Partnership Group with the work of the PRS team becoming a formal component of the city's wider tackling poverty approach in response to the impact of high rent to income ratios, the freezing of Local Housing Allowance (LHA), risk of homelessness, and sometimes poor living conditions including poor energy ratings. The team have used the partnership to network with the voluntary and community sector to increase resident awareness and uptake of support and reach tenants who may not otherwise access support. The team has also supported partnership discussions around housing affordability, the Renters Right Act, tenancy sustainment and the impact of rising private rents on low-income households, while raising awareness of the work undertaken by Private Sector Housing to help ensure residents in the private rented sector live in homes that are safe and free from significant hazards, and helping to shape wider interventions delivered through the Crisis and Resilience Fund and local advice services.

A recent case study highlights the value of partnership working in identifying vulnerable residents, improving housing conditions and ensuring tenants receive the support and protection they need. Shortly after moving in, a tenant reported issues including a major leak, faulty doors, missing smoke detection and difficulty obtaining tenancy documents needed for a benefit claim. Through connections developed via the Tackling Poverty Partnership, their support worker referred the case to the council's Private Sector Housing team. Officers identified several serious hazards, including unsafe electrics, which required emergency repairs. Further investigation found the property was operating as an unlicensed HMO, with potential licensing breaches and unauthorised subletting concerns. Enforcement action was initiated, including statutory notices and a full housing inspection.

4. Using data to support partnership working

a. Data sharing projects to target support

- Southern Water social tariff data share

The council continue to work in partnership with Southern Water to share information to enable them to identify customers who qualify for a reduction to their water bill. The legal basis for this is the performance of a relevant public task under the Digital Economy Act 2017, and data on households in receipt of Council Tax Support is shared on a quarterly basis. Since March



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2025, 5,693 households have been identified reducing household bills by an average of £177 a year, with savings totalling £1,049,610 per annum.

- Portsmouth Water social tariff data share

The council is currently working with Portsmouth Water to replicate the project which will be enhanced via the inclusion of Portsmouth Homes data in addition to Council Tax Support data so that all Portsmouth Homes tenants, e.g. those who pay their council tax to other councils, can benefit.

b. Community engagement and feedback

- Big Portsmouth Survey

The Council's Big Portsmouth Survey continues to be run on an annual basis and includes a section and series of questions on the cost of living. A report on the findings of the survey is shared with the Tackling Poverty Partnership Group following the analysis of the data.

The seventh wave of the Cost of Living Survey was conducted between August and September 2025 and received 1,464 responses. Findings of the survey identified that financial concern amongst residents remains high. Concern is greatest among younger adults, ethnic minority communities, low-income households, people with disabilities, renters, and families with children. The proportion of residents struggling to meet day-to-day living costs increased slightly from 40% in Wave 6 to 44% in Wave 7, although this remains below levels reported in Waves 4 and 5. Those most affected include households earning £20,000 or less, renters, people aged 25 to 34, and families with children.

Rising food prices and gas and electricity costs continue to be the main drivers of financial pressure, with transport costs becoming a growing concern. Residents reported making a range of coping changes, including reducing non-essential spending, increasing credit use, working additional hours, and claiming benefits. Awareness of available support remains mixed. While 38% of residents know where to seek help with the cost of living, an equal proportion do not. Awareness is higher among people with disabilities and social housing tenants, but lower among private renters, higher-income households, ethnic minority groups, and families with children.

The eighth wave of the Big Portsmouth Survey closed on 9th September 2026, with analysis and results expected towards the end of this year.



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- CRF stakeholder engagement

To inform the development and delivery of the Crisis and Resilience Fund (CRF), stakeholder engagement was undertaken between November 2025 and January 2026 through separate surveys of residents and frontline professionals. The engagement sought views on the design of crisis payments, the types of resilience support that should be funded, and how local welfare services could work together more effectively.

The public survey received 431 responses from residents who had accessed Household Support Fund support or were engaged through community organisations and advice services. Most residents preferred to apply for crisis support online, although older residents were more likely to favour face-to-face options. Direct cash payments were the preferred form of assistance, and most respondents said they would approach the council first during a financial emergency. There was strong support for linking crisis assistance with wider support services, with 85% agreeing that applicants should access additional help where appropriate.

A separate survey of 61 frontline professionals and partner organisations found that food, essential household items, and energy and water bills were the highest priorities for crisis payments. Respondents emphasised the need for simpler, more accessible application processes and faster access to support for households facing sudden financial difficulties. There was also strong support for an emergency fund that trusted professionals could access to provide urgent assistance without a full assessment where appropriate.

Professionals highlighted the importance of combining immediate crisis support with longer-term help to address issues such as debt, affordability and complex needs. Key priorities for resilience services included maximising household income, reducing priority debt, improving access to affordable food, and providing financial, debt, housing and benefits advice. A strong theme throughout the survey was the need for a more joined-up local welfare system with better partnership working, clearer referral routes and a "no wrong door" approach to support.

The findings from both surveys directly informed the design of Portsmouth's CRF delivery model, including the development of a dual-route crisis payment scheme. Evaluation for the delivery of year 1 of CRF is planned for later this year following further guidance from the DWP in September 2026.

- Healthy Living in Paulsgrove

The Healthy Living in Paulsgrove work continues, led by the community and supported by members of the working group. New and recent projects include a new coffee morning ran by Portsdown and Portsmouth North Primary Care Networks which takes place at Paulsgrove



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Library on the first Tuesday of every month and extension of Pompey Link to take people to Tesco North Harbour and Hilsea Lido. Paulsgrove ARK also created a summer timetable with information about activities taking place in July and August in Paulsgrove.

Appendix 3

Poverty heat maps

1. Indices of Deprivation (ID) 2025 [Cost of Living JSNA page](#)

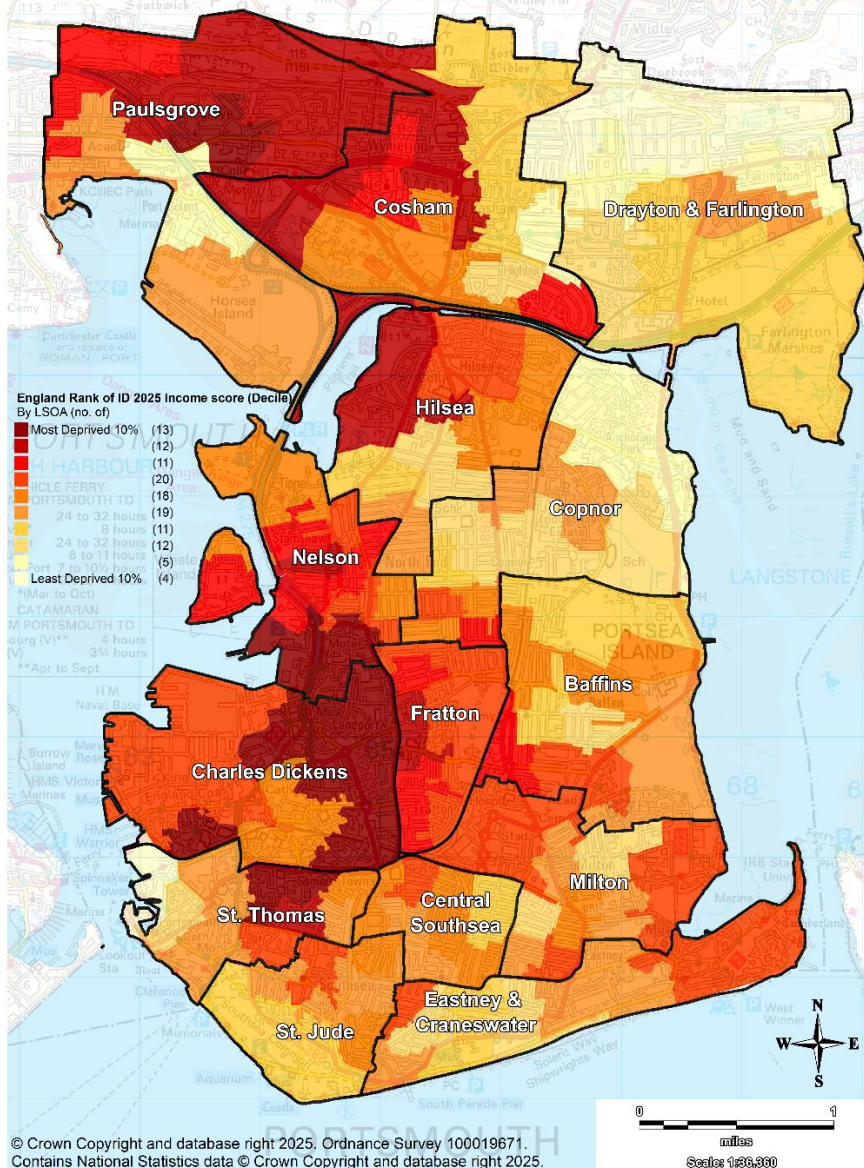
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a. Income Domain, Lower Super Output Areas (LSOAs)

Indices of deprivation (ID) 2025 - map of Portsmouth with the England rank of Index of Multiple Deprivation (IMD) 2025 Income Domain score in deciles by 2021 Census Lower Super Output Areas (LSOAs) overlaid with electoral wards.

Source: Ministry of Housing, Communities and Local Government, English Indices of Deprivation 2025.



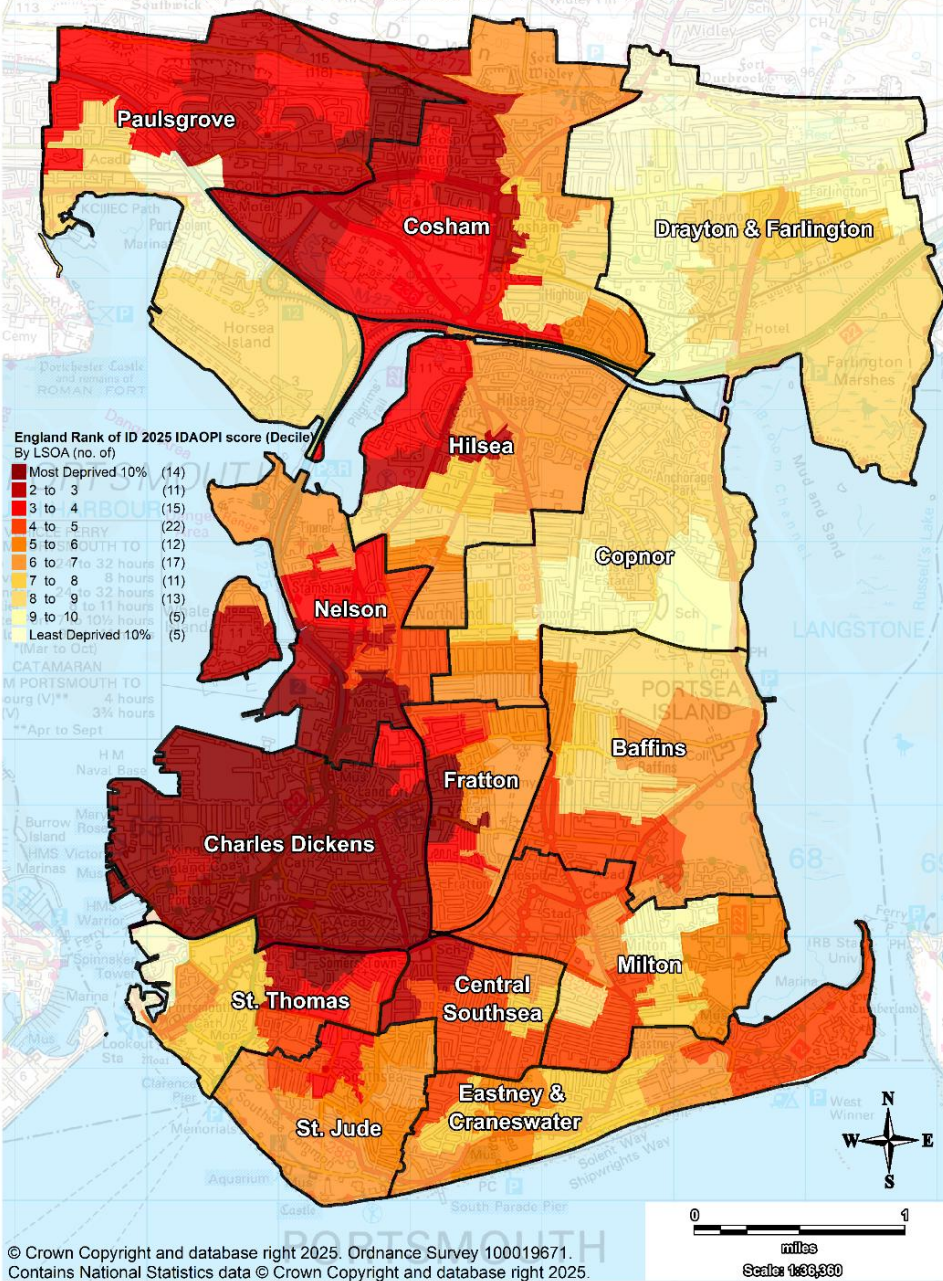
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b. Income Deprivation Affecting Older People Index (IDAOP), Lower Super Output Areas (LSOAs)

Indices of deprivation (ID) 2025 - map of Portsmouth with the England rank of Income Deprivation Affecting Older People Index (IDAOP) score in deciles by 2021 Census Lower Super Output Areas (LSOAs) overlaid with electoral wards.

Source: Ministry of Housing, Communities and Local Government, English Indices of Deprivation 2025.



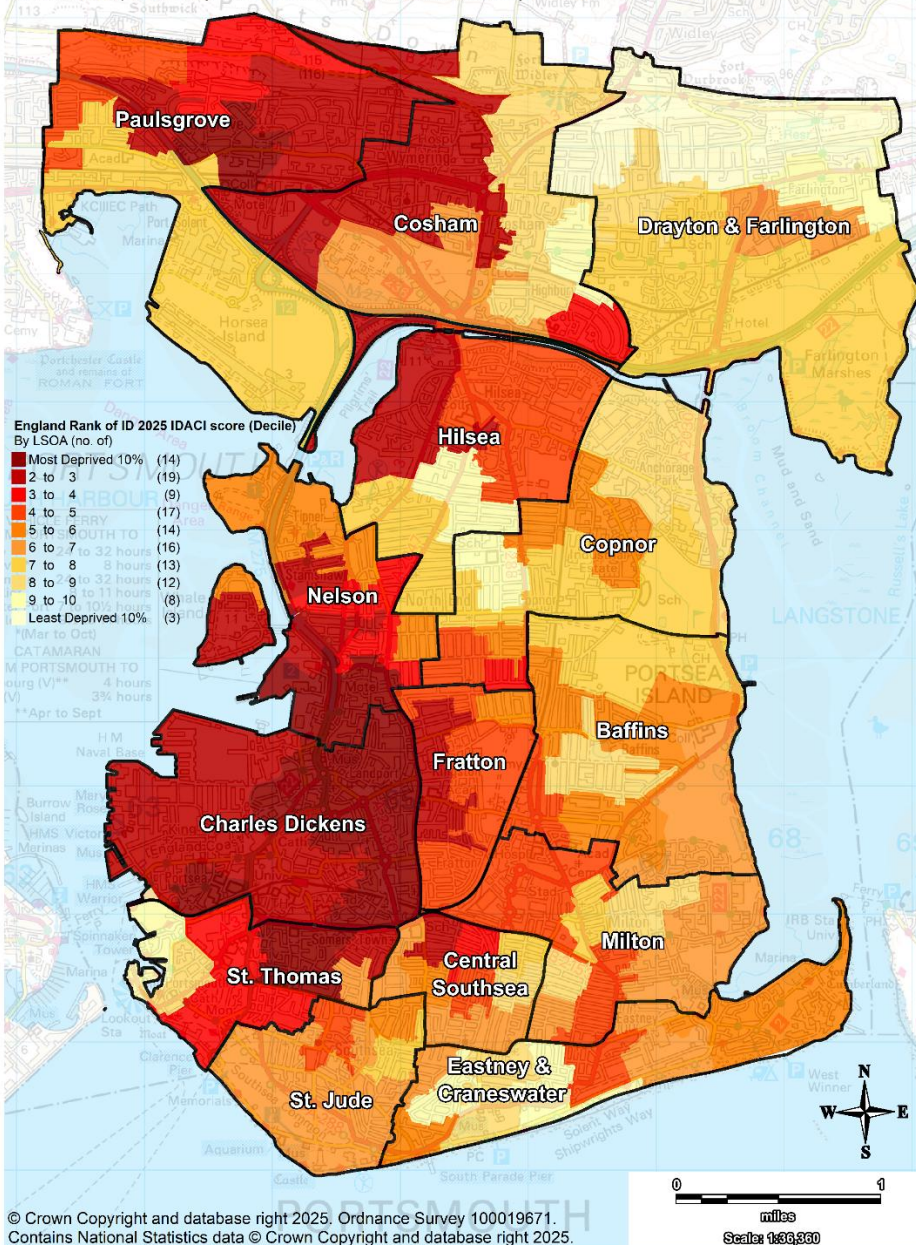
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c. Income Deprivation Affecting Children Index (IDACI), Lower Super Output Areas (LSOAs)

Indices of deprivation (ID) 2025 - map of Portsmouth with the England rank of Income Deprivation Affecting Children Index (IDACI) score in deciles by 2021 Census Lower Super Output Areas (LSOAs) overlaid with electoral wards.

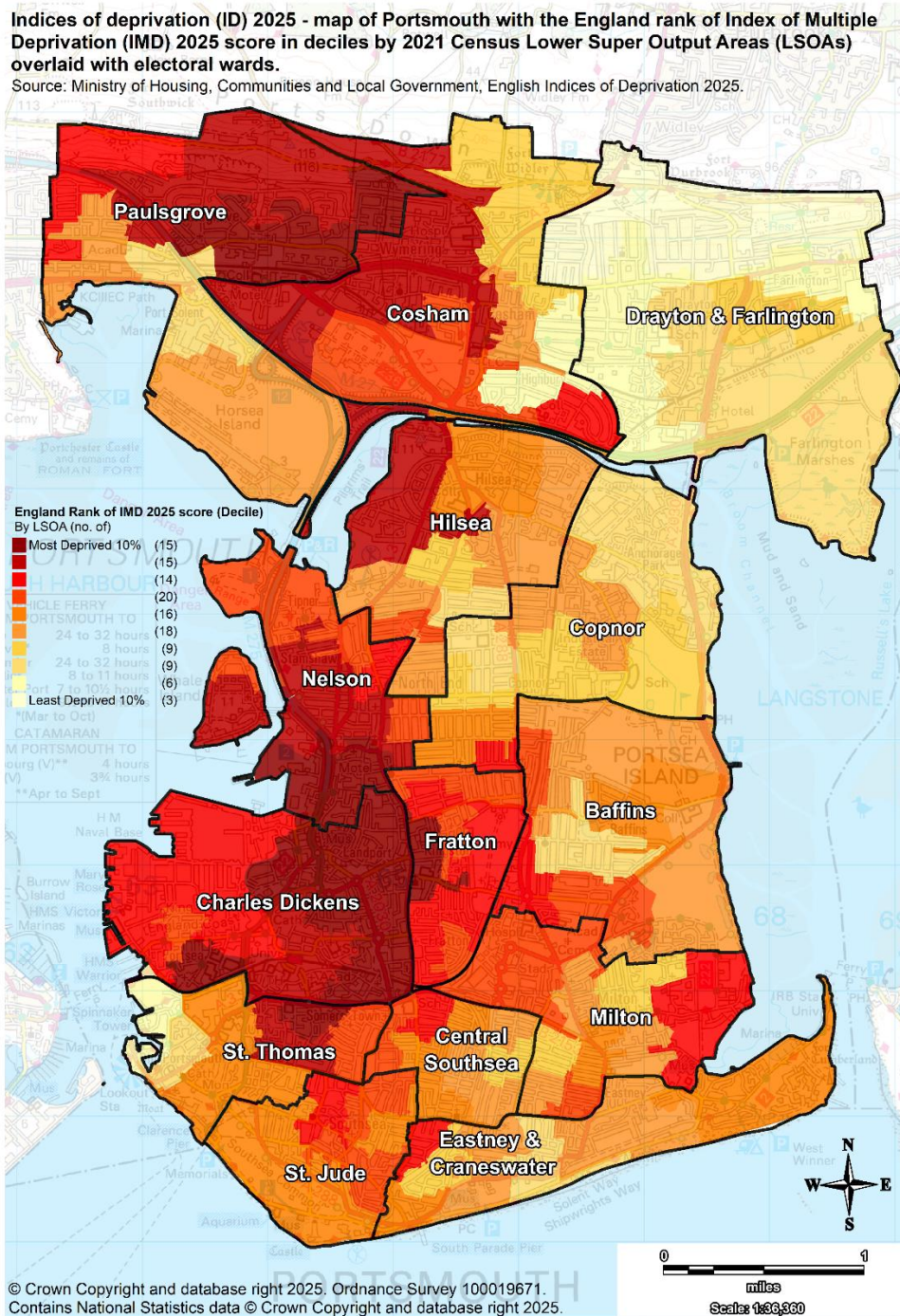
Source: Ministry of Housing, Communities and Local Government, English Indices of Deprivation 2025.



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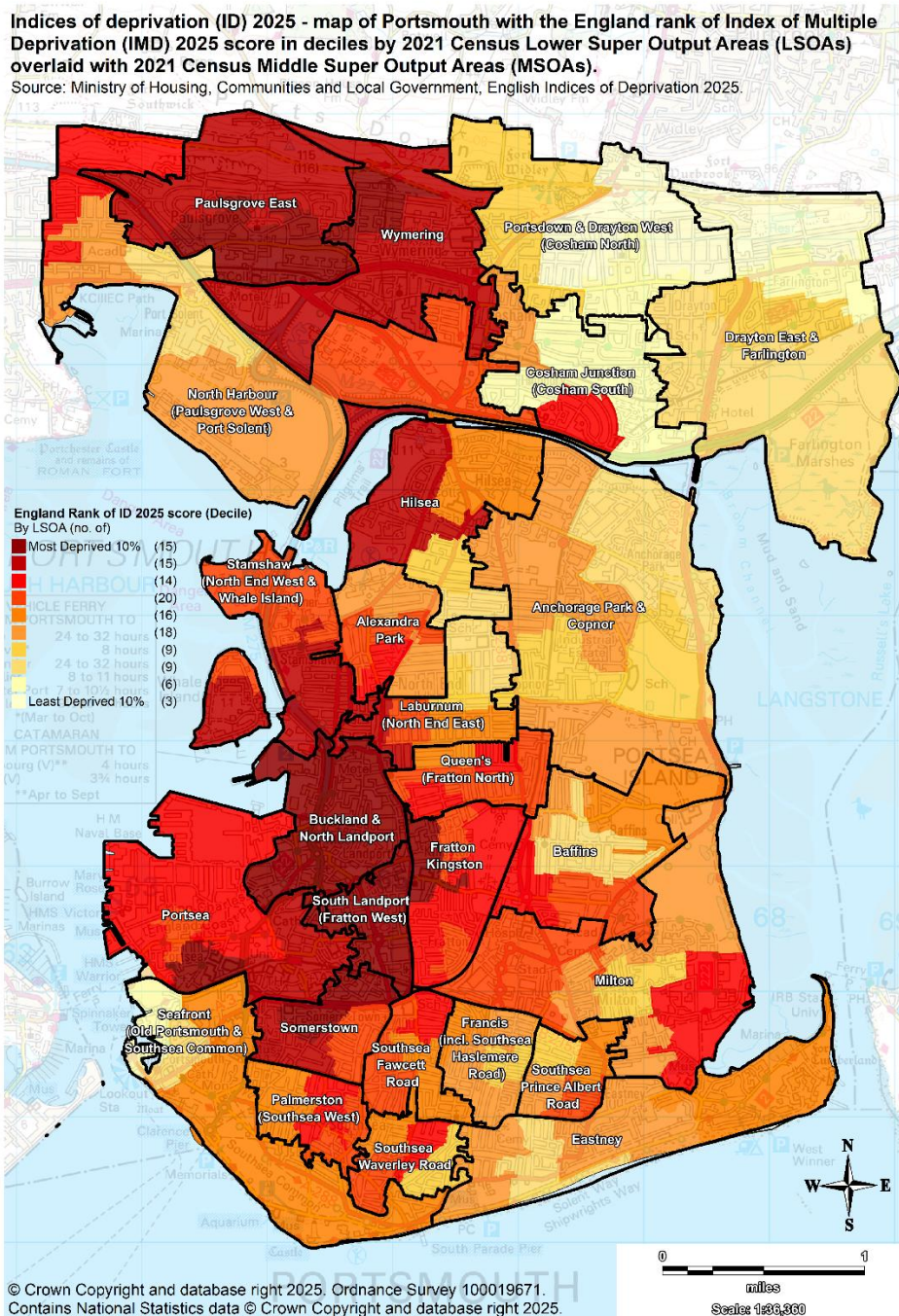
d. Index of Multiple Deprivation (IMD), Lower Super Output Areas (LSOAs)



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- e. Index of Multiple Deprivation (IMD), Lower Super Output Areas (LSOAs) overpaid with Middle Super Output Areas (MSOAs)



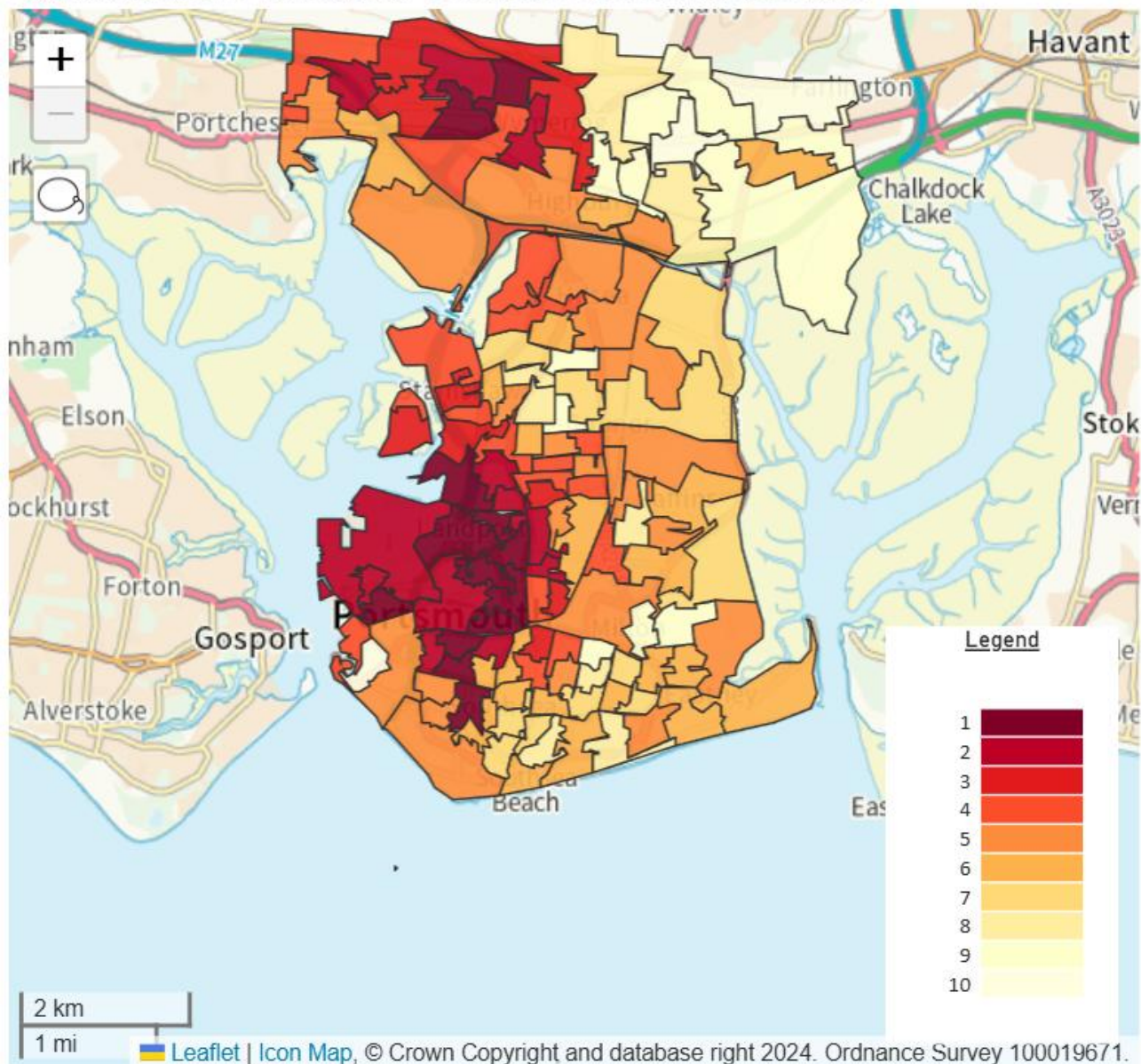
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2. Children in relative low-income families (CiRLIF) [Cost of Living JSNA page](#)

a. Before housing costs (BHC), Lower Super Output Areas (LSOAs)

% of Children aged under 16 years in Relative Low Income Families (CiRLIF) Before Housing Costs (BHC) by Lower layer Super Output Areas (LSOAs) ranked relative to England in deciles (1 being the 10% highest percentage), 2024/25

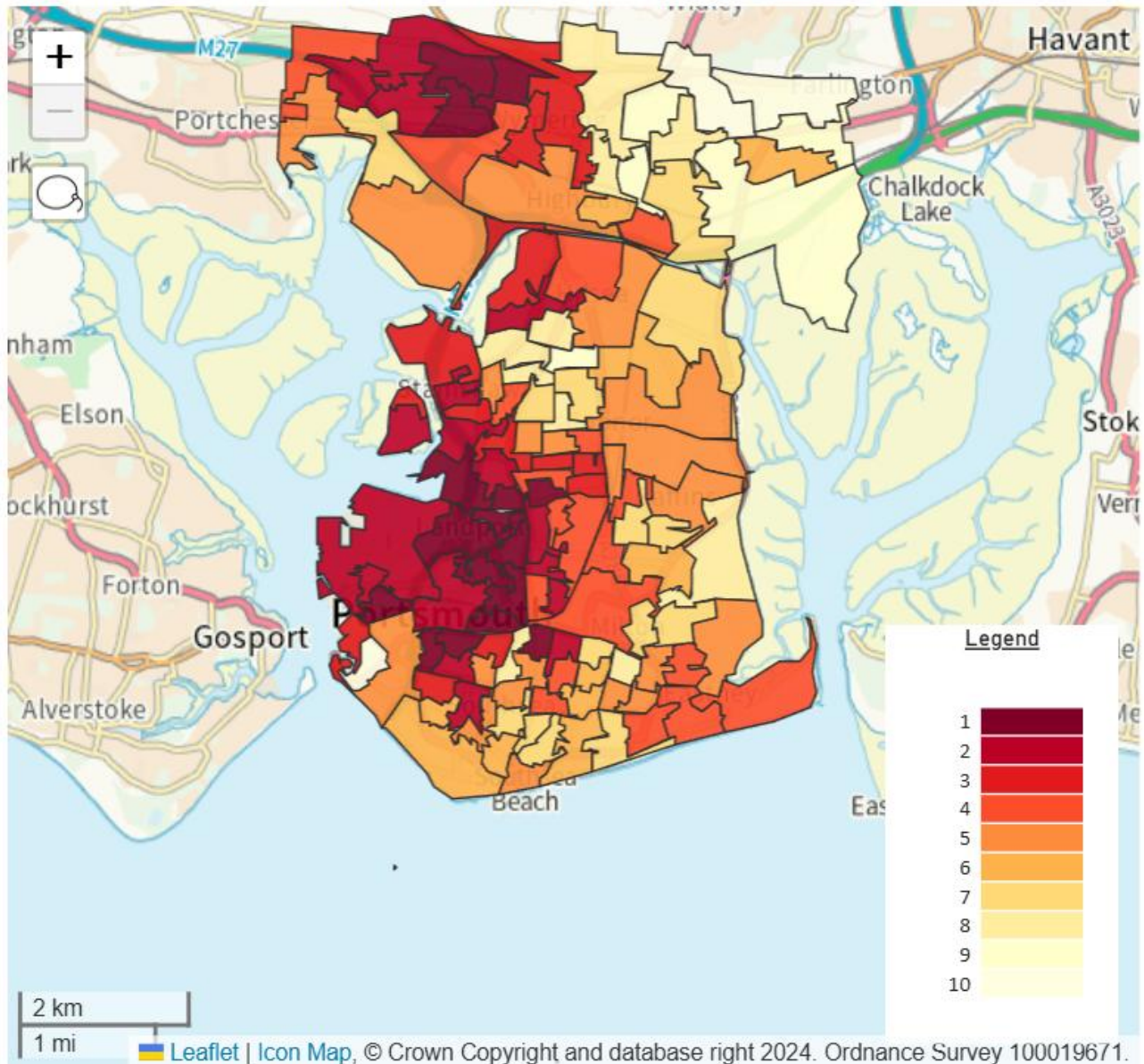


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b. After housing costs (AHC), Lower Super Output Areas (LSOAs)

% of Children aged under 16 years in Relative Low Income Families (CiRLIF) After Housing Costs (AHC) by Lower layer Super Output Areas (LSOAs) ranked relative to England in deciles (1 being the 10% highest percentage), 2024/25



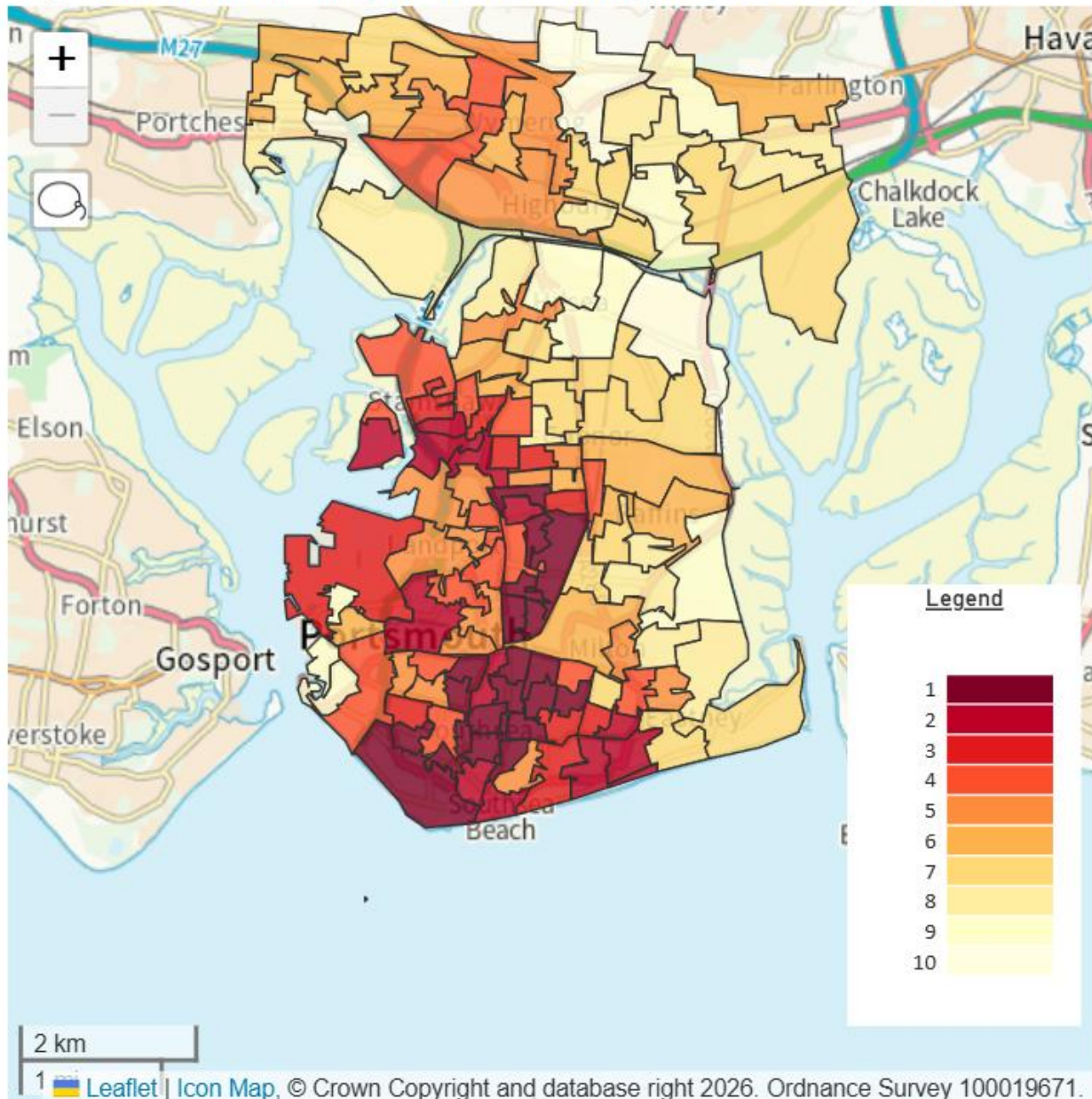
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3. Fuel poverty [Cost of Living JSNA page](#)

a. Low Income Low Energy Efficiency (LILEE), Lower Super Output Areas (LSOAs)

% of households fuel poor (Low Income Low Energy Efficiency (LILEE)) by Lower layer Super Output Areas (LSOAs) within Portsmouth ranked relative to England in deciles (1 being the 10% most fuel poor), 2026 (2024 data).



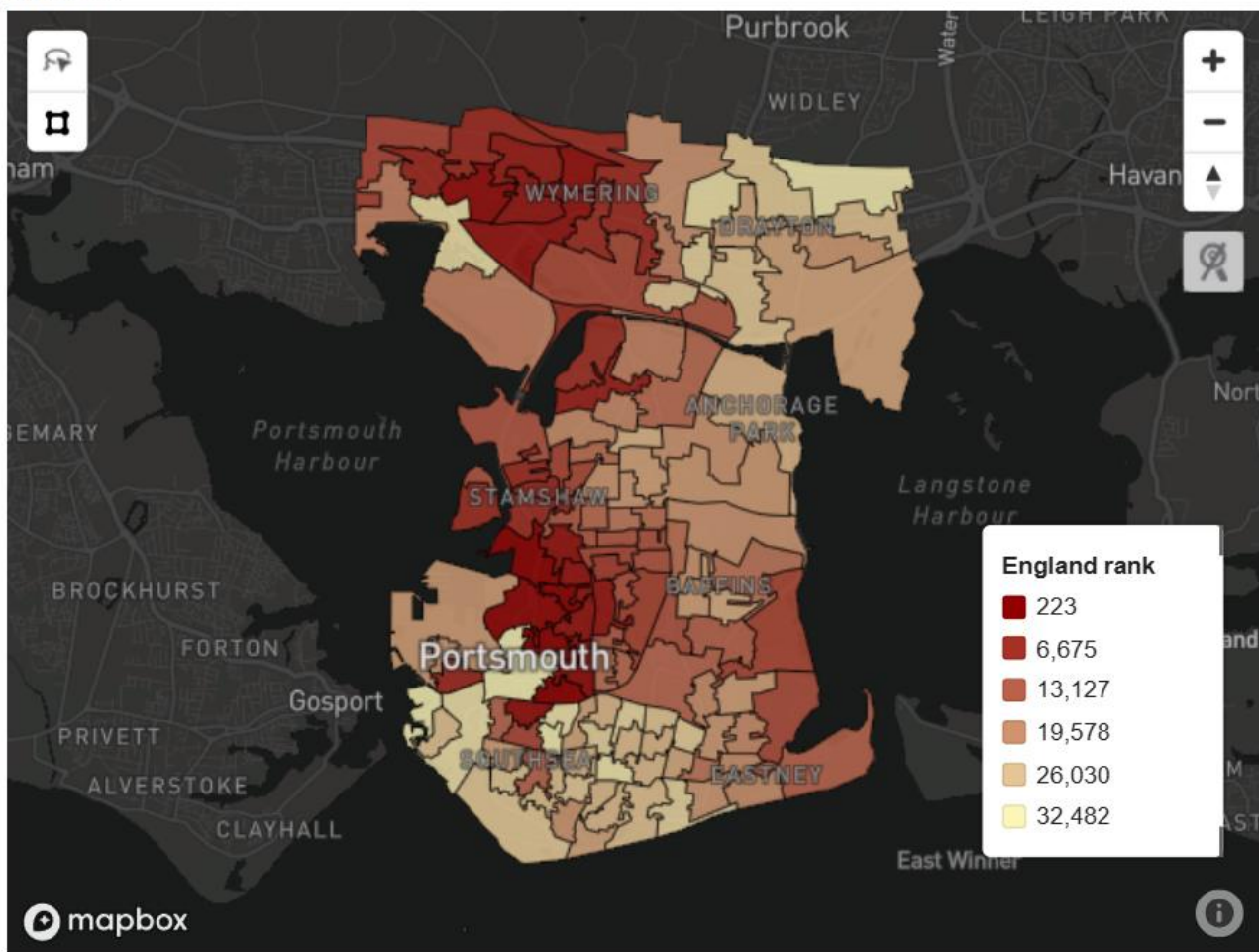
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4. Food insecurity [Cost of Living JSNA page](#)

a. Food Insecurity Composition with Stores Risk Index, Lower Super Output Areas (LSOAs)

The relative rank of Food Insecurity Composition with Stores Risk Index across local neighbourhoods in England (where 1 is the highest risk) by 2021 Census LSOA, Portsmouth; 2023-24



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Appendix 4

Health pen portraits: Portsmouth's six most deprived MSOAs

Paulsgrove East

Healthy life expectancy (HLE) at birth is the clearest concern in Paulsgrove East (middle super output area (MSOA)). In 2019–23, healthy life expectancy at birth was 57.6 years for males and 58.5 years for females. Both were statistically significantly worse than England and Portsmouth. Overall life expectancy at birth was also worse than both comparators, at 74.2 years for males and 80.2 years for females. This combination suggests the area has not only lower life expectancy at birth, on average, but fewer years lived in good health.

Outcomes for children and young people are mixed. Low birth weight and Reception obesity prevalence were similar to England and Portsmouth, but Year 6 obesity prevalence was worse than both. Admissions for injuries among children aged under five and all-cause emergency admissions among under-fives were similar to both comparators. However, injury admissions among those aged under 15 were worse than Portsmouth, while admissions among young people aged 15–24 were worse than both England and Portsmouth.

Hospital activity provides some indication of health need. All-cause emergency admissions, COPD admissions, intentional self-harm admissions and alcohol-attributable admissions were worse than both comparators. Coronary heart disease admissions were similar to England but worse than Portsmouth; stroke, heart attack and hip-fracture admissions were similar to both.

Mortality reinforces the picture of poorer health. All-cause mortality, mortality under age 75, cancer mortality, respiratory mortality and preventable mortality under 75 were worse than England and Portsmouth. Cardiovascular mortality was also worse than both, although premature cardiovascular mortality was worse than England but similar to Portsmouth. Coronary heart disease and stroke mortality were similar to both comparators.

Overall, the profile points to a substantial gap in healthy life expectancy at birth, alongside worse mortality rates and potentially avoidable hospital admissions. Priorities suggested by these data include prevention across the life course, with particular attention to healthy weight in later childhood, respiratory health, mental wellbeing, alcohol-related harm and reducing premature and preventable mortality.

Portsea

Portsea has the lowest healthy life expectancy at birth estimates among the six MSOAs for males, and one of the lowest for females. In 2019–23, healthy life expectancy at birth was 53.9



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years for males and 56.0 years for females; both were statistically significantly worse than England and Portsmouth. Life expectancy at birth was also worse than both comparators, at 72.6 years for males and 78.1 years for females. The close alignment of low healthy life expectancy at birth and low overall life expectancy at birth indicates a particularly marked local health disadvantage.

Available child health data show a mixed pattern. Low birth weight was worse than England and Portsmouth. Reception obesity prevalence and Year 6 obesity prevalence were similar to both comparators. However, the spreadsheet contains no Portsea data for childhood injury admissions, all-cause emergency admissions among under-fives, or injury admissions among children and young people. These gaps mean that no conclusions should be drawn for those indicators.

The detailed emergency hospital admission indicators available for four other MSOAs are not available for Portsea, so the profile cannot assess whether admission rates for COPD, self-harm, alcohol-attributable conditions or cardiovascular events differ from England or Portsmouth.

The mortality indicators that are available show consistently poor outcomes. All-cause mortality and mortality under age 75 were worse than England and Portsmouth. Mortality from cancer, cardiovascular disease, coronary heart disease, stroke and respiratory disease was also worse than both comparators. Premature cardiovascular mortality and preventable mortality under age 75 were likewise worse than England and Portsmouth. Premature cancer mortality was the exception, being similar to both.

Overall, Portsea's profile is dominated by very low healthy life expectancy at birth and worse mortality rates. The available data support a strong emphasis on preventing cardiovascular and respiratory disease, reducing premature and preventable deaths, and improving the conditions that enable people to live longer in good health. Low birth weight also warrants attention. Interpretation of emergency hospital admissions and several child-health outcomes must remain cautious because the relevant MSOA data are unavailable.

Somerstown

Healthy life expectancy at birth is substantially lower in Somerstown than in England and Portsmouth. In 2019–23, healthy life expectancy at birth was 55.7 years for males and 57.5 years for females, with both estimates statistically significantly worse than both comparators. Life expectancy at birth was also worse, at 73.6 years for males and 79.8 years for females.

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This combination suggests the area has not only lower life expectancy at birth, on average, but fewer years lived in good health.

The child and young people indicators are comparatively mixed and include some more better emergency admission rates. Low birth weight was worse than England and Portsmouth, while Reception obesity prevalence was worse than England but similar to Portsmouth. Year 6 obesity prevalence was similar to both. Injury admissions among children aged under five were better than England and similar to Portsmouth; all-cause emergency admissions among under-fives were better than both. Injury admissions among under-15s were better than England and similar to Portsmouth, and injury admissions among young people aged 15–24 were better than both comparators.

Among available emergency admission indicators, all-cause admissions were similar to England but worse than Portsmouth. COPD, intentional self-harm and alcohol-attributable admissions were worse than both. Coronary heart disease admissions were similar to England but worse than Portsmouth. Stroke and hip-fracture admissions were similar to both, while heart-attack admissions were worse than England but similar to Portsmouth.

All-cause mortality, mortality under age 75, cardiovascular mortality, premature cardiovascular mortality, coronary heart disease mortality and preventable mortality under 75 were worse than both comparators. Cancer and respiratory mortality were worse than England but similar to Portsmouth, as was premature cancer mortality. Stroke mortality was similar to both.

Overall, Somerstown combines a pronounced healthy life expectancy at birth gap and worse premature mortality with some relatively positive child hospital-admission indicators. Priorities suggested by the data include action on cardiovascular health, respiratory health, mental wellbeing and alcohol-related harm, while maintaining the factors associated with lower emergency admission rates among children and young people. Low birth weight remains an important early-life concern.

South Landport (Fratton West)

South Landport (Fratton West) has very low healthy life expectancy at birth for both sexes. In 2019–23, healthy life expectancy at birth was 54.1 years for males and 53.9 years for females, both statistically significantly worse than England and Portsmouth. The female estimate is the lowest among the six MSOAs in the spreadsheet. Life expectancy at birth was also worse than both comparators, at 75.1 years for males and 78.7 years for females. The particularly low female healthy life expectancy at birth, despite a longer overall life expectancy at birth than males, suggests many years may be lived in poorer health.

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The available child health indicators show several concerns. Low birth weight was worse than England and Portsmouth. Reception obesity prevalence was similar to both, but Year 6 obesity prevalence was worse than both. This pattern suggests that inequalities in healthy weight become more apparent by the end of primary school.

Data are not available in the spreadsheet for childhood injury admissions, all-cause emergency admissions among children aged under five, or injury admissions among children and young people.

Detailed emergency admission indicators for conditions such as COPD, self-harm, alcohol-attributable conditions, heart attack and stroke are also unavailable for this MSOA. The absence of these measures should not be interpreted as evidence of better or worse outcomes.

All-cause mortality and mortality under age 75 were worse than both England and Portsmouth. Cardiovascular, premature cardiovascular, respiratory and preventable mortality were also worse than both. Cancer mortality and premature cancer mortality were worse than England but similar to Portsmouth. Coronary heart disease mortality was worse than England but similar to Portsmouth, while stroke mortality was similar to both comparators.

Overall, the strongest feature is the severe healthy life expectancy at birth disadvantage, particularly among females, alongside significantly worse all-cause, premature, cardiovascular, respiratory and preventable mortality. The available evidence supports broad prevention focused on helping residents live longer in good health, with attention to cardiovascular and respiratory health, healthy weight in later childhood, low birth weight and the wider factors shaping health. Hospital-admission priorities cannot be assessed fully from the dataset.

West Buckland & North Landport (Landport)

West Buckland & North Landport (Landport) has one of the most disadvantaged healthy life expectancy at birth profiles of the six MSOAs. In 2019–23, healthy life expectancy at birth was 54.3 years for males and 55.4 years for females, statistically significantly worse than England and Portsmouth. Life expectancy at birth was also worse than both, at 72.7 years for males and 80.1 years for females. The large difference between male and female life expectancy at birth is notable, although healthy life expectancy at birth is low for both sexes.

Child health outcomes are mixed. Low birth weight and Reception obesity prevalence were similar to England and Portsmouth. Year 6 obesity prevalence, however, was worse than both. Injury admissions among children aged under five were similar to both, while all-cause emergency admissions among under-fives were similar to England but worse than Portsmouth.



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Injury admissions among those aged under 15 were also similar to England but worse than Portsmouth, and admissions among young people aged 15–24 were worse than both.

Emergency hospital admissions identifies several areas of concern. All-cause, stroke, heart-attack, COPD, intentional self-harm and alcohol-attributable admissions were worse than England and Portsmouth. Coronary heart disease admissions were similar to England but worse than Portsmouth. Hip-fracture admissions were similar to both.

All-cause mortality and mortality under age 75 were worse than both comparators, as were cancer, premature cancer, cardiovascular, premature cardiovascular, coronary heart disease, respiratory and preventable mortality. Stroke mortality was similar to England and Portsmouth.

Overall, this MSOA has a broad pattern of poorer health spanning later-childhood obesity prevalence, injury admissions among young people, emergency hospital admissions and premature mortality. Priorities suggested by the data include cardiovascular and respiratory prevention, cancer prevention and early diagnosis, mental wellbeing, alcohol-related harm and reducing avoidable hospital admissions. A life-course approach is important, with support for healthy weight before the end of primary school and sustained action to increase the number of years residents can expect to live in good health.

Wymering

Healthy life expectancy at birth is low in Wymering despite a less uniformly adverse pattern for overall life expectancy at birth and mortality than in several of the other MSOAs. In 2019–23, healthy life expectancy at birth was 58.8 years for males and 59.9 years for females, statistically significantly worse than England and Portsmouth. Male life expectancy at birth could not be calculated because the number of cases was too small and therefore was not compared. Female life expectancy at birth was 81.9 years and was similar to both England and Portsmouth. This illustrates why healthy life expectancy at birth adds important information beyond life expectancy at birth alone.

Several child health indicators are concerning. Low birth weight was worse than England and Portsmouth. Reception obesity prevalence was worse than England but similar to Portsmouth, and Year 6 obesity prevalence was worse than both. Injury admissions among children aged under five were similar to England but worse than Portsmouth. All-cause emergency admissions among under-fives were worse than both. Injury admissions among under-15s were similar to England but worse than Portsmouth, while admissions among young people aged 15–24 were worse than both.



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Emergency admission patterns show that all-cause, COPD, intentional self-harm and alcohol-attributable admissions were worse than England and Portsmouth. Stroke admissions were worse than England but similar to Portsmouth. Coronary heart disease, heart-attack and hip-fracture admissions were similar to both comparators.

Mortality results are more mixed. All-cause mortality, mortality under age 75, respiratory mortality and preventable mortality under 75 were worse than England but similar to Portsmouth. Cancer and premature cancer mortality were worse than both. Cardiovascular, premature cardiovascular, coronary heart disease and stroke mortality were similar to both comparators.

Overall, Wymering's central issue is a clear shortfall in years lived in good health, accompanied by adverse outcomes in early life, childhood obesity prevalence, children and young persons injury admissions and several forms of emergency hospital admissions. Priorities suggested by the data include healthy weight across childhood, support in pregnancy and early years, respiratory health, cancer prevention and early diagnosis, mental wellbeing and alcohol-related harm. The unavailable male life expectancy at birth estimate should be reported explicitly and not inferred from other indicators.

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Comparison matrix: key differences

Worse = worse than both England and Portsmouth; Similar = similar to both; Mixed = classifications differ by comparator or indicator; NA = unavailable/not calculated. This matrix is a high-level summary; the narratives retain the indicator-level nuance.

MSOA	Healthy life expectancy at birth	Life expectancy at birth	Children & young people	Emergency admissions	Mortality	Distinctive feature
Paulsgrove East	Worse: M 57.6; F 58.5	Worse: M 74.2; F 80.2	Mixed; Year 6 obesity prevalence and children and young persons injuries Worse	Broadly adverse; COPD, self-harm, alcohol Worse	Broadly adverse	Low HLE with higher emergency admission and mortality rates
Portsea	Worse: M 53.9; F 56.0	Worse: M 72.6; F 78.1	Mixed; low birth weight Worse; many admission indicators NA	NA for detailed admission set	Broadly adverse; premature cancer Similar	Lowest male HLE and worse mortality rates
Somerstown	Worse: M 55.7; F 57.5	Worse: M 73.6; F 79.8	Mixed; several child admission indicators better	Mixed; COPD, self-harm, alcohol-related Worse	Broadly adverse	Some child admission rates better than England and Portsmouth despite generally

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						poorer health outcomes in adults
South Landport (Fratton West)	Worse: M 54.1; F 53.9	Worse: M 75.1; F 78.7	Mixed; low birth weight and Year 6 obesity prevalence Worse	NA for detailed admission set	Broadly adverse	Lowest female HLE in Portsmouth
West Buckland & North Landport (Landport)	Worse: M 54.3; F 55.4	Worse: M 72.7; F 80.1	Mixed; Year 6 obesity prevalence and children and young persons injuries Worse	Broadly adverse	Broadly adverse	Very low HLE and wide male–female LE difference
Wymering	Worse: M 58.8; F 59.9	M NA; F 81.9 Similar	Broadly adverse	Broadly adverse; some cardiovascular indicators Similar	Mixed	Low HLE despite female LE similar to comparators



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Data notes

The six MSOAs included in this report are the six most deprived of Portsmouth's 26 MSOAs, based on the Index of Multiple Deprivation (IMD) 2025 population-weighted average score. A further six MSOAs have IMD 2025 population-weighted average scores above the Portsmouth average. Visual profiles for all Portsmouth MSOAs are available through the Office for Health Improvement and Disparities' Local Health tool:

<https://fingertips.phe.org.uk/>

For wider context, Portsmouth's healthy life expectancy at birth in 2019–23 was 63.1 years for males and 65.0 years for females, compared with 65.1 and 66.5 years respectively in England. Life expectancy at birth was also lower in Portsmouth, at 77.8 years for males and 82.5 years for females, compared with 79.1 and 83.0 years in England. This means the MSA figures should be interpreted against a local baseline that is already below England, particularly for healthy life expectancy.

Comparisons with Portsmouth for adult hospital admission and mortality indicators should be interpreted with caution, as these comparisons are based on indirectly standardised ratios. Comparisons with England are more directly comparable and should therefore be given greater weight.

Time periods vary by indicator. Life expectancy at birth and mortality values for 2019–23 are marked as based on provisional population data. Hospital admission indicators generally cover 2016/17–2020/21, child obesity prevalence 2022/23–2024/25, and low birth weight 2018–2022.

Data source:

[Office for Health Improvement and Disparities](#). Local health, public health data for small geographic areas. 2026. <https://fingertips.phe.org.uk/> © Crown copyright 2026. Accessed 10/9/2026.



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Title of meeting:	Health and Wellbeing Board
Subject:	Community Safety Update
Date of meeting:	23 rd September 2026
Report by:	Paul Markham, Superintendent, Hampshire and Isle of Wight Constabulary, Portsmouth District, Chair of Community Safety Focused sub-group of HWB
Cabinet Member:	Councillor Lee Hunt, Portfolio holder for Community Safety, Leisure & Sport
Wards affected:	All

-
- 1. Requested by Councillor Hunt**
 - 2. Purpose:** To provide an update on the work of the Community Safety focused sub-group (CSF) of the Health & Wellbeing Board (HWB).
 - 3. Recommendations:** That the Health and Wellbeing Board note the progress made through multi-agency work to deliver the Community Safety Action Plan 2025–28.
 - 4. Summary:** This report updates the Health and Wellbeing Board on key areas of Community Safety partnership work since the last report. It covers the developing response to serious violence and knife crime, progress across the Violence Against Women and Girls Strategy, work to strengthen community cohesion and positive relationships through the Safe and Connected Community Task and Finish Group, and findings from the 2026 Community Safety Survey.
 - 5. Background to this report:** The CSF provides a space to explore Community Safety issues more deeply, as part of the overall work of the HWB. Since the last update to the HWB in June 2026, we have continued to take forward work across the main priority areas within the Community Safety Action Plan, alongside wider partnership activity relevant to community safety and prevention.

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6. Tackling Serious Violence including Knife Crime

- 6.1** Since the last update, partners have continued to strengthen the city's strategic response to serious violence, including knife crime. This has involved bringing together enforcement, prevention, safeguarding and community insight within a more coordinated whole-system approach. Development of Portsmouth's approach to the Knife Crime Concentration Fund (KCCF) is being used not simply as a funding opportunity, but as a means of aligning existing violence reduction activity, testing shared understanding of risk, and supporting partners to move from analysis into practical, jointly owned planning.
- 6.2** Work to date has focused on strengthening the evidence base for the city's response. This includes consolidating and analysing KCCF and serious violence datasets, alongside reviews of habitual knife carrier and wider weapons data. The analysis has supported a clearer shared understanding of priority risk themes, including robbery, weapon-enabled offending and assault trends, and is helping partners to identify where activity can have the greatest collective impact. It is therefore being used to inform strategic prioritisation and system-wide problem-solving, rather than viewing incidents in isolation.
- 6.3** The emerging response has been shaped through partnership discussion to ensure future activity is targeted, proportionate and connected. A problem-solving plan will be submitted to the Home Office in September and will set out the proposed approach in more detail. At this stage, partners are focused on ensuring that the plan is informed by shared analysis, live data, community intelligence and an understanding of the places, networks and conditions that enable repeat offending. This will support a coordinated response that addresses immediate harms while also influencing the wider context in which violence occurs.
- 6.4** Alongside this, Portsmouth's focused deterrence programme, known locally as Next Move, continues to progress within the wider enforcement and prevention framework. The model brings together restorative practitioners, police, education and other partners to provide a coordinated response to young people at risk of serious violence, while strengthening links with community engagement and positive opportunities.
- 6.5** The Portsmouth cohort includes young people affected by exploitation, association with peer networks linked to violence and criminality, weapon carrying, violence, robbery, drug activity and disrupted education. Each participant has a named practitioner, coordinated support from relevant services, access to positive activities, education support and an individual plan. This reflects a relational practice model of high support and high challenge: building trusted relationships

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and practical support around young people, while maintaining clear boundaries and consequences where serious harm continues. This balanced approach supports the wider strategic aim of reducing escalation and strengthening longer-term prevention through a partnership response that is both relational and firm on harm.

7. Violence Against Women and Girls (VAWG)

- 7.1** Partnership work to address Violence Against Women and Girls (VAWG) continues to progress across the four priorities of the Portsmouth VAWG Strategy: domestic abuse, early intervention and prevention, creating safer places, and driving organisational change. The VAWG Board is strengthening its oversight through a revised monitoring framework, supporting more proportionate assurance, exception reporting and shared problem-solving where risks, gaps or opportunities are identified.
- 7.2** Domestic abuse remains a significant area of demand and complexity. Recent monitoring shows increases in reported incidents, recorded crimes and high- and medium-risk referrals. The Board noted that the increase in arrests leading to charge or caution should be understood in the context of strengthened evidence-led practice, more robust scrutiny and faster police and CPS processes, rather than simply as an increase in enforcement activity.
- 7.3** Prevention and early intervention activity is developing across education, health, community and online settings. This includes the “How’s It Going?” pilot in sexual health services, school and college engagement, film-based prevention resources, active bystander training and development of the Safer Together Hub. Together, these areas of work support earlier, wider and more inclusive conversations about relationships, consent, harmful behaviours and routes to support.
- 7.4** Work to create safer places continues through We Stand Together, night-time economy activity, licensing, transport safety and promotion of reporting routes such as StreetSafe. Following the end of external funding, We Stand Together has moved to a more sustainable self-service and assurance model while retaining its focus on visible, welcoming and safer venues.
- 7.5** White Ribbon remains an important strand of organisational and partnership prevention work. Portsmouth City Council’s refreshed White Ribbon Action Plan for 2026–2029 is being aligned more explicitly with the VAWG Strategy, organisational change, workforce culture, commissioning, community safety and partnership governance. Planned campaign activity will continue to strengthen visible leadership, allyship and community engagement.

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- 7.6** Discussion at the VAWG Board has also led to further work to strengthen the response to Global Majority communities affected by VAWG. This is being taken forward through a pan-Hampshire task and finish group led by Stop Domestic Abuse and Portsmouth City of Sanctuary. The work recognises that barriers around access, trust and reach often sit across systems rather than within any single service, and that partners need to understand how services and systems may be hard to reach for people experiencing VAWG.
- 7.7** The Board continues to consider wider system issues, including access to emotional support, safe accommodation, learning from health-based pilots and the sustainability of specialist provision. These discussions underline the importance of coordinated pathways, trauma-informed support, clear referral routes and continued attention to hidden harm, exploitation and the needs of those experiencing multiple and complex barriers.

8. Safe and Connected Community Task and Finish Group

- 8.1** The Safe and Connected Community Task and Finish Group is continuing to provide a partnership space for strengthening community cohesion, belonging and connection across Portsmouth. Its work is increasingly focused on how the city can move from individual engagement activity towards a more coordinated approach to community insight, early identification of tension and shared prevention activity.
- 8.2** The group has identified an opportunity to better connect Portsmouth's existing community engagement routes, trusted networks and community anchors so that community insight can more consistently inform partnership thinking and action. The emerging proposal is for a light-touch community voice, listening and cohesion framework that builds on what already exists, supports earlier understanding of emerging issues, and strengthens feedback to communities about what has been heard and how it is being used.
- 8.3** This is being recognised as a proportionate and developmental area of work, with a focus on strengthening the system rather than creating new structures. Further exploration will consider how the model could be developed in practice, including appropriate governance, community feedback mechanisms, measures of impact and any capacity or funding options needed to support a sustainable approach.
- 8.4** Alongside this, work continues to develop the Share Your Story project as a practical way of bringing the positive relationships theme to life. The project is using co-produced personal stories to support dialogue about belonging, connection and

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community in Portsmouth, with participants now being supported to develop material for filming and wider use through trusted local networks.

- 8.5** The immediate ask of the Health and Wellbeing Board is therefore to note and acknowledge the importance of this developing work as part of the city's wider positive relationships, prevention and community resilience agenda.

9. Bi-annual Community Safety Survey 2026

- 9.1** The 2026 Community Safety Survey provides an important local evidence base, complementing police and partner data by capturing residents' experiences of crime and anti-social behaviour, perceptions of safety and confidence in reporting. The survey has been undertaken over the long term and continues to inform the annual Strategic Assessment and the priorities recommended through the community safety partnership.
- 9.2** Findings from the 2026 survey were considered by the Community Safety Sub-Group in August. The face-to-face survey achieved 1,074 interviews and remained broadly representative of Portsmouth's population, while an online pilot generated 352 responses and provided useful learning about future survey methods. The online responses cannot be combined with the face-to-face survey, but they offer additional insight and may support future work if used as part of a mixed-method approach.
- 9.3** The findings show that exposure to anti-social behaviour is widespread, with 77% of residents reporting that they had experienced or witnessed ASB in the previous 12 months. However, reporting remains low, with many residents describing ASB as normalised or expressing limited confidence that reporting will lead to change. This reinforces the importance of clear reporting routes, visible partnership responses and feedback to communities about action taken.
- 9.4** The survey also highlights important perception and reassurance issues. Around one third of residents reported being a victim of crime in the previous year, with increases linked mainly to threats, intimidation, verbal abuse and hate crime. Cybercrime continues to be a growing concern. Direct experience of knife crime remains low and broadly stable, but concern about knife crime has increased significantly, underlining the need for balanced communications that provide reassurance without minimising residents' concerns.
- 9.5** Place-based concerns remain significant, with just over half of respondents identifying places in Portsmouth that they avoid or where they feel unsafe. The city

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centre and Commercial Road were most frequently identified, with concerns focused on drug and alcohol-related activity, anti-social behaviour, groups gathering, and visible rough sleeping and related support needs. Women were more likely than men to report feeling unsafe, reinforcing the continued relevance of women's safety, guardianship, lighting, surveillance and wider place-based prevention activity.

9.6 Moving forward these findings will be used to inform priorities, and support clearer public reassurance. This includes work to strengthening confidence in reporting, targeting persistent ASB hotspots, improving cybercrime prevention and support, continuing women's safety work, and seeking to implement a "you said, we did" approach so residents can see how their feedback is shaping partnership activity.

10. Conclusion: The update demonstrates continued progress in taking a more coordinated, prevention-focused approach to community safety in Portsmouth. Across the areas covered, common themes include the importance of partnership intelligence, relationship-based practice, community confidence, visible reassurance and earlier intervention. The Community Safety Focused Sub-Group will continue to provide oversight of delivery, support shared problem-solving where risks or gaps emerge, and report progress to the Health and Wellbeing Board.

.....
Signed by: Paul Markham, Superintendent, Portsmouth District, Hampshire and Isle of Wight Constabulary, Chair, Community Safety focused sub-group (CSF) of the HWB

Appendices:

Appendix 1 - Community Safety Survey 2026 Executive Summary

Appendix 2 - Community Safety Survey 2026

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
Community Safety Survey 2026 Executive Summary	Public Health
Community Safety Survey 2026	Public Health



Portsmouth Community Safety Survey, 2026

Executive Summary

May 2026

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1. Background & Methodology

The Community Safety Survey captures residents' experiences of and views about crime and ASB. Fieldwork was coordinated by the research team with trained university students conducting 1,074 face-to-face interviews across multiple city locations in February and March 2026.

An online survey was also launched in March 2026 to assess whether an online approach is comparable to the face-to-face method and would address challenges in traditional data collection with sufficient demographic reach. The online survey was promoted via council communications and social media, receiving 352 responses. These responses cannot be combined with the face-to-face ones, but any key findings and differences between the two survey methods will be outlined in this report and discussed in more detail in the main survey report.

This survey is an important data source for understanding the broader landscape of crime and ASB in Portsmouth, as it captures experiences that may not have been reported to the police or other agencies. It provides an independent dataset that can be triangulated with police and other datasets, strengthening the credibility and validity of local analytical work. The survey has been running for almost 30 years, helping to identify emerging concerns and changes in trends.

Findings from the survey directly inform the annual *Strategic Assessment of Crime, Anti-social Behaviour, Reoffending and Substance Misuse*, which in turn recommends community safety priorities for the Health & Wellbeing Board.

2. Did our participants represent Portsmouth's population?

2.1 Face-to-face interviews with participants

The face-to-face survey participants were broadly representative of the Portsmouth population, particularly in terms of gender and ethnic background. The proportion of women and men was very close to the city's Census profile, and the ethnic makeup reflected Portsmouth's White British majority.

However, some differences were identified. **Older residents, particularly those aged 65–74, were over-represented, while adults aged 25–44 were slightly under-represented.** This is likely linked to where and when interviews took place. **Retired people were also more common in the sample than in the general population,** while people in employment were under-represented.

The survey **included a higher proportion of people reporting a disability or long term condition than shown in the 2021 Census,** suggesting good engagement with disabled residents. **Members of the armed forces community were under-represented** compared with Portsmouth's estimated armed forces population.

Geographically, respondents were not evenly distributed across the city. Charles Dickens ward was over-represented due to the frequent use of Commercial Road as a high-footfall location for interviews, while **some wards, such as Cosham and Paulsgrove, were under-represented.**

2.2 Participants who completed the online survey

The online survey participants showed greater differences from the Portsmouth population than the face-to-face participants. **Older residents were heavily over-represented, with almost three-quarters of respondents aged over 55, and half of participants identifying as retired.**

Women were slightly over-represented, and although the proportion of respondents reporting a disability was closer to Census levels than in the face-to-face survey, **people from ethnic minority backgrounds were under-represented online.** Participation from the armed forces community was slightly higher online than face-to-face but still did not fully reflect the estimated size of this group in Portsmouth.

In terms of geography, the ward profile also differed, **with residents from wards such as Charles Dickens, Nelson and Paulsgrove under-represented in the online survey.**

3. Overall quality of life and wellbeing

65% of residents reported a good overall quality of life in Portsmouth. However, **average quality of life scores remain lower than those recorded prior to 2022 and have not recovered to pre-pandemic levels.** Residents who had not experienced crime or ASB, who were not worried about victimisation, and who did not feel unsafe reported significantly higher quality of life.

While it is not possible to attribute causation, these findings suggest that community safety contributes to wider wellbeing. Addressing community safety concerns therefore has the potential to support both crime reduction and broader public health outcomes.

4. Antisocial behaviour: perceptions and lived experience

The perception of ASB being a problem has remained relatively stable since 2018, with around a third of residents agreeing that ASB is a significant issue in their local area. However, **77% of residents reported that they personally witnessed or experienced ASB in the previous 12 months**, which is higher than the 2024 survey and the highest proportion since the current methodology was introduced in 2014. This gap between perception and experience suggests that ASB is widely visible in communities but not always experienced as serious or disruptive enough to be seen as a major problem for most residents.

The **most commonly reported ASB issues were people using or supplying drugs, traffic-related problems** (including e-scooters), noise in the street, street drinking, and people hanging around. **Since 2024, most ASB types have increased, with particularly notable rises in drug-related ASB and traffic issues.**

Reporting of ASB to agencies remains low with fewer than one quarter of incidents described to the survey reported to services. This continues a long-standing pattern and reasons given by residents indicated apathy, normalisation of ASB, and a lack of confidence that reporting will lead to effective action. This represents an ongoing challenge for partners, as non-reporting limits the visibility of problems in data and can undermine residents' trust in local services.

5. Fear and experience of crime

Around one third of participants reported being a victim of at least one crime in the previous year, which is higher in comparison with 2022 and 2024, though broadly stable overall since 2014. The increase from 2024 was **driven mainly by a sharp rise in threats, intimidation and verbal abuse, alongside an increase in reported hate crime.** In contrast, most traditional property crimes have remained stable or declined over time.

Victimisation was higher among younger adults (25-34), unemployed, sick/disabled individuals, and ethnic minority residents.

Fear of crime has increased since 2024, though it remains lower than levels recorded before the COVID-19 pandemic. As in previous years, fear of crime was substantially higher than actual experience for the offences residents feared most, particularly robbery and assault. Women, people with disabilities, young adults, and participants from ethnic minority backgrounds were significantly more likely to report fear of victimisation. Additionally, those who had experienced ASB or crime were significantly more likely to report fear of victimisation supporting **an association between lived experience and feelings of safety.**

Cybercrime continues to be an area of growing concern, with reported victimisation higher than in previous survey years (22% compared with 16% in 2024). Online fraud, phishing and personal hacking were the most common types experienced. **Younger adults and people with disabilities or long term conditions were more likely to report experiencing cybercrime.**

Approximately half of crimes were reported, mainly to the police (75% of incidents that were reported). Cybercrimes were more commonly reported to banks, credit card companies, websites or social media platforms. The reasons for not reporting included the perception that nothing would be done or that they did not think it was worth reporting.

6. Knife crime

Although direct experience of knife crime remains relatively rare and shows a stable trend, concern about knife crime has increased substantially since 2024, with over half of respondents now viewing it as a problem in Portsmouth. This increase appears to be driven largely by media coverage and wider awareness of local incidents, rather than personal experience.

Just over 1 in 10 residents reported seeing someone carrying a knife which is similar to previous surveys.

These findings relate to the general adult population (aged 18 and over), and it is important to recognise that some groups may not be fully represented in the survey and could have different experiences. We cannot assume that the same findings apply to young people. However, the most recent police and hospital data do not indicate an increase in knife-related offences or knife-related hospital admissions. This suggests that, if knife carrying among young people is increasing, this has not yet led to a corresponding rise in physical harm or in reported experiences of knife crime.

7. Places people avoid or feel unsafe

Just over half of respondents said there were places in Portsmouth that they avoided or where they felt unsafe, a proportion that has remained relatively stable over the last decade.

The City Centre/Commercial Road was the most frequently mentioned location where residents felt unsafe for the second consecutive survey, followed by Somerstown and Buckland. Reasons for feeling unsafe were driven by concerns about drug use and dealing, alcohol-related issues and ASB, groups or “gangs”¹ hanging around, and the visible presence of rough sleeping and related support needs.

Women were significantly more likely than men to report feeling unsafe or avoid areas, although the areas where they felt unsafe and reasons why were similar to responses from men.

Suggestions to improve safety consistently focused on visible policing and patrols, better lighting and CCTV, targeted responses to drug and alcohol-related ASB and more provision for children and young people.

8. Key differences between the face-to-face and online surveys

The **face-to-face approach to survey fieldwork continues to provide the most demographically representative sample**, with broader reach across age groups, ethnic backgrounds, and wards, and the ability for trained interviewers to clarify questions and avoid prompting effects. The **online survey was less representative** and particularly skewed towards older, retired and White British respondents.

Online participants **were more likely to view ASB as a problem in their area, but less likely to report personal experience**. Where they did report experiencing ASB, **they tended to identify a wider range of ASB types** than face-to-face participants. Online responses appeared to reflect **wider awareness of antisocial behaviour across the local area**, with participants more likely to recognise and select multiple ASB types they have seen. Alternatively, face-to-face responses are more likely to highlight the specific ASB issues people feel most concerned about, as participants tend to focus on the behaviours that affect them most strongly.

Online participants were less likely to experience crimes and cybercrimes but those who did experienced a **similar average number of crime types** as face-to-face participants.

There were no significant differences between the two groups for thinking knife crime is a problem, witnessing or experiencing knife crime.

Online participants **were more likely to express uncertainty** or concern around topics such as knife crime which could be a result of not being about to seek clarification. However, they **provided more detailed free-text responses giving more insight** into their experiences and views.

Differences in the demographic profile of the two participant groups may have contributed to the variation in findings. Older and retired participants were less likely to experience crime and cybercrime,

¹ Where participants referred to 'gangs' comments typically did not distinguish between organised criminal gangs and informal groups of people hanging around.

which may partly account for the lower proportion of online respondents reporting personal experience of crime. However, demographic differences alone do not appear to fully explain the other variations observed between the two survey methods.

Overall, the findings indicate that used carefully, and potentially alongside weighting or targeted samples, an online survey could be used, particularly in the context of wider geographical requirements and changing patterns of public engagement. However, it is **recommended that this is part of a mixed method approach where face-to-face engagement is also used to mitigate the limitations of the online survey and ensure that the survey is accessible to any resident who wants to participate.**

9. Conclusion

The 2026 Community Safety Survey provides a strong and independent evidence base on residents' experiences of crime and ASB, perceptions of safety, and fear of victimisation in Portsmouth. By combining a long-established face-to-face approach with a pilot online survey, the findings offer insight both into current community safety issues and into how different survey methods influence what is captured. Taken together, the results highlight the value of maintaining a mixed-method approach to ensure broad reach, inclusivity and depth of understanding.

Overall, **perceptions of ASB and fear of crime remain relatively stable, but exposure to ASB is widespread and has increased, with many incidents remaining unreported. The proportion of residents experiencing crime has increased since 2024**, driven largely by threats, intimidation, verbal abuse and hate crime and cybercrime. **Cybercrime continues to present growing risks**, particularly for younger adults and people with disabilities. **Although direct experience of knife crime remains rare, concern has increased substantially**, reflecting wider awareness rather than personal experience. Place-based concerns, especially in the city centre, continue to contribute to how safe residents feel, with women consistently more likely to report feeling unsafe.

9.1 Recommendations for the Community Safety Subgroup

- **Improve confidence in reporting crimes and ASB**, including clearer reporting pathways and visible feedback to communities about action taken.
- **Tackle persistent ASB hotspots**, particularly for drug-related ASB and traffic issues.
- **Focus on reassurance and visibility**, particularly in the areas where residents feel most unsafe.
- **Strengthen cybercrime prevention and support**, particularly for younger adults and people with disabilities.
- **Continue to embed women's safety into place-based work**, including improvements to lighting, surveillance and guardianship in identified locations.

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- **Continue targeted work to tackle violence and related harmful behaviours including intimidation, harassment, sexual harassment and hate crime.**
- **Work with the Health Determinants Research Collaboration (HDRC)² & Portsmouth City Council Research and Engagement team to prepare for the 2028 survey** to use community researchers to engage residents who are less likely to complete the survey online and use different channels to advertise the survey to reach a broader audience.

² [HDRC Portsmouth - Portsmouth City Council](#)

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Portsmouth Community Survey

Survey

2026

May 2026

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1. Background & methodology

1.1 Background

The Community Safety Survey gathers residents' perspectives and lived experiences relating to crime and anti-social behaviour (ASB). It also explores views on knife crime, perceptions of safety, locations that are avoided and the reasons why, as well as suggestions for actions that would help residents feel safer (see Appendix 1 for survey questions).

This survey remains a critical source for understanding the broader landscape of crime and ASB in Portsmouth, as it captures experiences that may not have been reported to the police or other agencies. It provides an independent dataset that can be triangulated with administrative and operational data, strengthening the credibility and validity of local analytical work. Findings from the survey directly inform the annual Strategic Assessment of Crime, Anti-Social Behaviour, Reoffending and Substance Misuse, which in turn recommends Community Safety priorities for the Health & Wellbeing Board.

The survey has been conducted for more than two decades, although its approach has evolved. Between 1999 and 2009, IPSOS MORI delivered the fieldwork, initially through stand-alone face-to-face interviews and later as part of broader telephone and postal residents' surveys covering various council services. Following council-wide budget reductions, the 2009 Residents' Survey was the final iteration delivered by IPSOS MORI, and no community safety survey was undertaken for the next three years.

A new approach was introduced in 2012 in partnership with the Institute of Criminal Justice Studies at the University of Portsmouth. The survey was embedded within a research methods module, with fieldwork carried out by a large cohort of students. However, the scale of student involvement (around 100 students each completing 5–10 surveys) and limited oversight of training and supervision created challenges in maintaining consistent quality. Consequently, from 2014 onwards, the survey has been managed in-house on a biennial basis. While incremental refinements have been made to enhance the usefulness of the data, the core elements have been retained, allowing for long-term comparison and the identification of trends and patterns.

1.2 Method

The fieldwork was coordinated and delivered by the research team, who recruited ten University of Portsmouth students to support data collection. Prior to commencing fieldwork, students received structured training designed to standardise interviewing practice and enhance data quality. The training covered:

- The background and purpose of the Community Safety Survey
- Key terminology relating to crime and anti-social behaviour (ASB), including definitions of each category

- Core interviewing skills
- Opportunities to practise, ask questions and confirm understanding

Under supervision, students conducted face-to-face interviews with residents across a range of locations within the city (see Appendix 2 for the full list). A face-to-face method was used to avoid providing participants with visible lists of ASB experiences or crime-related concerns. This is because these questions are highly subjective and if participants are shown a list of all options, they may be tempted to tick all ASB types that they are aware of in their area, rather than recording those which are having an impact on their quality of life.

Participants were asked about their experiences of crime and ASB in Portsmouth over the previous 12 months, so the survey covers crime and ASB occurrences from February 2025 to March 2026 depending on when the fieldwork was carried out. The fieldwork period has been similar since the 2014 survey.

It is important to acknowledge the limitations of this methodology. The survey records whether an individual has experienced a particular crime or ASB type but does not capture the number of times an incident has occurred. Certain crimes, particularly those of a sensitive nature, such as sexual offences or domestic abuse, may be under-reported due to the public setting of interviews and the demographic of the fieldwork team, who were predominantly university students. For safeguarding purposes, interviewers did not directly ask about domestic abuse or violence; however, space was provided for respondents to disclose such experiences if they chose to. In addition, the survey does not capture offences without a victim who can be interviewed (e.g., homicide, possession of weapons, drug offences) or crimes primarily affecting businesses, such as shoplifting.

1.3 Sampling & statistics

The most recent population estimate (mid-2024) indicates that Portsmouth has approximately 171,300 residents aged 18 and over. Based on this population size, a target sample of 1,065 participants was set to ensure results were statistically robust and unlikely to be attributable to chance. Further information on the analytical approach is provided in Appendix 2.

The survey adopted a convenience sampling method, meaning participants were not selected randomly. Members of the public were approached in various locations across the city and participation was voluntary. As a result, individuals with direct experience of crime or ASB, or those with strong views on community safety, may have been more inclined to take part. This introduces a likelihood that the proportion of respondents reporting crime or ASB will be higher than in the general population. However, this challenge is common across many forms of social research and has been a consistent limitation of previous community safety surveys and other comparator crime surveys.

To achieve a sample that reflected the wider Portsmouth population as closely as possible, demographic data collected during fieldwork was reviewed regularly against official population statistics. Fieldworkers were instructed to prioritise engagement with under-represented demographic groups where appropriate.

A detailed breakdown of the achieved sample is provided in Chapter 2. Nonetheless, due to the nature of the methodology, some groups are inherently less likely to participate, such as businesses, residents in care homes, prisons or hospitals and findings should not be assumed to represent these populations.

For readers interested in the technical detail, key statistical outputs are summarised in Appendix 3, with full analytical results available on request.

1.4 Research phase

The fieldwork took place in multiple locations (see Appendix 2 for list of locations) over a six-week period from 10th February 2026 to 21st March 2026 to fit in with the availability of the students. However, conducting the fieldwork during February and March meant that a fieldwork session was cut short due to bad weather.

It was noted that some of the key areas were a bit quieter than in previous years, with less footfall so number of surveys completed for sessions was slightly lower than in previous years. This was particularly notable in Paulsgrove but also to some degree in Cosham, Milton and Drayton & Farlington.

As previously mentioned, the demographics were carefully monitored during the fieldwork period and adjustments were made to ensure a proportional distribution of the demographic characteristics of the participants. For instance, two sessions were held on a Saturday to try and include more respondents in full-time employment and in the age range of 25-64 years.

1,074 surveys were completed, which met the target of 1,065 and is sufficient to allow robust analysis.

1.5 Online sample

In 2026, an online version of the Community Safety Survey was introduced with a target of at least 200 participants. The survey went live on the 11th March 2026 and ran until the 24th March.

1.5.1 Rationale for the online sample

The purpose was to compare the demographic profile and responses of online participants with those gathered through face-to-face fieldwork. This comparison will help assess whether an online approach

could produce comparable findings in future years and identify its strengths, limitations, and potential use in calibrating subsequent survey results.

The exploration of an online sample was prompted by several challenges affecting traditional in-person data collection:

- **Declining engagement in public spaces.** Increased phone use and headphones in public areas, and reduced footfall in shopping areas and housing offices are making it harder for fieldworkers to approach potential participants.
- **Hard-to-reach age groups.** Residents aged 25–54 and those in full-time work remain difficult to recruit as participants even with weekend and lunchtime sessions.
- **Changes to recruitment processes.** New human resources policy and procedures prevent emphasising the “work experience” aspect of fieldworker roles during recruitment, attracting applicants seeking full-time hours. This led to higher drop-out rates and reduced flexibility to recruit quickly or via word-of-mouth.
- **Future geographical requirements.** With Local Government Reorganisation (LGR), future surveys will need to include residents across a wider area (Fareham, Gosport, Havant, Rowlands Castle, Clanfield, Newlands & Horndean). This will be difficult to achieve via student fieldworkers given travel, time and budget constraints.

1.5.2 Online sample methodology notes

The online survey was advertised by the Portsmouth City Council Communications team providing links to the survey via the Ebulletin, Facebook and Instagram. 352 surveys were completed online, with most responses coming from the Ebulletin (91%, n=322) and a few from Facebook (8%, n=28) and only one via Instagram.

The online survey was very similar to the face-to-face survey but used logic so that where participants clicked some of the 'no' options, they were taken to the next question and did not see the follow up questions that the fieldworkers would have naturally skipped, when interviewing face-to-face.

The main differences between the two surveys were for the questions asking about personal experience of ASB and fear of crime. In the face-to-face surveys, the fieldworkers did not show the list of ASB types or crimes. In the online survey, the questions were amended slightly starting with a 'yes/no' option and if they selected yes, they were presented with a list of ASB or crime types.

Key details about how the online sample compared to the face-to-face sample can be found throughout this report but a summary of the differences can be found in Appendix 4.

2. Demographics

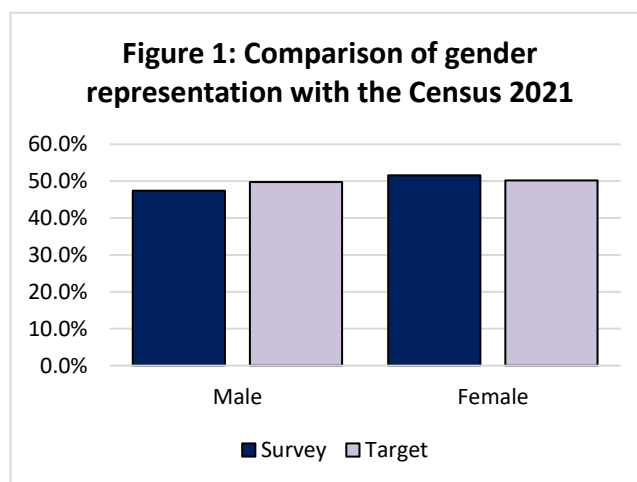
This section summarises the demographic characteristics of survey respondents and assesses how closely the achieved sample reflects the wider Portsmouth population. There were slight variations in the number of participants who answered these questions.

The results are presented through a series of charts that compare the survey sample with official population estimates from the Office for National Statistics (2021 Census).¹ There are also boxes in each section which summarises how the online sample compares.

2.1 Gender

Where gender was recorded, just over half of participants identified as female (51.6%, n=556), with 47.5% identifying as male (n=511). This **closely reflects the gender distribution in Portsmouth reported in the 2021 Census** (Figure 1).

Additionally, just under 1% of respondents preferred not to say, aligning with proportions observed in the Census data on gender identity.²



There was a greater difference between genders for the online sample compared with the face-to-face with 55% of respondents being female, 42% male and 3% preferring not to say. This difference is not statistically significant, but the proportions are not as close to proportions observed in the Census as the face-to-face sample.

2.2 Age

Participants aged 65-74 years were over-represented, accounting for 16.9% of respondents (n=182), which is 7.3 percentage points higher than the Portsmouth population based on the mid 2024 estimate (9.6%, Table 1).

¹ [Portsmouth demography - JSNA report - Portsmouth City Council](#)

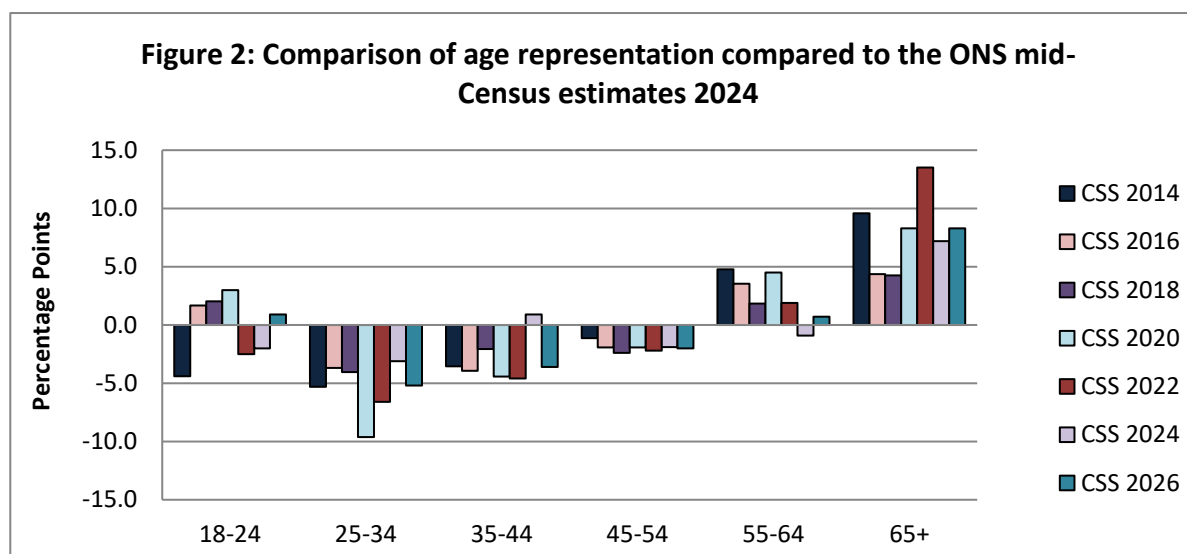
² <https://app.powerbi.com/view?r=eyJrIjoibNTYzMWQ3YzYtNGJkOC00ZmEwLWJmODMtNTk0MDAyNzk2ZDMxliwidCI6ImQ2Njc0YzUxLWRhYTQtNDE0Mi04MDQ3LTE1YTc4YmJlOTMwNiJ9>

This is consistent with previous survey years and is likely due to a combination of factors: individuals in this age group are more commonly present in survey locations during working hours, may have greater availability, and are often more willing to engage with fieldworkers compared with other age groups (Figure 2).

Most other age groups were broadly in line with the demographic profile of Portsmouth, although the 25–34 and 35–44 age groups were slightly under-represented.

Table 1: Participants by age group, 2026

Age Group	Survey		Target (mid 2024 estimate) (%)	Difference (Percentage points)
	(n)	(%)		
18-24	178	16.5%	15.6%	0.9%
25-34	151	14.0%	19.2%	-5.2%
35-44	157	14.6%	18.2%	-3.6%
45-54	132	12.3%	14.3%	-2.0%
55-64	159	14.8%	14.1%	0.7%
65-74	182	16.9%	9.6%	7.3%
75+	109	10.1%	9.0%	1.1%
Total	1076			

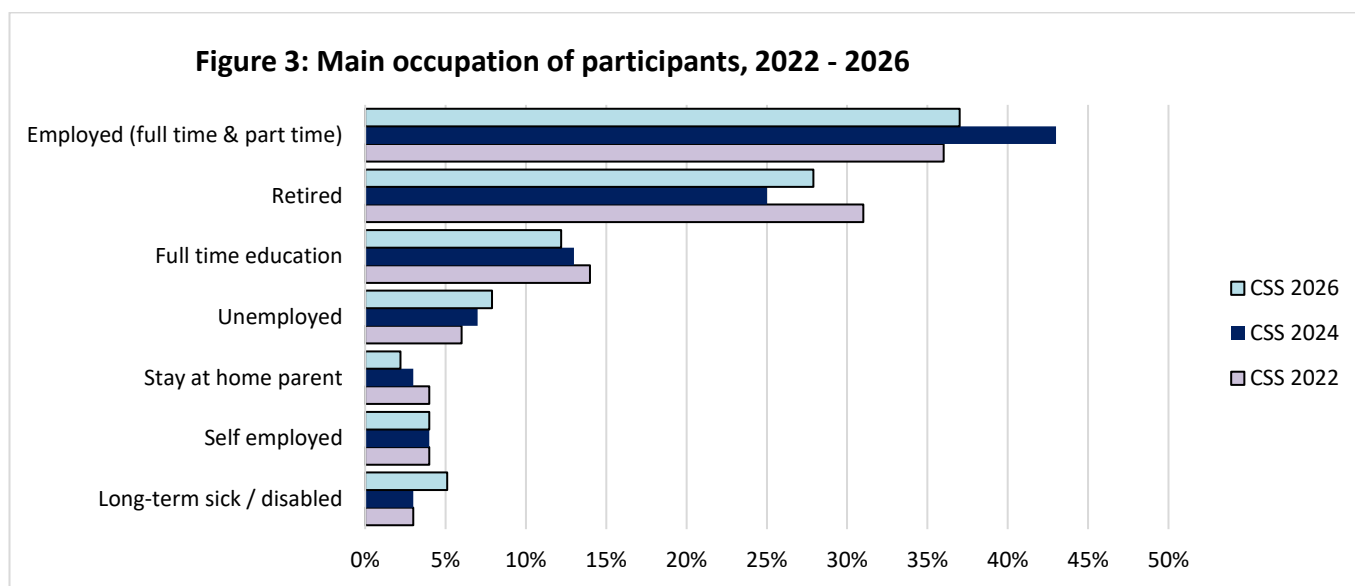


The online sample was less representative of Portsmouth residents than the face-to-face sample, with 74% of online respondents aged over 55 years compared with 42% F2F. The online survey had far fewer responses from 18-44yrs (9% compared with 45%). A similar number of people aged 45–54 took part in both surveys (online -13%, F2F - 12%).

2.3 Main occupation

Overall, 41% of respondents (n=438) were in employment, including full-time, part-time and self-employed roles. This is lower than the proportion recorded in the 2024 survey but broadly consistent with earlier years. A substantial proportion of participants were retired (28%, n=98), and 12% (n=131) were in full-time education (Figure 3).

Retired and unemployed residents were over-represented in the sample, reflecting their greater availability at fieldwork locations and higher likelihood of stopping to participate compared with other occupational groups.



More retired people took part in the online survey than the F2F survey (50% compared with 28%), while groups such as unemployed people (1.4%), students (0.6%) and carers (0.3%) under represented.

2.4 Disability

The 2021 Census asked residents whether they had any physical or mental health conditions or illnesses lasting, or expected to last, 12 months or more; a question designed to align with the Equality Act 2010 definition of disability.

Using this measure, 19.2% of Portsmouth residents reported having a disability or long-term condition. In comparison, a higher proportion of 2026 Community Safety Survey respondents (33.6%, n=361) reported

at least one disability or long-term condition. This is a higher proportion compared with previous years, although this is likely due to a change in the question to include long-term conditions.³

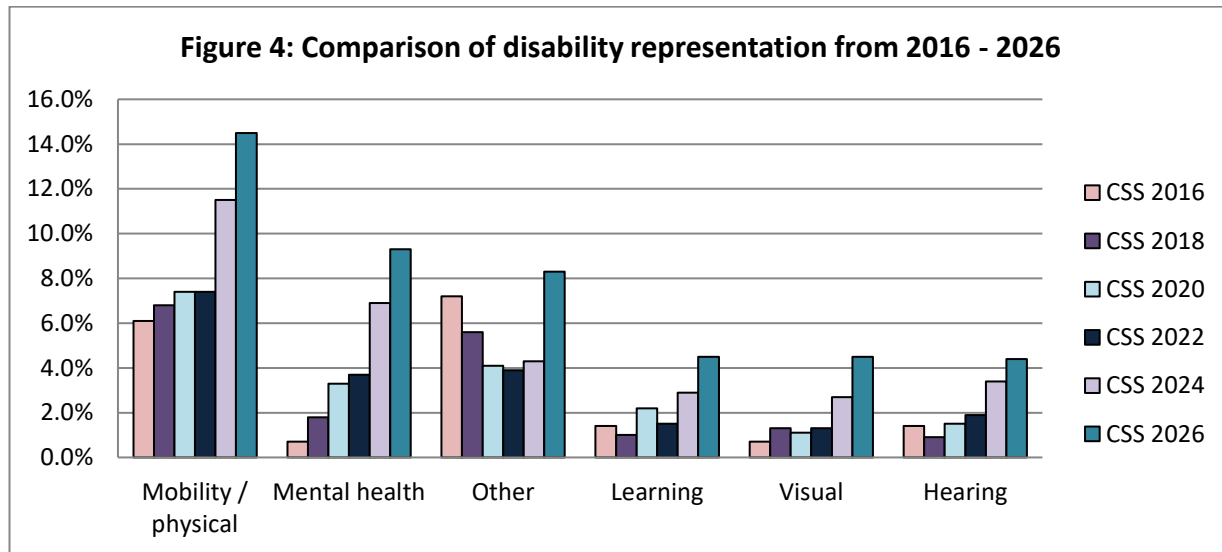


Figure 4 shows the proportion of participants who reported the categories of disabilities/long-term conditions. The most common was mobility/physical (14.5%, n=156), which may be linked to the high proportion of older participants.⁴ This was followed by mental health conditions (9.6%, n=100) and 'other' (8.3%, n=89) which included conditions such as heart and respiratory conditions, cancer, diabetes and autism.

Fewer people with disabilities took part in the online survey (26%) than the face-to-face survey, which is closer to Census levels. The online survey included more people with physical disabilities and fewer with learning, visual or mental health conditions, which could be because more older people responded online.

2.5 Ethnicity

Respondents to the survey were predominantly White British (78.5%, n=840), with 21.4% (n=229) identifying with other ethnic backgrounds.

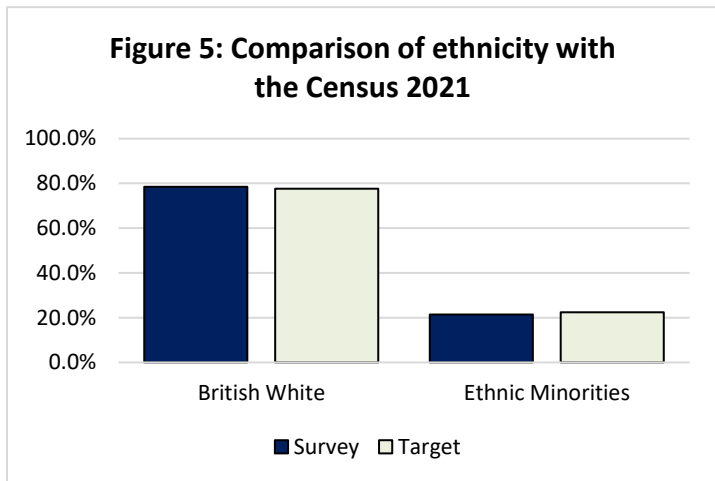
This represents a slightly higher proportion of White British participants (around one percentage point) compared with the 2021 Census profile for Portsmouth (Figure 5).

³ From 'Do you consider yourself to have a disability' to 'Do you consider yourself to have a disability or long-term illness/physical/mental condition that reduces your ability to carry out day-to-day activities?'

⁴ [CBP-9602.pdf \(parliament.uk\)](https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-and-social-care/committees/health-and-social-care-committee/2019-2020/cbp-9602)

Although the range of ethnicities represented in the sample broadly reflects the city's population, the numbers within individual minority ethnic groups are too small to support meaningful group-level analysis. As a result, comparisons in this report focus on differences between White British respondents and all other ethnic backgrounds combined.

A detailed breakdown of respondent ethnicity, alongside the corresponding Census 2021 proportions, is available in Appendix 5.



*There was a **significantly smaller proportion of ethnic minority participants in the online survey (6.2%)** and participants from ethnic minority backgrounds were substantially under-represented in comparison with the 2021 Census.*

2.6 Armed forces

In this survey, 13% of respondents (n=137) identified as serving members of the armed forces, veterans, or spouses/dependents of someone currently serving. Based on the latest estimates, Portsmouth's armed forces community numbers approximately 29,114 people (around 18% of the city's adult population). This indicates that the armed forces community was under-represented in the survey sample.

The survey sample of armed forces included less than 1% (0.6%) (n=6) currently serving, 5.6% (n=60) veterans and 6.6% (n=71) who were spouses or dependents of those currently serving or veterans.

More people from the armed forces community took part in the online survey, mainly because more veterans responded (11% compared with 5.6%). This means the online survey was closer to the target level for armed forces participation.

2.7 Ward

There was a good representation from most wards, although Cosham, Drayton & Farlington, Milton and Paulsgrove were slightly under represented with between 2.2 and 2.6 percentage points lower than the target. A detailed breakdown of the ward demographic data can be found in Table 2 below and a ward map can be found in Appendix 6.

Efforts were made to try and get additional participants from the wards with fewer responses, with at least two sessions in each ward:

- Farlington Sainsbury and Drayton Co-op, although the footfall at Drayton Co-op was very low.
- Eastney Road Co-op in Milton, Bransbury Park, Bedow Library & Milton Parks.
- Paulsgrove Community 'Sofa,' outside Paulsgrove Community Centre and the Food and Bathroom banks and surveys were completed ad hoc by the Cost of Living Support Officer.
- Cosham High Street on market days.

Table 2: Residents by ward, 2026

Ward	Survey		Target (SAF from Census 2021)	Difference (pp)
Baffins	68	6.3%	7.2%	-0.8
Central Southsea	68	6.3%	7.6%	-1.3
Charles Dickens	235	21.9%	10.0%	11.9
Copnor	47	4.4%	5.9%	-1.5
Cosham	48	4.5%	6.9%	-2.4
Drayton and Farlington	42	3.9%	6.4%	-2.5
Eastney and Craneswater	79	7.4%	6.6%	0.8
Fratton	92	8.6%	7.4%	1.2
Hilsea	62	5.8%	6.4%	-0.6
Milton	56	5.2%	7.6%	-2.3
Nelson	78	7.3%	7.2%	0.1
Paulsgrove	45	4.2%	6.3%	-2.1
St. Jude	52	4.9%	6.7%	-1.9
St. Thomas	90	8.4%	7.7%	0.7
Homeless	4	0.4%		
Portsmouth misc.	5	0.5%		
Total	1071	100%		

Residents from Charles Dickens were over-represented in the survey, but this was expected as there were a number of sessions in Commercial Road which is in the Charles Dickens ward. This was because it was a good place to speak to residents from all parts of the city and has the highest footfall of any area in the city. As Charles Dickens consistently has higher levels of crime and ASB than other wards, it is considered advantageous to have a larger sample for this ward.

The ward profile differed between the two surveys. In particular far fewer people from Charles Dickens took part in the online survey (5.7%).

While some wards that were under-represented in the face-to-face survey, such as Cosham, Milton, and Drayton and Farlington, were closer to the target online, other areas including Charles Dickens, Nelson and Paulsgrove were under-represented instead.

3. Survey findings

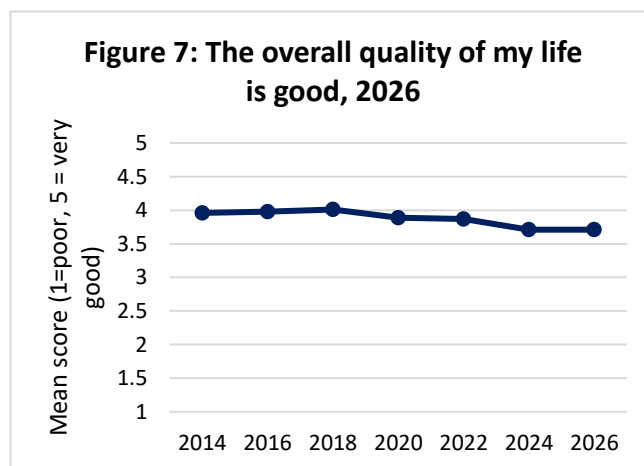
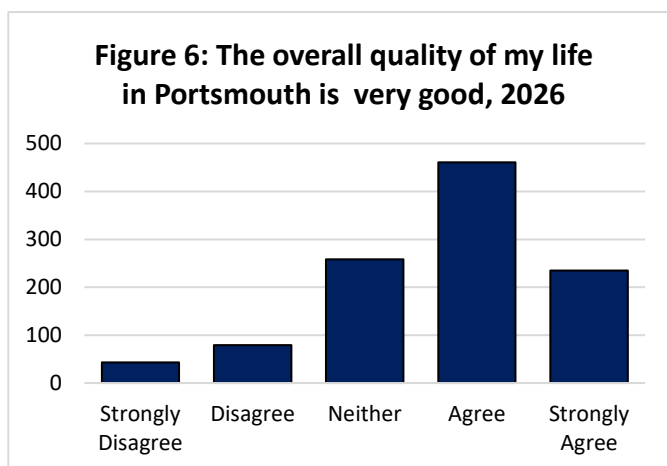
This chapter sets out the key findings from the survey and where possible compares with previous Community Safety Surveys.

Further details about the statistical tests used and the results discussed in this section can be found in Appendix 3 and detailed comparison with the online sample can be found in Appendix 4.

3.1 Quality of life

Quality of life is a subjective concept and may be influenced by many factors, including health, employment and/or financial status, relationships, housing, and social networks. This question was included to help us understand crime and ASB as part of our residents' broader lived experience. It allows exploration of the links between crime/ASB and wellbeing.

Respondents were asked to indicate their level of agreement with the statement "The overall quality of my life in Portsmouth is very good" on a scale where 1 indicated a poor quality of life and 5 indicated a very good quality of life. **More than half of participants (65%, n= 696) felt their overall quality of life was good**, with 11% (n= 122) of participants indicating that they disagreed with the statement to some extent (Figure 6).



The average reported quality of life score for all respondents was 3.71. This was unchanged from the 2024 survey but was lower than scores recorded in earlier years (Figure 7).⁵ This suggests that **residents reported slightly lower satisfaction with their quality of life in 2024 and 2026 compared with previous survey periods**. While it is not possible to determine the precise cause of this change, it is possible that

⁵ Statistically significant means that tests have been carried out and the result was not likely to have occurred by chance.

the ongoing cost of living crisis and rising household expenses may be adversely affecting residents perceived quality of life.

It is important to note that although some factors were found to be associated with quality of life, this does not mean that they are the reason for lower or higher reported quality of life, which is likely to be the result of numerous factors, many of which have not been captured by this survey.

Quality of life was found to be associated with both fear of crime and experiences of crime or anti-social behaviour (ASB).

Participants had a lower reported average quality of life score if they:

- Had experienced or witnessed crime or ASB,
- Worried about becoming a victim of crime,
- Perceived knife crime to be a problem, and
- Felt unsafe or avoided areas in Portsmouth.

Some demographic groups also had a lower reported average quality of life score:

- British white participants (M=3.67) had a lower average score than ethnic minority participants (M=3.86)
- Participants with physical disabilities (M=3.5) and poor mental health (M=3.09).
- People who reported that they were not working due to being permanently sick or disabled (M=3.05).

Table 3: Mean quality of life scores by ward in 2026

Ward	Quality of life (mean score) 2026
St Jude	4.18
Milton	3.98
Drayton & Farlington	3.95
Eastney & Craneswater	3.88
Baffins	3.84
Copnor	3.79
Hilsea	3.77
Paulsgrove	3.73
Central Southsea	3.68
St Thomas	3.61
Charles Dickens	3.61
Nelson	3.59
Cosham	3.54
Fratton	3.46
All Portsmouth	3.71

The ward where people lived also affected their mean quality of life, with residents living in St Jude's having the highest mean score (M=4.18), which is a significantly higher mean score than for residents

living in Fratton, (M=3.46). Table 3 presents the average scores for all the wards, with those in green having a significantly better and those in red having a significantly worse reported quality of life. See Appendix 6 for a map showing Portsmouth wards.

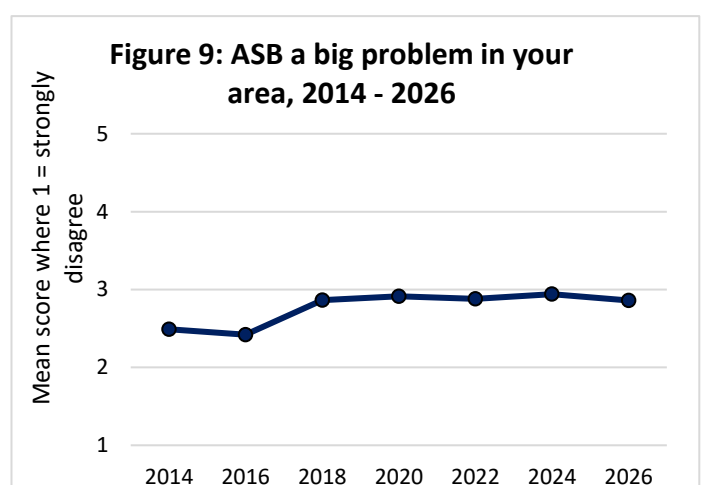
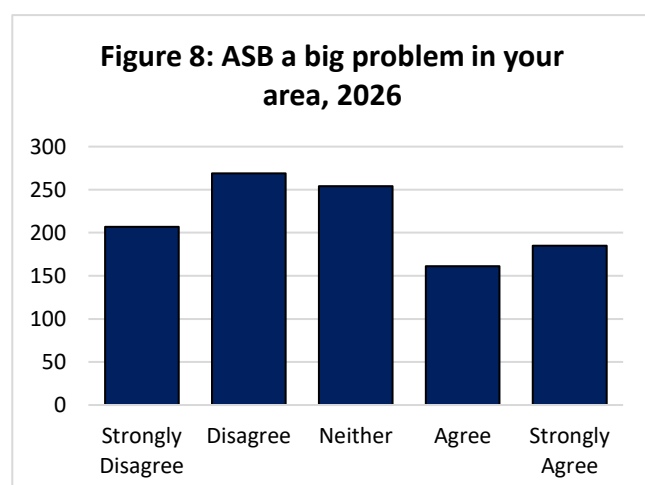
Online participants reported lower mean quality of life than the F2F participants (M=3.55 and 3.71 respectively).

3.2 Perception of anti-social behaviour

Anti-social behaviour (ASB) is highly subjective; a behaviour which causes distress to one person may be barely noticed by another. It refers to a wide range of behaviours from environmental issues like littering, fly tipping and dog mess through to personal nuisance such as neighbour disputes and noise. While criminal behaviour is distinct from ASB in law, the subjective nature of ASB means that some crimes may nevertheless be perceived as ASB by those who witness them, or by individuals who experience them but regard the impact as minor.

Respondents were asked to indicate on a scale their level of agreement with the statement "ASB is a big problem in the area where I live," where 1 indicated that they did not think it was a problem and 5 indicated that they thought it was a very big problem. This question is exploring residents' perception of ASB and responses may be influenced by what they have heard from friends, family and in the media, rather than just personal experience. It may also be influenced by the impact the witnessed or experienced ASB has on them.

32% of participants (n=346) agreed with the statement to some degree, indicating that they thought ASB was a big problem in their area (Figure 8), which is 6 percentage points fewer than in the 2024 survey. Conversely, 44% (n=476) did not think ASB was a problem in their area.



The average score for all respondents was 2.86 and this has **been fairly stable from since 2018** (Figure 9).

Perceptions of ASB being a big problem were associated with both fear and experience of ASB and crime. Respondents were more likely to perceived ASB as a big problem if:

- They had experienced or witnessed ASB or crime,
- Worried about becoming a victim,
- Perceived knife crime to be a problem, and
- Felt unsafe or avoided areas in Portsmouth.

Some demographic groups also were also more likely to perceived ASB as a big problem:

- White British participants (M=2.97).
- Participants with learning disabilities (M=3.42) and poor mental health (M=3.38)
- Participants living in Charles Dickens (M=3.22, Table 4).

Table 4: Perception of ASB as a big problem by ward of residence, 2026

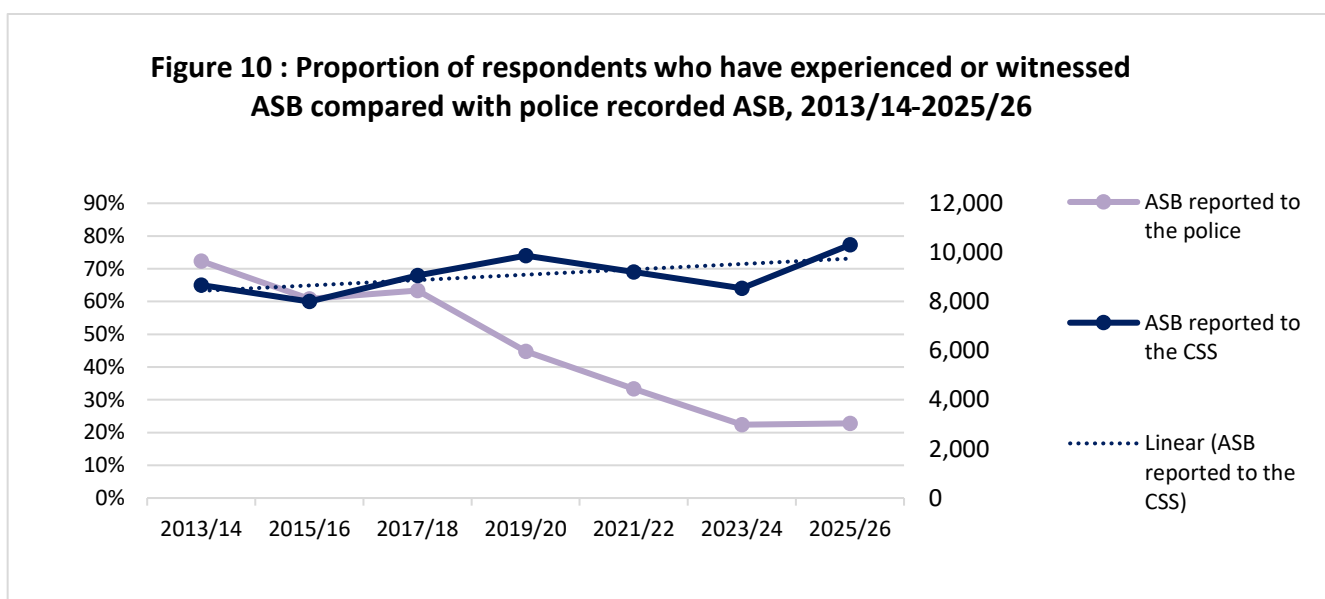
Ward	ASB is a big problem (Mean score) 2026
Drayton & Farlington	1.98
Copnor	2.28
Milton	2.39
Eastney & Craneswater	2.65
Cosham	2.67
Central Southsea	2.72
Paulsgrove	2.78
Nelson	2.82
Baffins	2.88
St Jude	2.90
Hilsea	3.00
Fratton	3.00
St Thomas	3.09
Charles Dickens	3.22
All Portsmouth	2.86

Online participants were more likely to think ASB was a problem in their area than F2F participants (M=3.23 and M=2.86 respectively).

3.3 Personal experience of anti-social behaviour

This survey measures the proportion of residents personally witnessing or experiencing ASB. It does not rely on them reporting to agencies and therefore is not affected by changes in reporting or recording systems. Since 2014, fieldworkers have not shown a list of options to participants, so that they only report the main issues that they feel are affecting them, rather than any issues that they have noticed in their area.

77.3% (n=829) participants reported witnessing or experiencing ASB in the previous 12 months (from March/April 2025 to February/March 2026). **This is a 13 percentage point increase compared with the 2024 survey.** While this is similar to the proportion reporting ASB in 2019/20, it is the highest level since we began collecting data using this method in 2014 (Figure 10).



An association was identified between witnessing or experiencing ASB and ethnicity. **British White respondents were more likely to report witnessing or experiencing ASB compared with respondents from other ethnic groups (80% compared with 67%).**

When interpreting these findings, it is important to note that ASB is reliant on the individual's perception rather than the behaviours themselves.

Online participants were significantly less likely to report experiencing ASB than F2F (58% compared with 77%).

However, when they did experience ASB they experienced over three times as many different types (F2F reported on average 2.5 ASB types, online respondents reported 9).

3.3.1 Types of ASB experienced or witnessed.

The most common issues that respondents had experienced or witnessed in their area in the last twelve months were:

- People using/supplying drugs (20%, n=216)
- Traffic issues (18%, n=193)
- Noise in the street (14%, n=150)
- Street drinking (13%, n=143)
- People hanging around (12%, n=131)

Where participants mentioned other ASB types that were not listed, the most common issues mentioned were witnessing violence or fighting (4.7%, n=39) and witnessing shoplifting (3.4%, n=29).

*While the top two issues reported by participants F2F also appeared in the top issues for the online samples, the **online sample focussed more on environmental issues**:*

- Traffic issues (48%, n=169)
- Dog mess (38%, n=134)
- Litter & rubbish (33%, n=116)
- Fly tipping (27%, n=96)
- People using/supplying drugs (26%, n=93)

The most common other types of ASB were witnessing shoplifting (2.3%, n=8) and people cycling on pavements (2.3%, n=8).

This year people gave more detailed information about the ASB they are experiencing and this information was passed to the Portsmouth City Council Clean, Safe and Tidy Team.

Examples of comments from participants include:

"I quite frequently see drug dealing in our neighbourhood, summer nights can be noisy out on the streets in the small hours of the morning. I see dog mess etc. in too many places to mention."

"Bikes, e-bikes and e-scooters on the pavement, whizzing past you so quickly, it frightens the hell out of me, nobody rings a bell anymore to let you know they are there. If you say anything, you just get verbal abuse."

Online participants often listed a number of connected issues:

"There is constant anti-social behaviour around Guildhall Square, anti-social behaviour in public toilets and on the benches around there, always people drunk, shouting, drug taking, selling drugs. A guy is continually shouting at people as they walk by, playing loud music, people urinating in public."

"Battenburg Avenue is used as a rat run. There is inconsiderate parking due to the overflow from Stamshaw permits and the multitude of HMOs in the area. There is drug smoking and dealing in College Park and Gatcombe Gardens. The flats/unlicensed HMOs on the corner of Battenburg Avenue and London Road are a fly tip magnet."

3.3.2 Comparison with the Crime Survey for England and Wales

The findings of this survey cannot be directly compared with the Crime Survey for England and Wales as the methodologies and ASB categories are different. However, the most recent CSEW for the period ending March 2025⁶ found that the most common ASB types causing a fairly or very big problem nationally were groups hanging around on the streets, vehicle related behaviour, people using/dealing drugs, inconsiderate behaviour and drink related behaviour.

The comparison of the two surveys demonstrates that the **ASB types experienced in Portsmouth are broadly similar to the national picture.**

3.3.3 ASB trends

In the early surveys (from 2001 to 2008) the two consistently experienced and witnessed types of ASB experienced were 'speeding cars' and 'litter.' By 2009, the most common ASBs had shifted to 'teenagers hanging around', 'people being drunk' and 'vandalism'. Since 2022, 'traffic issues', 'people using/supplying drugs' and 'people hanging around' have become the most prominent issues for residents.

Table 5 below shows the proportion of respondents reporting each type of behaviour for each survey since 2014 and the change from 2024 to 2026.

⁶ [Crime in England and Wales - Office for National Statistics](#)

People using/supplying drugs has remained the most reported issue to the survey since 2020 and approximately a fifth of participants reported this as an issue in 2026.

The **largest increase was for traffic issues**, rising by 6 percentage points, **remaining as the second most reported issue**. This was driven by 9.4% of respondents reporting issues with e-scooters.

Table 5: Trends in the most common types of ASB from 2014

ASB Type	2014	2016	2018	2020	2022	2024	2026	Change from 2024 (pp.)	DOT ⁷ since 2024
People using/supplying drugs	5.7%	5.8%	12.9%	21.3%	17.7%	15.4%	20.1%	4.7	↑
Traffic issues	6.7%	9.4%	7.3%	6.0%	10.4%	12.0%	18.0%	6.0	↑
Noise in the street	13.4%	13.7%	11.5%	13.4%	15.1%	8.9%	14.0%	5.1	↑
Street drinking	11.5%	11.4%	12.4%	12.2%	12.8%	9.2%	13.3%	4.1	↑
People hanging around	11.4%	9.4%	16.4%	17.1%	18.7%	10.9%	12.2%	1.3	↑
Intimidating behaviour	6.2%	6.2%	11.6%	11.0%	12.2%	8.4%	11.9%	3.5	↑
Domestic noise	14.4%	10.5%	8.9%	12.8%	9.8%	8.1%	11.1%	3.0	↑
Vandalism/graffiti	9.4%	9.4%	10.0%	14.1%	14.1%	7.4%	11.1%	3.6	↑
Dog mess	n/a	9.6%	5.7%	6.4%	5.7%	5.7%	9.9%	4.2	↑
Litter and rubbish	13.7%	11.7%	9.8%	10.4%	10.3%	5.3%	9.7%	4.4	↑

Since 2024, there have been increases in most types of ASB reported to the survey and for the ten most reported issues in table 5. However, with the exception of people using/supplying drugs and traffic issues, the proportion reported to the survey for other ASB types in 2026 is similar to 2022 and/or previous years.

3.3.4 What ASB is reported and to whom?

Participants were asked whether they reported the ASB that they had experienced and if they did, who they reported it to. This question was asked to explore the disparity between previous surveys/anecdotal evidence and the amount of ASB reported to the police. It was hoped that the survey could shed some light on the issue of whether there had been a genuine reduction in ASB or whether people were just less likely to report it.

Participants told us about 2,086 incidents of ASB types⁸ that they had experienced during the previous 12 months, of which **23% (n=483) were reported to agencies**.⁹ This is a smaller proportion than in 2024 when 35% was reported to agencies but similar to 2022 when 25% was reported.

⁷ Direction of travel

⁸ This varies from the 2,109 incidents reported as some of the responses to this question were incomplete and were not included.

⁹ Some participants reported experiencing a number of different ASB types in the previous 12 months. It is important to note that some of these reports may be for ongoing issues and not individual occurrences.

The types of ASB that were **most reported to agencies** were similar to those most reported in 2024:¹⁰

- **Fly tipping (50%, n=37)**
- **Neighbour disputes (50%, n=22)**
- Vandalism/graffiti (39%, n=45)
- Domestic noise (35%, n=41)
- People supplying drugs (33%, n=36)

The ASB types that were less likely to be reported were 'rough sleeping' (5%, n<5), 'noise from licensed premises' (5.2%, n<5), 'begging' (6.9%, n<5), 'noise in the street' (11%, n=16) and 'street drinking' (11%, n=16).

Where people gave details about **who they reported to (n=498)** the most common agencies were: **Portsmouth City Council (42%, n=211)**, the police (38%, n=190), their landlord (5%, n=26) or a local councillor (4.2%, n=21). Unfortunately, responses mostly did not specify which teams within PCC, but where this information was given respondents most commonly reported to PCC housing teams (n=44) or community wardens (n=10).

Online participants reported a similar proportion of the ASB they experienced (22%).

Both online and F2F participants were more likely to report fly tipping and people dealing drugs than most other types of ASB. However Online participants also were more likely to report noise from licensed premises, bullying/intimidating behaviours and commercial noise.

Online participants also were more likely to report ASB to Portsmouth City Council (53%, n=182), the police (28%, n=96) or their local councillor (9.2%, n=31) than other agencies.

The 2026 survey did not explore why people did not report ASB, but in 2024, the most common reason people did not report was due to a feeling that the ASB was normal or general apathy (29%, n=220), with participants saying things like,

"It happens so often."

"Not much people can do about it."

"There's no point."

"I don't care enough about it to report it."

Other common reason were: that they felt that agencies would not do anything about it anyway (lack of action - 21%, n=154), that they did not feel they needed to (7%, n=53), the issue had already been reported by someone else (6.6%, n=50) or they did not know who to report to (6.1%, n=48).

¹⁰ Where more than 10 respondents reported this ASB type to the survey

Where 2026 participants left general comments for this question, they were consistent with the responses from 2024, **conveying a sense of apathy about reporting ASB and a feeling that nothing would be done, even if they did report it.**

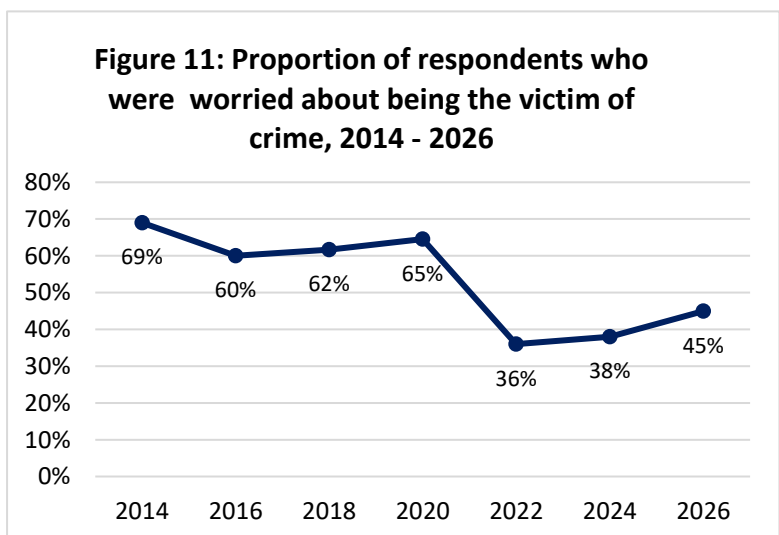
3.3.5 ASB: What do the findings mean?

- ASB is widely experienced by residents on a regular basis, but this is not always perceived as a big problem.
- The amount of ASB that residents are experiencing has increased, with particularly notable rises in drug-related ASB and traffic issues.
- Low reporting rates of ASB limits the ability of services to respond effectively may undermine residents' confidence in community safety partners.

3.4 Fear of crime

Fear of being a victim of crime has increased from last year (from 38% to 45%) but has remained lower than it was prior to the Covid pandemic (Figure 11).¹¹

The reduction observed in 2022 was thought to be associated with changes in behaviour during the COVID-19 pandemic, particularly increased home working and the amount of time people spent at home. During lockdown periods, there was also some evidence of strengthened community cohesion, with some residents improving relationships with their neighbours. This enhanced sense of community may have contributed to lower levels of fear of crime at that time.



However, since 2022, fear of crime has increased, suggesting that these pandemic-related effects may be gradually diminishing. While some longer-term impacts of the pandemic may persist (such as continued

¹¹ The increase from 2024 was statistically significant, and the proportion fearing being a victim of a crime is statistically significantly lower than 2014 to 2020.

home working for some residents and enduring neighbourhood connections), their influence on feelings of safety appears to be reducing over time.

3.4.1 Who is most likely to fear being a victim of crime?

Some demographic groups also had a higher reported levels of fear of being a victim of crime:

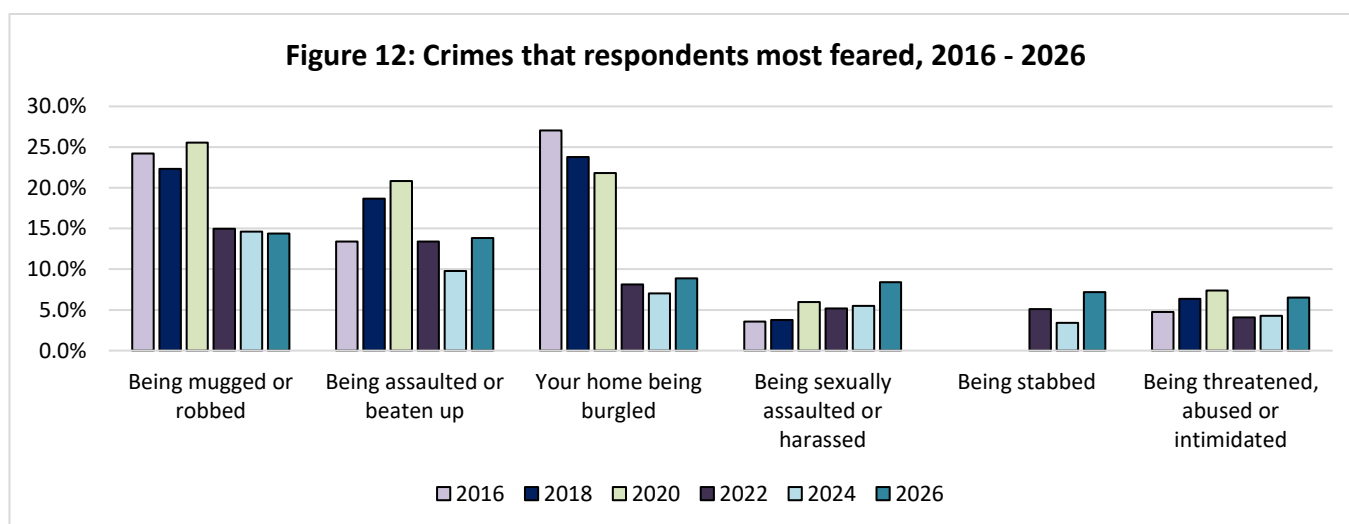
- **Women** (53% compared with 37% for men).
- **Those working part time** (60%) and **those whose main role was looking after the home and family** (67%). In contrast, **respondents who were retired were less likely to report fear of being the victim of crime** (40%).
- **Individuals with a disability or long term condition** (56% compared with 39%).

The crimes that participants were most worried about happening to them were:

- **Being mugged or robbed** (14.4%, n=154)
- **Being assaulted** (13.8%, n=148)
- **Being burgled** (8.9%, n=95)
- **Being sexually assaulted/harassed** (8.4%, n=90)

3.4.2 What crimes are residents most concerned about?

Since the 2014 survey, participants have been consistently more worried about 'being mugged or robbed', or 'being assaulted or beaten up' than any other type of crime, while concern about being burgled reduced substantially in 2022 and has remained lower (Figure 12). The option of 'being stabbed' was included for the first time in 2022 to reflect concern around knife crime and was higher for the 2026 survey than previous years. **Concern about being the victim of a stabbing or sexual harassment/abuse has increased slightly since last year.**



Analysis of survey data from 2022 to 2026 shows an **association between fear of crime and people's experiences and behaviours**. Fear of crime was consistently higher among people who had:

- Experienced ASB,
- Been a victim of crime,
- Experienced online crime,
- Felt unsafe or avoided certain areas.

Some participants commented on why they were worried about being the victim of crime. The most common theme was from people who worried about being targeted because of their race or religion. For example, one participant commented:

"Due to the discourse around illegal immigrants, even though I can legally work full time and don't claim benefits, I feel people will put me in the same category due to my race and may target me due to this."

Other themes from the comments included people feeling a general wariness, an increased fear when it is dark or at night, being worried about their safety as a woman and being worried for their own children or young people, particularly them being the victim or caught up in something. Comments from participants included:

"I worry about my 14 year old son being the victim of mistaken identity and being caught up in gang violence"

"I carry a rape alarm at all times"

"When you are a woman, you're vulnerable"

Slightly more online participants worried about being the victim of a crime (50%) compared with F2F participants (45%) but this difference was not statistically significant.

Where participants reported being concerned about being the victim of a crime, online respondents reported being fearful of more crimes (on average 7 crimes per person) than those responding F2F (2 on average).

The crimes people were most worried about were similar for both samples: being mugged/robbed, being burgled and being assaulted.

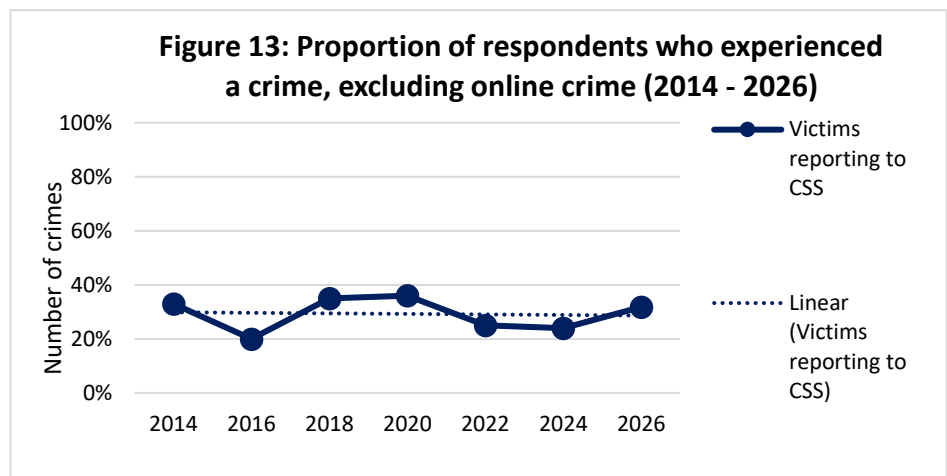
3.5 Crimes reported to the survey

32% of participants reported that they had been a victim of at least one crime in the previous twelve months (from March/April 2025 to February/March 2026). ¹²

This is higher than in 2022 and 2024 (both 24%), similar to levels seen in 2014 and 2018 (33–35%), and lower than in 2020 (36%).

Figure 13 shows that the proportion of participants reporting at least one crime to the Community Safety Survey has fluctuated over time, ranging between 20% and 36%, but the overall trend is fairly stable overall.

This increase was mainly due to more people reporting that they had been **threatened, intimidated or verbally abused**, as well as an increase in **hate crime**. Since 2024, reports of both have **more than doubled**, rising by 7 percentage points and 2.7 percentage points respectively.



Online participants were significantly less likely to report being the victim of a crime (21% online compared with 32% F2F).

While fewer people in the online sample told us that they were victims of crime online than the F2F sample, those who did reported a similar average number of crime types (on average 1.5 crimes).

3.5.1 What crimes are residents experiencing?

Overall, 340 participants reported being a victim of crime. While each person could only report each type of crime once, participants could report multiple different types, resulting in 528 crime types being reported in total.

The **most common crime reported to the survey in 2026 was threats/intimidation**, with 12.7% (n=136) of participants reporting this type of crime, substantially more than any other crime type. Threats/

¹² It is important to note that while the sample for this survey is broadly similar to Portsmouth's population, there are some sections of the community who may not be represented and who may experience different levels of crime (for example businesses, those in residential homes/hospitals or prison).

intimidation has been the most commonly reported crime since the 2018 survey but has more than doubled since 2024. The other crimes commonly reported to the survey were:

- **Hate crime (5.5%, n=59** - where this was mentioned it was largely in relation to race hate), and
- Being assaulted (3.4%, n=36).
- Being harassed/stalked (3.4%, n=36)
- Being sexually assaulted or harassed (3%, n=32).

*The **most common crime type experienced by online participants was also being threatened / intimidated / abused, although a smaller proportion of online participants reported being the victim of crime (5.6% compared to 12.7% for F2F participants).***

*However, the **pattern of other common crimes varied substantially;** with the other commonly experienced crimes for online participants being damage to car/motorbike, damage to home and garden and having things stolen from homes and gardens.*

Due to this survey being conducted in a public place by students, it is expected that many people who have experienced sexual offences or domestic abuse would not feel comfortable disclosing them and this is likely to be an under-estimate both for this survey and in previous ones.

Themes that were common in the comments about people's experience of crime included being abused when challenging anti-social behaviour, having parcels or items stolen from the front of their house (ranging from parcels to plant pots or items from their vehicle), witnessing shoplifting and being intimidated or threatened. Feedback from participants included:

"I was verbally abused and threatened by a cyclist that I challenged who'd been riding fast on the pavement and knocked someone over"

"Things have been stolen from my front garden and my plants have been chopped down"

"I have witnessed lots of shoplifting from local shops"

3.5.2 Trends in crime reported to the survey

Table 6 (overleaf) shows how crimes reported to the survey have changed over time. **Since 2014, most traditional property crime categories have remained broadly the same or reduced. Conversely experiences of interpersonal/targeted offences have either increased or stayed the same.**¹³

¹³ Broadly the same is an increase or reduction of less than 1%.

Table 6: Crimes that people experienced in the previous 12 months and reported to the 2026 survey

RANK	Crime type	2014	2016	2018	2020	2022	2024	2026	change from 2024 (pp.)	overall trend since 2024	overall trend since 2014
1	Being threatened/intimidated/abused	6.9%	2.5%	8.2%	12.1%	7.2%	5.7%	12.7%	7.0%	↑	↑
2	Hate crime (targeted behaviour because of race, religion, disability or sexuality)	0.0%	2.5%	2.3%	4.1%	2.1%	2.8%	5.5%	2.7%	↑	↑
3	Being assaulted or beaten up	2.5%	3.5%	3.1%	3.8%	2.5%	2.5%	3.4%	0.9%	↔	↔
4	Being harassed / stalked (e.g. being purposely targeted)	1.1%	0.2%	1.9%	4.7%	2.4%	1.6%	3.4%	1.7%	↑	↑
5	Being sexually assaulted or harassed	0.6%	0.1%	2.0%	2.6%	1.1%	2.8%	3.0%	0.2%	↔	↑
6	Damage to your car or motorbike	5.7%	3.7%	5.5%	5.8%	2.0%	2.1%	2.8%	0.7%	↔	↓
7	Having a bicycle stolen	5.3%	2.5%	4.9%	4.8%	2.2%	1.3%	2.7%	1.4%	↑	↓
8	Having a car broken into	1.6%	2.4%	3.6%	3.1%	1.3%	2.4%	2.0%	-0.3%	↔	↔
9	Criminal damage to your home / garden	3.3%	1.9%	3.5%	3.2%	1.8%	1.4%	2.0%	0.5%	↔	↓
10	Having things stolen from your garage, shed or garden	2.0%	0.7%	3.3%	2.9%	3.2%	0.9%	1.7%	0.7%	↔	↔
11	Domestic Abuse						0.5%	1.4%	0.9%	↔	
12	Identity theft	0.1%	0.5%	1.5%	1.3%	0.2%	0.3%	1.2%	0.9%	↔	↑
13	Being mugged or robbed	1.0%	1.5%	2.6%	1.0%	1.5%	1.1%	1.1%	0.0%	↔	↔
14	Other fraud	0.7%	0.2%	1.1%	1.6%	0.6%	0.7%	1.1%	0.5%	↔	↔
15	Your home being burgled	2.0%	1.8%	2.1%	1.8%	1.8%	0.9%	0.9%	0.0%	↔	↓

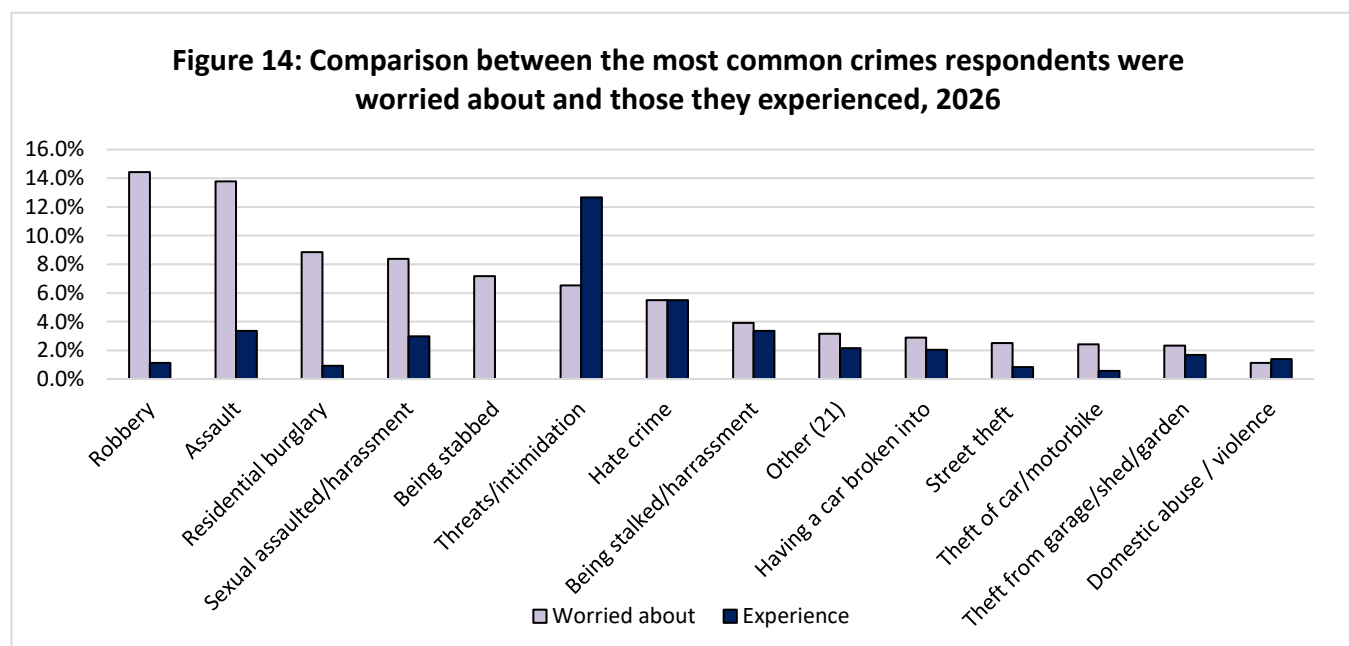
3.5.3 What groups of participants were more likely to experience crimes

Some demographic groups had an increased or reduced likelihood of being a victim of crime (excluding online crime):

- **Older adults were less likely to be victims of crime** (65–74 years - 25% and 75 years plus - 17%).
- **Adults aged 25–34 years were more likely to report being a victim of crime** (44%).
- People who were retired were less likely to report being a victim of crime (21%).
- **Those who were sick or disabled (47%) or unemployed (46%) were more likely to report victimisation.**
- **Participants with a disability or long term condition were more likely to report being a victim of crime** (37%).
- **Participants from ethnic minority backgrounds were more likely to report being victims** (38%).

3.5.4 Perception versus experience of crime

Overall fear about being the victim of crime has been similar to the proportion who have been a victim of crime (45% worried, 44% experiencing at least one crime including online crime) from 2022 to 2026.

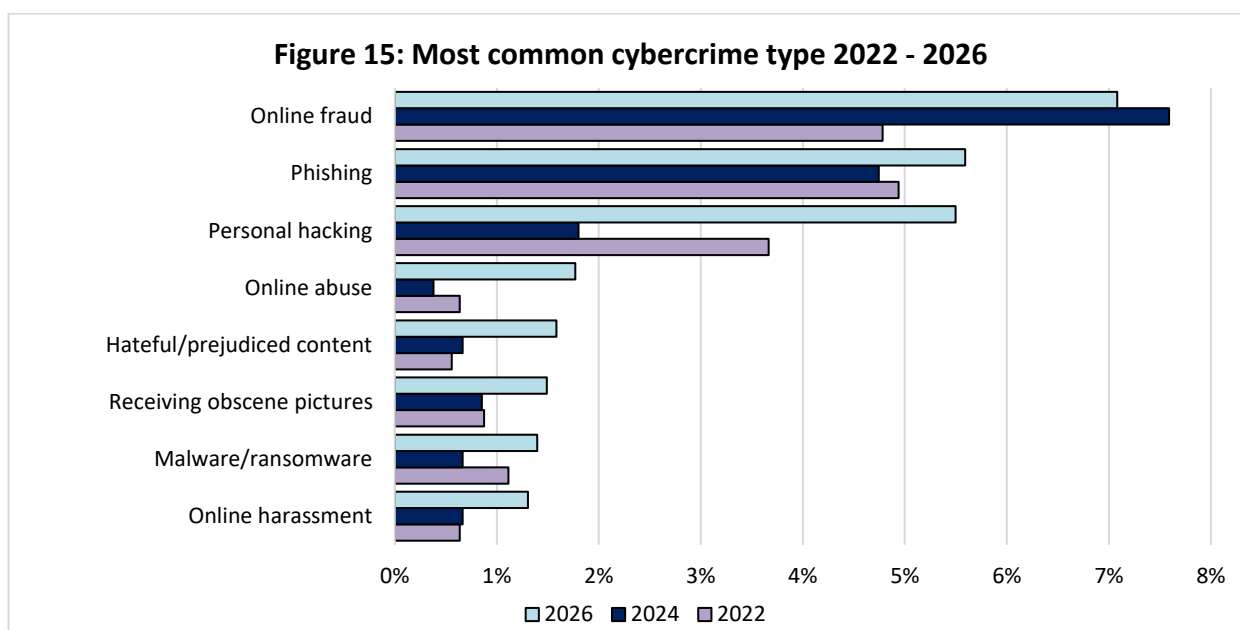


As in previous years, **fear of crime was much higher than the number of people who actually experienced the crimes that were most feared**, such as being mugged or robbed, burgled, or assaulted. For example, **14% of participants said they were worried about being mugged or robbed, but 1.1% had experienced robbery in the previous 12 months** (Figure 14). This gap is likely to reflect the **serious physical or emotional impact** these crimes can have, as well as the **level of media attention** they receive.

In contrast, for some crimes that are generally less feared, particularly threats or intimidation, levels of concern were lower than or similar to the proportion of people who had actually experienced them. This may be because these offences do not usually involve physical harm, and some people may feel they have had less impact on them or that there was not enough evidence to report to police.

3.5.5 What cybercrimes are residents experiencing?

In 2026, 22% of participants reported being a victim of at least one cybercrime in the previous 12 months (March/April 2025 to February/March 2026). This represents an increase compared with 2022 and 2024, when 16% of participants reported experiencing cybercrime.



The **most common types of cybercrime reported were: online fraud** (7.1%, n=76), **phishing** - not just received emails, but had money or data stolen (5.6%, n=60) and **personal hacking** (5.5%, n=59).

*There was a slightly lower proportion of reported cybercrime from the online sample (18%) and **both samples had very similar average numbers of crime types experienced** (online - 1.3 crime types and F2F - 1.5).*

The most common types of cybercrimes for both samples were online fraud, phishing and personal hacking.

Online participants provided more comments; the most common about scams and attempts at fraud and experiences of online fraud.

Most types of cybercrime saw slight increases and personal hacking increased by 3.7 percentage points.

Certain groups were more likely to report being a victim of cybercrime:

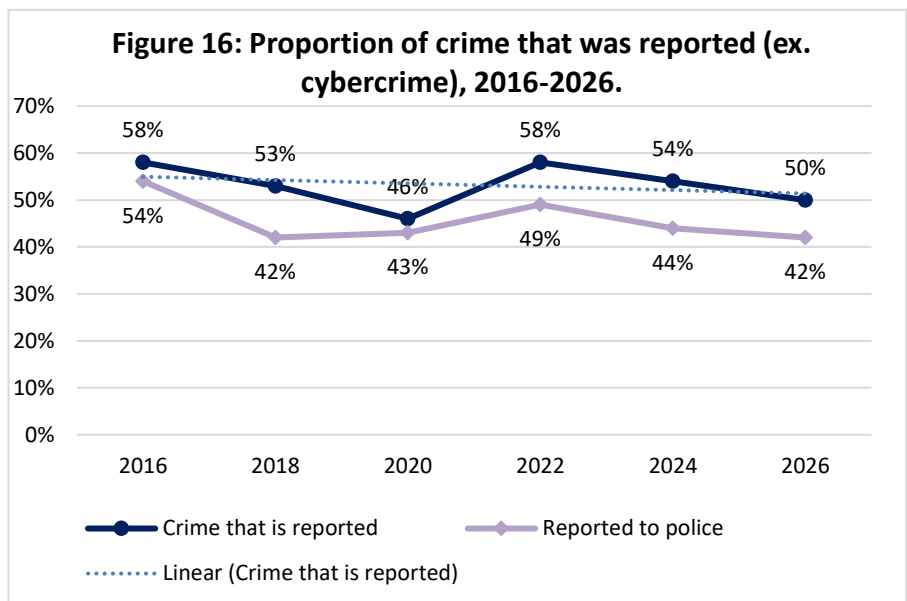
- **People with a disability** (26%).
- **Younger adults aged 25–34 years** (36%).
- **Unemployed participants** (41%).

3.5.6 What crimes do people report and to whom?

Respondents told us that they reported 50% (n=257) of the crime types they told us about to agencies during 2025/26.¹⁴

There has been a fluctuating trend in reporting since 2015/16, ranging from between 46% and 58% (Figure 16).

When cybercrime types were included the reporting rate increased to 55% (456 out of 825).



Where crimes were reported, they were largely reported to the police (75% of reported crime / 42% of all crime, n=215), followed by their bank or credit card company (6%, n=17), Portsmouth City Council (6%, n=16) and their employer/manager/colleagues (4.6%, n=13).

When cybercrimes are included, the proportion of crime reported to the police reduced to 32% (n=267) overall, with only **26% (n=52) of cybercrime being reported to the police. Most commonly cybercrime was reported to the participants' bank or credit card company (39%, n=78).** Participants also reported to the social media platform (16%, n=32), the relevant website (5.5%, n=11) or their email provider (4.5%, n=9).

Only 1% (n<5) participants said they reported the crime to Action Fraud, which is where most of the national data for cybercrime comes from. It is not known whether banks, companies or websites routinely pass this information on to Action Fraud.

¹⁴ This includes reporting to the police but also other agencies like the City Council, Bank, employer, housing association, insurance company, fraud agency, credit card company, landlord, phone/internet supplier, mediation services, GP, university, school and Citizens Advice / Advice Portsmouth.

The crimes **most likely to be reported** were:

- **Identity fraud** (92% of people who experienced the crime, n=12)
- **Online fraud** (84%, n=65)¹⁵
- **Hateful, prejudiced content online** (82%, n=14)
- Burglary (80%, n=12)
- Domestic abuse (80%, n=8)
- Other Fraud (75%, n=9)
- Criminal damage (70%, n=14)

The crimes that were least likely to be reported were generally those that were also reported by only small numbers of participants overall. Among these, the crimes reported to the survey by **at least 10 participants** included:

- **Hate crime** (27%, n=16)
- **Online sexual threats** (30%, n=5)
- Receiving unsolicited obscene pictures (31%, n=5)
- Malware/ransomware (40%, n=6)
- Threats or intimidation (41%, n=55)

This supports the fact that theft-type offences are often well reported as there is often some kind of physical evidence to support the report, while evidence that often rest on the victims' word, such as hate crime or harassment tend to be less well reported. It is interesting that domestic abuse featured in the well reported group in 2024, but it could be that those who reported domestic abuse were more willing to disclose it to the fieldworkers, and there were very small numbers so caution should be taken when interpreting the findings.

If residents had not reported the crime they had experienced to any agency, there were asked about the reasons for their decisions.¹⁶

The most common reasons people did not report were:

- **The perception that nothing would be done or they wouldn't be taken seriously** (28%, n=74),
- **Felt that they didn't need to or did not think it was worth it as they crime seems minor** (22%, n=57)
- They dealt with it themselves (6.5%, n=17), and
- A fear of repercussions or shame (6.2%, n=16).

¹⁵ Online fraud was both a commonly experienced and commonly reported crime: 80 experienced online fraud and 83% (n66 reported it).

¹⁶ 260 respondents gave reasons for not reporting.

Examples of comments from participants include:

"Men. When you say no they get angry, it is so common and not going to be taken seriously. What's going to happen anyway"

"I chose to ignore the comments. It was minor, but felt uncomfortable. I felt vulnerable and carried on walking away."

"I did not have evidence, it is an everyday occurrence, not taken seriously"

"Ultimately nothing would get done about it, would just be logged"

Fewer online participants reported the crimes that they had experienced (36% compared with 50% F2F). Almost half of those who did not report gave the reason that they did not think anything would be done if they did (47%, n=60).

If they did report crimes, similarly to F2F participants, they largely reported to the police or bank/credit card company. Cybercrime was largely reported to their bank/credit card company or to a social media platform.

3.5.7 Crime: what do the findings mean?

- The proportion of residents experiencing at least one crime has remained broadly stable over the last decade. However, there have been increases in cybercrime, as well as threats, intimidation, verbal abuse and hate crime.
- Older residents aged 65 and over were less likely to experience both crime and cybercrime, while younger adults and those with disabilities or long-term conditions were more likely to be affected.
- Around half of crimes were reported to agencies. As with ASB, low reporting levels limit the ability of services to respond effectively and may reduce residents' confidence in community safety partners.
- Fear of crime remains higher than actual experience, particularly for more serious offences such as robbery and assault.

3.6 Knife crime

Police recorded knife-enabled crime and possession of a weapon offences account for only a small percentage of crime (3.2%, n773 in 2025/26) but have the potential to cause serious harm. There volume of knife-enabled offences has been broadly stable over the last five years, but there has been a slight reduction (6%, n=53) since 2024/25.

A serious violence profile has been produced for Portsmouth and is included in the Community Safety Strategic Assessment, but this has relied mainly on crimes that were reported or detected by police, and it is known that changes to recording practices influence this data. It is not possible to know whether the increases in police recorded knife-enabled crime means that there is more knife-enabled crime or whether the police have improved the way they record it.

Questions were added to the 2020 survey to try and find out more about knife crime from the perspective of Portsmouth residents and this is the fourth time we have asked these questions to see if there has been any change.

3.6.1 Perception of knife crime

Over half of participants (56%, n597) said they thought knife crime was a problem in Portsmouth, which is an increase of 12 percentage points compared with 2024 survey (44%).

Some groups of residents were more likely to think knife crime was a problem, and these included:

- **Females** (61% compared with 50% for males).
- **Unemployed participants** (73%).
- **White British participants** (58%).

People who completed the survey online were slightly less likely than those interviewed F2F to say that knife crime is a problem. However, a higher proportion of online respondents said they were unsure, and fewer said that knife crime was not a problem.

Where respondents thought knife crime was a problem, they were asked why, and thematic analysis was used to find out the main reasons. **65% of respondents (n=388) had heard about incidents involving knives in the media or by word of mouth.** There has been a large amount of media coverage in relation to knife crime, including a stabbing during the fieldwork for the survey, so this may have affected participants views and beliefs.¹⁷

It was also common for people to give reasons based on general ideas rather than personal experience, thinking that:

- It is common for people to carry knives (but haven't seen this personally) (8.8%, n=51)

¹⁷ E.g. [Six men arrested after man suffers serious injuries in shocking stabbing incident](#)

- Knife crime is common (5.9%, n=34)
- Knife crime is linked to drugs (4.3%, n=25)
- There is a lack of punishment or consequences for carrying knives (2.8%, n=16)
- Kids carry knives to fit in or because they think it is cool (2.6%, n=15)

However, some respondents held their belief as they had personal experience of knife crime or knew someone who had with:

- 1.9% (n=11) had witnessed knife crime
- 2.8% (n=16) had come across knife crime at their place of work (where specified, at schools or in the police)
- 1.5% (n=9) knew someone who had been a victim of knife crime
- 0.3% (n<5) had previously been a victim of knife crime themselves

Comments from participants included:

"I hear regular stories in news but don't know if it has gotten worse if it is worse than other areas."

"Why? What a stupid question! I have personally lost count of the amount of stabbings that have occurred in Portsmouth in the last 12 months. Just 2 days ago, near a place of education and learning!"

"You see it on the news a lot. Machete attacks on Tangier Rd in an Indian takeaway."

"I know of knife crime due to work but not sure it is a problem. It depends on your point of view, but it could be argued that one crime is too many."

Approximately 10% (n=57) of people who thought knife crime was a problem were concerned about children and young people being impacted by knife crime, either because they are trying to fit in or influencers make it seem like everyone is doing it, knives are easy to get hold of, they have heard about knife-related incidents in schools, or because they are carrying for protection or involved with gangs.

Participants noted:

"Because they're easily obtainable and a weapon, feels kids may take them out for defence which can turn into a fatal altercation"

"My kids tell me about it and I have seen it by their school in the past"

3.6.2 Witnessing and experiencing knife crime

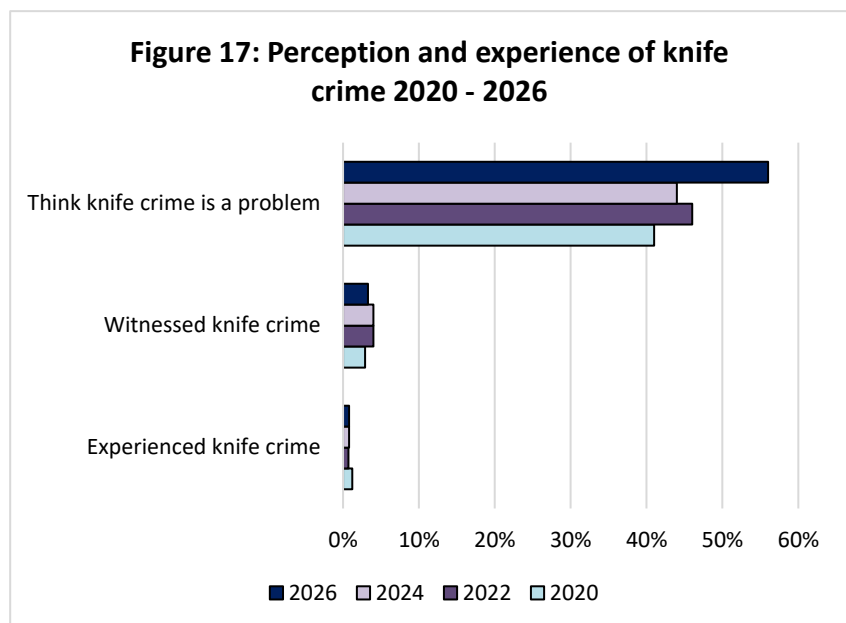
Participants were then specifically asked about whether they **had seen someone carrying a weapon or knife in the previous 12 months** (from March/April 2025 to February/March 2026), and **11% (n=122) had done**. This is consistent with previous surveys that asked about knife crime; with 11% in 2024 and 2020 and 10% in 2022.

The 122 respondents reporting seeing 144 weapons and most were knives (85%, n=123). Where extra detail was given, the knives ranged from small pocket knives to kitchen or in some cases, machetes; 30 people reported seeing kitchen knives and 10 people reported seeing zombie knives.

Most of the respondents who had seen someone carrying a knife were able to state whether a young person or adult was the one carrying a knife. In 68% (n=81) of cases, the person carrying the knife was 18 years or older, while in **31% (n=37) of cases it was someone 17 years or younger. The proportion of young people carrying knives has reduced since 2024 (52%) and is lower than previous years (2022 - 41% and 2020 - 39%).**

Most respondents had not personally experienced or witnessed knife crime during 2025/26 (96%, n=905), but 0.8% (n=8)¹⁸ had experienced a knife crime and a further 3.3% (n=31) had witnessed one.¹⁹

These are similar proportions to the previous surveys and **suggest that the levels of knife crime in the general community are likely to have remained fairly stable, despite the increase in people thinking that knife crime is a problem** (Figure 17).



A limitation of this survey is that **has not engaged with young people under 18 years** and may not have engaged with the sections of the community most likely to be involved in knife crime. **However, the findings indicate that knives are present and causing great concern in the community.**

¹⁸ Where people gave details about their experience, most reported being threatened and no-one reported being injured.

¹⁹ For those who answered (n945)

Fewer people who completed the survey online said they had seen people carrying knives, compared with those interviewed F2F.

When online respondents did report seeing people carrying knives, they were more likely to say this involved under-18s, and less likely to say it involved people aged over 25, compared with F2F.

Overall, similar proportions of people in both survey groups said they had witnessed or experienced knife crime.

3.6.3 Knife crime: what do the findings mean?

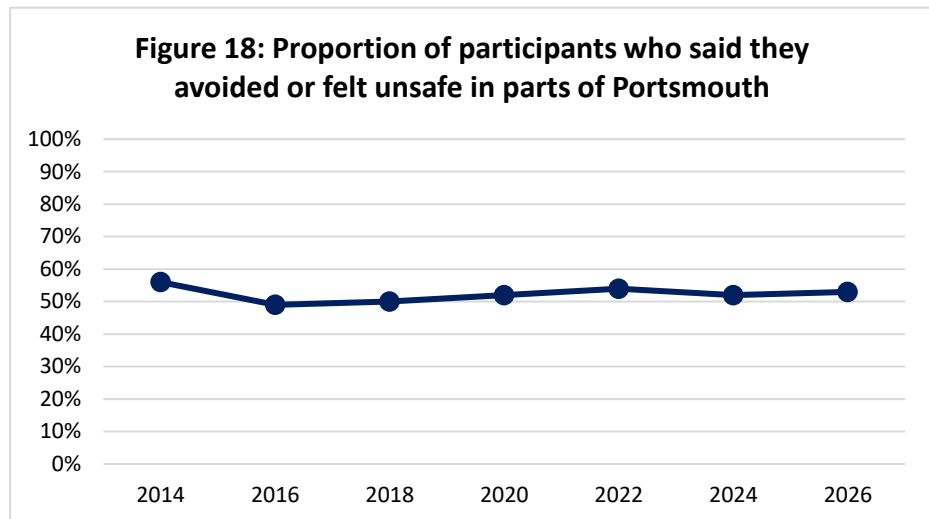
- Direct experience of knife crime remains relatively rare and has shown a stable trend over time. However, concern has increased substantially since 2024, with over half of respondents now viewing knife crime as a problem in Portsmouth.
- This increase in concern appears to be driven more by media coverage and wider awareness of local incidents than by personal experience.
- These findings reflect the views of the general adult population (aged 18 and over). Some groups may be underrepresented, and experiences may differ, particularly for young people.
- Current police and hospital data do not indicate an increase in knife-related offences or hospital admissions. This suggests that, even if knife carrying among young people is increasing, it has not yet resulted in a rise in physical harm or reported experiences of knife crime.

3.7 Areas that people avoid or feel unsafe

3.7.1 Who feels unsafe?

Just over half of participants (53%, n=569) stated that there were parts of Portsmouth that they avoided or felt unsafe.

The proportion of participants avoiding or feeling unsafe in areas has remained fairly stable since the 2016 survey.



Some groups of residents were more likely to feel unsafe or avoid areas:

- **Females** (64% compared with 41% for men)
- **25–34 year age group** (61%)
- **Baffins residents** (74%)

While other groups of residents were less likely to feel unsafe:

- **Veterans were less likely to feel unsafe** (32%)
- **45–54 years age group** (42%)
- **Charles Dickens residents** (49%)

3.7.2 Where do residents feel unsafe and why?

Participants were then asked an open question about where they felt unsafe or avoided. Fieldworkers noted the general area but also encouraged them to be specific and drill down to roads, alleys, parks etc. if possible. Most participants did not give specific details, suggesting they felt generally unsafe in some neighbourhoods or general areas. The general areas were ranked in order of the highest frequency of participants feeling unsafe to lowest. Table 7 shows the trends for the most unsafe/avoided areas over the last 20 years.

The **City Centre/Commercial Road** was the area where residents felt most unsafe or avoided for the **second year in a row** (15.4%, n=165) and **the proportion has increased slightly since 2024** (13.3%). The City Centre has been increasingly negatively perceived over the last decade. Just over half of respondents who felt unsafe in the city centre were most likely to feel this way when it was dark or at night (55%, n=90).

Thematic analysis was conducted to explore the reasons why people felt unsafe or avoided the city centre and the most common reasons were:

- **A visible presence of rough sleeping and related support needs (21%, n=34)**
- **Drug-related issues or ASB (20%, n=32)**
- Alcohol-related issues or ASB (12%, n=20)
- Gangs²⁰ or groups hanging around (7.9%, n=13)
- The area feeling run down/neglected (6.1%, n=10)

These are similar reasons to those provided to the 2024 survey, but **there have been increases in the number of participants reporting they feel unsafe due to the visible presence of rough sleeping and related support needs, and also drug use and/or dealing** in the City Centre.

Table 7: Areas were participants felt unsafe or avoided by rank from 2004 to 2026

Ranking	2007	2009	2012	2014	2016	2018	2020	2022	2024	2026	Direction from 2024	Direction from 2004
City Centre / Commercial Rd	7	9		9	4	3	4	3	1	1	↔	↑
Somerstown	1	1	1	1	1	1	1	1	2	2	↔	↓
Buckland	2	2	3	2	2	2	2	2	3	3	↔	↓
Fratton	8	8	2	4	3	4	3	4	5	4	↑	↑
Northend	Did not rank in the top ten			10	9	9	7	7	8	5	↑	
Southsea	9	7		8	5	6	6	5	4	5	↓	↑
Guildhall area	4	4	4	3	6	5	5	6	6	7	↓	↓
Paulsgrove	3	3	5	5	7	7	9	8	7	8	↓	↓
Landport	6	5	7	7	10	10	10	10	9	9	↔	↓
Portsea	5	6	6	6	8	8	8	9	10	10	↔	↓

Somerstown ranked as a close second most avoided/unsafe area (14.8%, n=159), followed by Buckland (9.6%, n=103). The proportion of people reporting feeling unsafe in Somerstown and Buckland has been reducing over the last decade, with Somerstown reducing from 22% in 2014 and Buckland from 16% in 2014).

Somerstown continues to have an issue with reputation, with this being the most common reason for feeling unsafe (18%, n=29), followed by describing the area as 'rough', a term used by respondents to express general feelings of unease rather than specific incidents or behaviours (10%, n=16) and concern about alcohol and youth related ASB (both 6.9%, n=11). Just over half of respondents who felt unsafe, reported that they felt unsafe at night or when it was dark (55%, n=87).

²⁰ Where participants referred to 'gangs' comments typically did not distinguish between organised criminal gangs and informal groups of people hanging around.

Having a 'bad reputation' was also the most common reason given for feeling unsafe in Buckland (17%, n=18), closely followed by describing the area as 'rough' (15%, n=16) and concern about youth-related ASB (13%, n=14). Of those who felt unsafe, 63% (n=66) felt unsafe when it was dark or at night.

Fratton ranked as the 4th most avoided/unsafe area (7%, n=75), with the most common reasons given as concern about 'gangs' or groups of people hanging around (19%, n=14), people perceived as 'dodgy'²¹ (9.3%, n=7) and feelings of unease linked to unfamiliar people, including references to immigrants (9.3%, n=7). No specific behaviours or incidents were described in relation to these perceptions.

Northend has gradually been becoming an area where more residents report feeling unsafe. It did not rank in the highest ranking ten areas until 2014, following which it gradually moved higher in the rankings, **ranking joint 5th in 2026 with Southsea**. The most common reasons people felt unsafe in Northend were reputation (19%, n=10) and people perceived as 'dodgy' (13%, n=7), while for Southsea it was alcohol-related (32%, n=17) and drug-related (15%, n=8) issues or ASB.

Approximately 7% of participants (7.1%, n=76) felt unsafe generally in Portsmouth, with 80% of them (n=61) feeling unsafe in the dark or at night. There is an alternative table for this which shows all the areas that rank in the top ten since 2004 in Appendix 6.

Online participants also said they felt most unsafe or avoided the City Centre, Somerstown and Buckland. However, online participants were slightly more likely to feel unsafe in Southsea and less unsafe in Northend than the F2F participants.

The reasons given by online participants for feeling unsafe in the City Centre, Fratton and Southsea were similar to those given by F2F participants.

However, online participants gave more varied responses for Somerstown, Buckland and Northend. They were less likely to mention that these areas had a bad reputation or describe the area as 'rough'.

²¹ 'dodgy' is terminology often used by participants to convey a feeling of unease about some of the people in the area without being able to articulate exactly why.

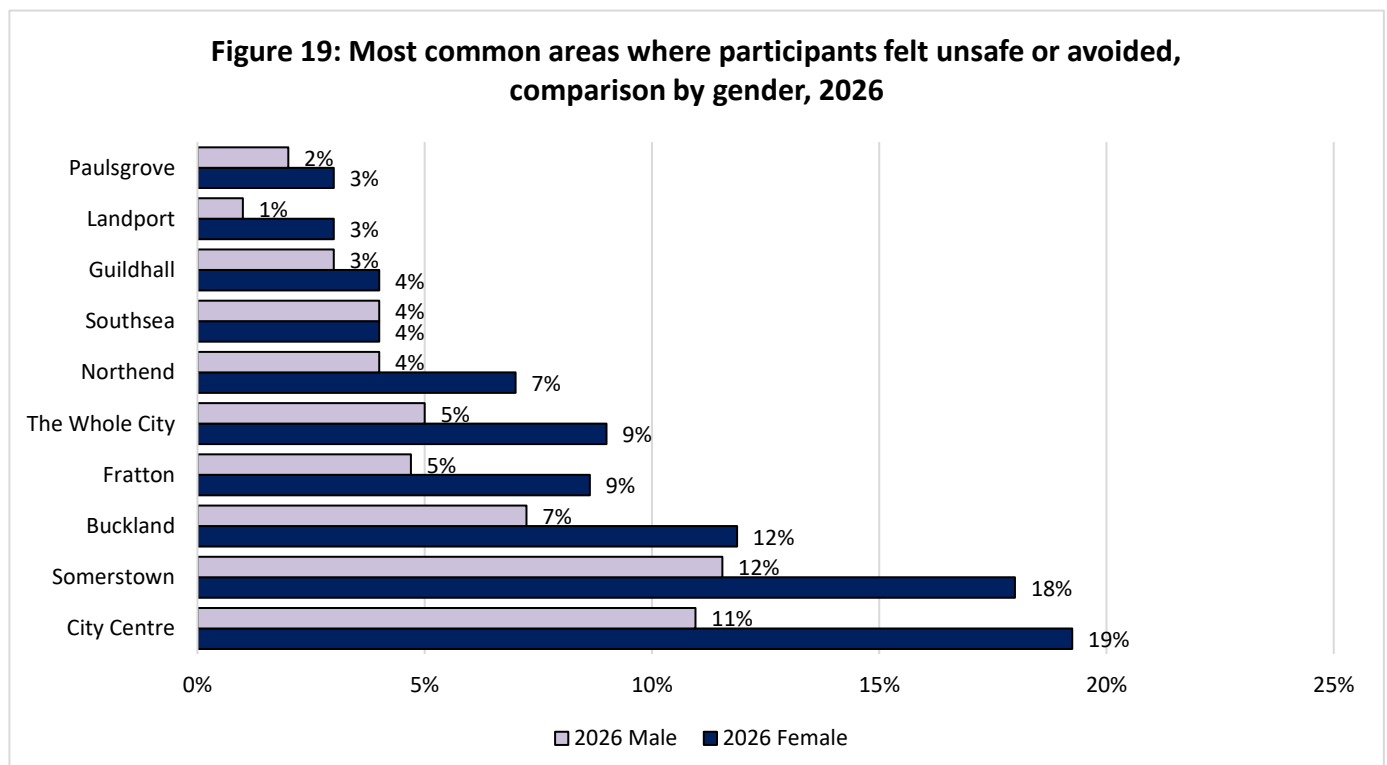
3.8 Locations women feel unsafe and what could be done to improve feelings of safety?

At an extraordinary City Council meeting held on in December 2021, members discussed the importance of tackling male violence against women and girls. The discussion recognised that women and girls should not have to change their behaviour to stay safe and should be able to go about their daily lives freely and without fear.

As part of this, councillors supported the idea of giving local residents an opportunity to share their views on how Portsmouth's streets and public spaces could feel safer. It was agreed that the Community Safety Survey could be adjusted slightly to capture this feedback. The question was designed to be open-ended, allowing respondents to suggest a wide range of ideas rather than focusing only on specific measures, and to gather broader perspectives on how safety in public spaces could be improved for women and girls.

Females were more likely to say that there was at least one area that they felt unsafe or would avoid compared to men (64% compared with 41% of men).

Overall, the places that women commonly avoided or felt unsafe were similar to those mentioned by males, although a higher proportion of women felt unsafe in these areas than men (Figure 19); **the city centre (19%, n=106), Somerstown (18%, n=100) and Buckland (12%, n=66) were the most commonly mentioned areas.** Furthermore, 9% (n=50) of women said they felt unsafe everywhere in Portsmouth (compared with 4.9%, n=25 of men); where specified, this was largely at night or when it was dark (44 of 50 responses from females and 17 of 25 males).



Women who completed the survey online reported similar patterns of feeling unsafe and avoiding areas as those who took part F2F. However, a higher proportion of online respondents said they felt unsafe in the city centre (38% compared with 19%), Cosham (10% compared with 1.1%), and across Portsmouth overall (21% compared with 9%).

3.8.1 City Centre/Commercial Road

Where women felt unsafe in the City Centre/Commercial Road, they were **slightly more likely to feel unsafe when it was dark or at night** (56%, n=59).²²

The reasons given for feeling unsafe in the area were: 'gangs'/groups of people hanging around (n=27), visible presence of rough sleeping and related support needs (n=21), alcohol-related issues and ASB (n=21), drug related issues and ASB (n=17) and fear of being a victim of crime (n=10). It is notable that only two respondents mentioned the area having a bad reputation.

Common suggestions for improving safety in the area were:

- More police (n=76)
- More patrols / security (n=25)
- Better lighting (n=16) and
- Reducing large or intimidating groups in public areas (n=14).

Examples of suggestions from female participants included:

"More police and more deterrents e.g. CCTV, police patrols. It will make it more likely that they'll be caught and punished if they commit crimes."

"Visible police presence. I feel that reporting doesn't achieve much. Police have so much to do."

"More police on the beat. A safe hub would be good in different locations for if you feel threatened or for reassurance"

"More street lights, more security, more police presence"

"Do more to fill the empty units, Patrol at night, move people on"

²² Where this information was recorded

3.8.2 Somerstown

Where female participants felt unsafe in Somerstown, 56% (n=56) felt unsafe when it was dark/at night.²³

While the majority of participants did not specify where exactly in Somerstown they felt unsafe, three women mentioned the blocks of flats, another three mentioned St Andrews Road and from Baileys Road the community centre and someone else mentioned near the health centre.

Women reported feeling unsafe in Somerstown largely due to it having a bad reputation (n=22), fear of being a victim of crime (n=10), 'gangs'/groups of people hanging around (n=8) and alcohol-related issues and ASB (n=7).

When asked what could make them feel safer in Somerstown, the most common suggestions were:

- More police (n=70)
- Better lighting (n=22)
- More security and patrols (n=16)
- More CCTV (n=7), and
- More education/awareness/resources (n=6)

Examples of suggestions to improve safety from female participants included:

"Police patrol in streets and help local businesses."

"Light it up better, lose some of the areas to hide in."

"More street lights and community police presence."

"Young people need youth groups and a focus for their time and energy to avoid being in the wrong crowd."

"Poverty is driving this, and ignorance. Young people need more spaces to socialise e.g. youth clubs. There are not enough family centres and community. Need positive messages around diversity & immigration."

²³ Where this information was recorded

3.8.3 Buckland

Where female participants felt unsafe in feel Buckland, they were more likely to feel unsafe during the night or when it was dark (67%, n=44). Once again, participants rarely specified areas within Buckland, but when they did, specific areas included Buckland Park, the Estella Road flats, high rise flats, Mayo Close, Seymore Close and Malins Road.

The reasons were similar to those for Somerstown: a bad reputation (n=9), fear of being a victim of crime (n=9), youth-related ASB (n=8) and 'gangs'/groups of people hanging around (n=7).

The most common suggestions to improve safety in the area were:

- More police (n=58)
- More security and patrols (n=12)
- Better lighting (n=11), and
- Increased enforcement (n=9)

Examples of suggestions to improve safety from female participants included:

"Not enough police around, not a lot of patrols so increase these "CCTV and more police on foot."

"More police power, harsher discipline, more deterrence."

"More street lights, cameras and police presence."

3.8.4 Women's safety: what do the findings mean?

- Women were most likely to feel unsafe or avoid the same key areas identified across the wider population, particularly the city centre/Commercial Road, Somerstown and Buckland.
- Women most commonly reported feeling unsafe in these areas at night. Concerns focused on groups of people hanging around, alcohol-related issues and ASB, the visible presence of rough sleeping and related support needs, and a fear of being the victim of crime.
- Women highlighted the importance of increased visible policing and patrols, targeted action in key hotspot areas, and partnership work to address street drinking, drug-related activity and support for young people.
- Improving safety requires a combination of practical environmental changes and visible reassurance.

5. Conclusion

This year's Community Safety Survey provides a robust picture of residents' perceptions of safety and experiences of crime and ASB in Portsmouth. By combining a long-established face-to-face methodology with a pilot online survey, the findings offer valuable insight not only into local community safety issues, but also into how different survey methods affect the findings.

Overall, the findings show that **levels of perceived ASB and fear of crime remain relatively stable, but exposure to ASB is widespread and has increased**. More than three-quarters reported witnessing or experiencing ASB in the previous year, the highest level recorded since the introduction of the current methodology in 2014. The gap between perception and experience suggests that much of the ASB encountered by residents is low-level or episodic, visible within communities but not always experienced as sufficiently serious or disruptive to shape broader views of local safety.

The survey **highlights important challenges around reporting**. Fewer than one in four ASB incidents described by respondents were reported to any agency, continuing a long-standing pattern of under-reporting. Reasons given point to normalisation of ASB, apathy, and a lack of confidence that reporting will result in meaningful action. This remains a critical issue for partners, as low reporting limits how well problems are captured in official data and can undermine trust in services.

Patterns of crime victimisation were broadly stable over the longer term, though victimisation has increased since 2024, driven mainly by threats, intimidation, verbal abuse and hate crime. In contrast, many traditional property crimes have remained stable or declined. As in previous years, fear of crime remained higher than actual experience, particularly for offences such as robbery and assault. Women, younger adults, people with disabilities and those from ethnic minority backgrounds were more likely to report feeling fearful. Additionally, residents who had experienced crime or ASB were more likely to report feeling unsafe, supporting an **association between lived experience and perceptions of safety**.

Cybercrime continues to present a growing area of concern. Victimisation increased compared with previous survey years, with online fraud, phishing and personal hacking most commonly experienced. **Younger adults and people with disabilities or long-term conditions were particularly affected**, underlining the importance of continued prevention activity and accessible support for those most at risk.

Direct experience of knife crime continues to be rare and broadly stable, but concern has increased substantially since 2024, with over half of respondents now viewing knife crime as a problem in Portsmouth. This pattern appears to be driven primarily by wider awareness and media coverage rather than personal experience, highlighting the importance of clear, evidence-based communication alongside operational responses.

The survey also provides valuable insight into place-based safety. **Just over half of residents reported avoiding certain areas or feeling unsafe, a proportion that has remained consistent over time**. The

city centre and Commercial Road continue to be the most frequently mentioned locations, with concerns strongly linked to the visible presence of rough sleeping and related support needs and drug and alcohol-related issues and ASB. **Women were significantly more likely to report feeling unsafe**, reinforcing the importance of embedding women's safety considerations into place-based work and environmental design.

Importantly, the comparison between face-to-face and online survey methods demonstrates that methodology matters. **The face-to-face approach continues to deliver the most demographically representative sample and appears more effective at capturing the ASB and crime issues that residents feel most strongly about.** The online survey, while less representative and skewed towards older, retired and White British respondents, provides useful insight into broader awareness of crime and ASB and elicited more detailed free-text responses from some participants. Differences in the demographic profile of respondents help to explain some, but not all, of the variation between the two approaches, indicating that survey mode itself may also influence how residents respond.

Taken together, the findings point to a pattern where visible, lower-level issues, such as widespread ASB and persistent challenges around reporting are shaping perceptions of safety as much as more serious crime.

5.1 Recommendations for the Community Safety Subgroup

Evidence from this survey can be used to strengthen and inform ongoing work, including activity led by the Violence Against Women & Girls sub-group. The following recommendations are proposed:

- **Improve confidence in reporting crimes and ASB**, including clearer reporting pathways and visible feedback to communities about action taken.
- **Tackle persistent ASB hotspots**, particularly for drug-related ASB and traffic issues.
- **Focus on reassurance and visibility**, particularly in the areas where residents feel most unsafe.
- **Strengthen cybercrime prevention and support**, particularly for younger adults and people with disabilities.
- **Continue to embed women's safety into place-based work**, including improvements to lighting, surveillance and guardianship in identified locations.
- **Continue targeted work to tackle violence and related harmful behaviours including intimidation, harassment, sexual harassment and hate crime.**
- **Work with the Health Determinants Research Collaboration (HDRC) & PCC Research and Engagement team to prepare for the 2028 survey** to use community researchers to engage residents who are less likely to complete the survey online and use different channels to advertise the survey to reach a broader audience.

Appendix 1. Community Safety Survey 2026



Portsmouth Community Safety Survey 2026

Check: Does the respondent live in Portsmouth? PO1, PO2, PO3, PO4, PO5, PO6 only.

Prompt: We would like to ask you about crime and ASB/nuisance behaviour in the area where you live and in Portsmouth as a whole. This survey will take about 10 minutes, and these findings will be used by the community safety partnership when they are planning how to address these issues and improve community safety, so your views are important to us.

I will ask you questions about your personal characteristics such as your age and ethnicity because we are trying to make sure the findings are representative for our community. I won't need your name though and the information I collect about you will not be used to identify you in any way.

Taking part in this survey is voluntary and you can decide not to answer any questions or to withdraw at any time.

About You (Show this page and next to the interviewee and fill it out together)							
1	Gender	Male (1)	Female (2)	Prefer to self-describe (3)	Prefer not to say (4)		
2	Age	18-24 (1)	25-34 (2)	35-44 (3)	45-54 (4)	55-64 (5)	65-74 (6) 75+ (7)
3	Main Occupation	Choose the most relevant category					
		Employee in full time job (30+ hours per week) 1					
		Employee in part time job (Under 30 hours/week) 2					
		Self Employed (full or part time) 3					
		Full time education 4					
		Unemployed and available for work 5					
		Permanently sick / disabled 6					
		Wholly retired from work 7					
		Looking after home 8					
		Carer 9					
Other, please specify: 10							
4	Do you serve, or have you ever served, in the Regular, or Reserve, UK Armed Forces?						
	Yes, I currently serve 1						
	Yes, I previously served but am now a veteran 2						
	No, but my spouse/partner/parent currently serves or is a veteran 3						
No 4							

5	Postcode / Ward	
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6	Ethnicity	Choose the option from this list that best describes your ethnic group or background	
White	British / English / Welsh / Scottish / Northern Irish		1
	Irish		2
	Gypsy or Irish Traveler		3
	Roma		4
	Any other white background (please describe)		5
Mixed or multiple ethnic group	White and Black Caribbean		6
	White and Black African		7
	White and Asian		8
	Any other multiple ethnic background (please describe)		9
Asian or Asian British	Indian		10
	Pakistani		11
	Bangladeshi		12
	Chinese		13
	Any other Asian background (please describe)		14
Black or Black British	African		15
	Caribbean		16
	Any other Black background (please describe)		17
Other ethnic group	Arab		18
	Any other ethnic group, (please describe)		19

7	Disability	Do you consider yourself to have a disability or long-term illness/physical/mental condition that reduces your ability to carry out day-to-day activities?	
No			0
Physical / mobility			1
Hearing problems			2
Visual problems			3
Learning disability			4
Mental ill health			5
Other (please describe)			6
Prefer not to say			7

Questions about Crime and Anti-Social Behaviour (ASB)					
Please indicate to what extent you agree or disagree with the following statements on a scale of 1 to 5					

Q1	The overall quality of my life in Portsmouth is very good.				
	1 - Strongly disagree	2	3	4	5 - Strongly agree

Q2	Anti-social behaviour is a big problem in the area where I live.				
	1 - Strongly disagree	2	3	4	5 - Strongly agree

Q3	What type of anti-social behaviour, if any, have you personally experienced or witnessed in your area in the last twelve months? (Do not show or read this list, just circle the codes for the most relevant box, and record whether the ASB was reported and to whom).			
	ASB Type	Code	Reported?	To whom?
	None	0		
Noise	Noise: domestic / neighbour / residential property	1		
	Noise: commercial property (industrial, shops etc.)	2		
	Noise: licensed premises (pubs, clubs, bars & restaurants)	3		
	Noise: in the street (general)	4		
	Noise: Traffic	5		
Environmental	Traffic issues: cars using streets as rat runs	6		
	Traffic issues: parking inconsiderately	7		
	Traffic issues: motorbike nuisance	8		
	Traffic issues: e-scooter nuisance	9		
	Traffic issues: other (specify)	10		
	Litter and rubbish in the street	11		
	Dog mess	12		
	Bin bags left out on the wrong day/time	13		
	Vandalism / graffiti	14		
	Fly tipping	15		
Personal	Neighbour / general disputes	16		
	Harassment / bullying or intimidating behaviour targeting individuals	17		
Nuisance / Drugs / Alcohol	People hanging around (specify)	18		
	Begging	19		
	Street drinking	20		
	Rough sleeping	21		
	Other alcohol related ASB (specify)	22		
	People using drugs	23		
	People dealing drugs	24		
	Drug litter	25		
Other	Dangerous animals / roaming or unsupervised dogs	26		
	Other (specify):	27		
Q3 Comments:				

If the participant experienced ASB but did not report it, you can skip to Q7 first, then return to Q4.

Q4	<u>Are you worried about being the victim of a crime? If so what type of crime? (Do not show or read this list, just circle the most relevant code).</u>	
No	No, I am not worried	0
Violence	Being mugged or robbed	1
	Being assaulted or beaten up	2
	Being stabbed	3
	Being sexually assaulted or harassed	4
	Being harassed or stalked (e.g. following, loitering, spying <u>on more than one occasion</u>)	5
	Being threatened, insulted or abused, or behaviour likely to cause fear or distress (one occasion)	6
	Experiencing domestic abuse / violence	7
Hate	Hate crime: targeted behaviour because of race, religion, disability, sexual orientation, or gender identity (please specify which)	8
Theft & Fraud	Your home being burgled	9
	Having things stolen from garage, shed or garden	10
	Doorstep scams where money or items was stolen (NOT unwanted cold callers)	11
	Having a car, van or motorbike stolen	12
	Having a car or van broken into	13
	Having a bicycle stolen	14
	Street theft such as being pick pocketed	15
	Identity theft	16
	Other fraud	17
Damage	Arson	18
	Criminal damage to your home / garden	19
	Damage to your car or motorbike	20
Other	Other (please specify):	21
	Don't know	22
Q4 Comments:		

Q5	Looking at the list below, what types of crime, if any, have actually happened to you in Portsmouth in the last twelve months? <i>(Show the list for this question and record whether it was reported and to whom).</i>			
	Crime Type	Code	Reported?	To whom?
No	None	0		
Violence	Being mugged or robbed	1		
	Being assaulted or beaten up	2		
	Being stabbed	3		
	Being sexually assaulted or harassed	4		
	Being harassed or stalked (e.g. following, loitering, spying on more than one occasion)	5		
	Being threatened, insulted or abused, or behaviour likely to cause fear or distress (one occasion)	6		
	Experiencing domestic abuse / violence	7		
Hate	Hate crime: targeted behaviour because of race, religion, disability, sexual orientation, or gender identity (please specify which)	8		
Theft & Fraud	Your home being burgled	9		
	Having things stolen from garage, shed or garden	10		
	Doorstep scams where money or items were stolen (NOT unwanted cold callers)	11		
	Having a car, van or motorbike stolen	12		
	Having a car or van broken into	13		
	Having a bicycle stolen	14		
	Street theft such as being pick pocketed	15		
	Identity theft	16		
	Other fraud	17		
Damage	Arson	18		
	Criminal damage to your home / garden	19		
	Damage to your car or motorbike	20		
Other	Other (please specify):	21		
	Don't know	22		
Q5 Comments:				

Q6	Have you experienced any of the following types of cybercrime in the last 12 months? <i>(Show the list for this question and record whether it was reported and to whom).</i>			
	Crime Type	Code	Report?	To whom?
No	None	0		
Online	Phishing: clicked on an email/link designed to look like a trusted source <u>and had money or data stolen</u>	1		
	Online fraud: personal details stolen via an organization suffering a data breach/or password accessed and your bank accounts/credit card used to buy goods or services	2		
	Malware/ransomware/denial of service: had your computer infected with a virus or other 'malware' which has caused your personal information to be manipulated, stolen or deleted or devices/data made inaccessible via ransomware	3		
	Personal hacking: unauthorised access to your online accounts e.g. social media and email accounts (hacking)	4		
	Received hateful or prejudiced content on an online platform targeting your race, religion, disability, sexual orientation, sex or gender identity <u>(please specify which):</u>	5		
	Online abuse: being bullied online or receiving violent, abusive or explicit online content which causes alarm or distress	6		
	Online harassment: being bullied online or receiving violent, abusive or explicit online content which causes alarm or distress <u>on more than one occasion by the same person or group.</u>	7		
	Cyberstalking (repeated use of electronic communications or accessing devices to frighten you and/or monitor your activity)	8		
	Online Sexualised threats: direct threats to commit sexual violence or inciting others to do so, sexualised comments, unwelcome sexual advances or requests for sexual activity, 'jokes' of a sexual activity.	9		
	Technology-Facilitated Domestic Abuse: technology used to facilitate domestic abuse, such as coercive and controlling behaviours, including tracking electronic devices, monitoring emails, social media activity and internet history, and using smart cameras and speakers to covertly monitor.	10		
	Image-based abuse: abuse of a sexual nature or sexual images/videos taken or shared without consent / deepfakes created depicting you / images or videos that may cause reputational damage.	11		
	Receiving unsolicited and unwanted obscene pictures or videos, (including cyberflashing)	12		
	Sextortion: A type of online blackmail involving threats to release sexualised materials unless money is paid or unwanted activities are engaged in.	13		
	Doxing: The release of personally identifiable information online.	14		
	Online grooming (If you are a parent or guardian, has your child been contacted online by an adult who has tried to befriend your child).	15		
	Other, please specify:	16		

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Q7	If you did not report crime that you experienced, what was the reason for not reporting it? (Please list each crime separately using the correct code and give a reason for not reporting – this can include 'don't know').			
	Crime which was not reported	Why didn't you report this crime?		
Q7 Comments:				

Q8a	Do you think knife crime is a problem in Portsmouth?		
	Yes	No	I don't know

Q8b	If you answered yes to the previous question, why do you think knife crime is a problem in Portsmouth?
	Comments:

Q8c	Have you seen someone carrying a knife or a weapon in the area that you live in (in the last 12 months)?	
	Yes	
	No	
	Don't know	

Q8d	If you have seen someone carrying a weapon, what type of weapon was it?
	Please specify:

Q8e	Was it a young person or an adult carrying the weapon?	
	Young person (17 or under)	
	Young adult (18-24yrs)	
	Adult (25+)	
	Not sure	

Q8f	Have you experienced or witnessed a crime involving a knife or bladed weapon in the past 12 months?	
	No	
	Experienced	
	Witnessed	
	Comments:	

Q9a	Are there any parts or places in Portsmouth where you feel unsafe or where you avoid going due to feeling fearful of crime?	
	Yes	No

Q9b	<i>(add this for female residents: The partnership is doing work around violence against women and girls, and so we want to hear from you about places you don't feel safe in Portsmouth)</i> Please tell us where you feel unsafe or avoid, giving as much detail as possible about the location. Thinking about each location can you tell us why you feel unsafe or avoid these locations? What could we do so that you feel safer in this location?			
	Where? Please tell us about the area and the specific location	Night/dark only	Why do you feel frightened or avoid these locations?	What could we do so you feel safer in this location?

Thank you for taking part in this survey, the findings will be published on the Portsmouth City Council website by the end of May 2026.

If you would be happy for us to contact you in the future about any other crime and safety issues please leave your details on the contact sheet.

Appendix 2: Fieldwork locations & details about analysis

- **Baffins** - Library as base
- **City Centre** - Commercial Road (busy area frequented by residents from all over the city)
- **Copnor**-College Park and Copnor Road area leading to the park
- **Cosham** - High Street
- **Drayton & Farlington** - Farlington Sainsbury's, Havant Road shopping area (Drayton)
- **Eastney Seafront** - Promenade, Rose Gardens and Canoe Lake
- **Fratton** - The Bridge Centre, Asda and Fratton Road and also Tesco Extra
- **Guildhall Square & Civic Offices reception area**
- **Portsea** - John Pounds Community Centre
- **Milton & Eastney** -Eastney Road Co-op, Bransbury Park & Milton Park (Beddow Library)
- **Northend** - Library as base
- **Paulsgrove** - Paulsgrove community centre as base, Allaway Avenue shopping area
- **Southsea** - Palmerston Road, Library as base

The analysis was completed using Excel for descriptive statistics and thematic analysis (quantitative) and SPSS for the statistical analysis. Comparisons within groups were only made where the groups were large enough to allow for a meaningful comparison. For this reason, comparisons have been made between British white residents and all other ethnicities, and those with or without a disability, rather than between different types of disability or ethnic background.

The sample for each ward was not large enough to allow for detailed analysis per ward but can provide some information about particular issues in each area if requested.

For the purposes of this report, a 'statistically significant finding' means that after a statistical test there was at least a 95% certainty that this result did not occur by chance. The full detailed statistics are available on request. The current report does not use any weighted data,²⁴ instead the sample was matched as closely as possible to the ONS population estimate.

²⁴ Weighting is used to adjust the results of a study to bring them more in line with what is known about a population. For example, if a sample contains 40% males and the population contains 49% males weighting can be used to correct the data to correct for this discrepancy.

Appendix 3: Key statistical findings

This appendix sets out the tests used and the results where significant differences were found. The full SPSS outputs are available on request.

Quality of life

One Way ANOVA and t-tests for independent groups were used to explore whether there were any differences between groups for the scale data obtained for the question on quality of life. T-tests were used where there were only two groups, while ANOVAs were used for more than two groups, and Tukey's HSD post hoc test was used to show where the significant differences were following an ANOVA.

The mean reported average for all respondents was 3.71, which is slightly but statistically significantly lower than 2022²⁵ (M=3.87), 2020 (M=3.89), 2018 (M=4.01), 2016 (M=3.98) and 2014 (3.96). This indicates that **overall residents were slightly less satisfied with their quality of life in 2026 and 2024 than in previous years since 2014.**

Those who did not experience/witness ASB or crime, those who are not worried about being a victim, those who do not think knife crime is a problem and those who do not feel unsafe reported a slightly (but statistically significantly) better quality of life than those who had been a victims / were fearful of crime:

- Those who had not experienced/witnessed ASB in the last year (M=4.04) had a better quality of life than those who had experienced/witnessed ASB (M=3.62).²⁶
- Those who had not been a victim of crime in the last year (M=3.81) had a better quality of life than those who had been a victim of crime (M=3.5).²⁷
- Those who had not been a victim of online crime in the last year (M=3.76) had a better quality of life than those who had been a victim of crime (M=3.55).²⁸
- Those who were not worried about being a victim of crime (M=3.89) had a better quality of life than those who were worried about being a victim (M=3.49).²⁹
- Those who did not think knife crime was a problem in Portsmouth (M=3.99) had a better quality of life than those who did think knife crime was a problem ASB (M=3.54).³⁰
- Those who did not feel unsafe in any areas in Portsmouth (M=3.9) had a better quality of life than those who felt unsafe ASB (M=3.54).³¹

²⁵ Overall F = 17.973, df = 6, p < 0.001

²⁶ t=5.775, df=1074, p <0.001

²⁷ t=4.469, df=603, p <0.001

²⁸ t=2.768, df=1074, p = 0.006

²⁹ t=6.584, df=1034, p <0.001

³⁰ t=-6.538, df=638.5, p <0.001

³¹ t=-5.928, df=1066.5, p <0.001

Statistically significant differences were found between some ethnicity groups, disability types, occupations and wards.

- Ethnic minority participants (M=3.86) reported a statistically significantly higher mean quality of life scores than British white participants (M=3.67).³²
- Participants with no disability (M=3.82) and hearing loss (M=3.98) reported a statistically significantly higher mean quality of life scores than those with physical disabilities (M=3.5), poor mental health (M=3.09) and 'other' disabilities (M=3.48).³³
- People who reported that they were not working due to being permanently sick or disabled had a significantly lower mean quality of life score (M=3.05) than other occupations.³⁴
- The ward where people lived also affected their mean quality of life, with residents living in St Judes having the highest mean score (M=4.18), which is significantly higher mean scores than residents living in Fratton, (M=3.46).³⁵

Perception of ASB

One Way ANOVA and t-tests for independent groups were used to explore whether there were any differences between groups for the scale data obtained for the question on perception of ASB. T-tests were used where there were only two groups, while ANOVAs were used for more than two groups, and Tukey's HSD post hoc test was used to show where the significant differences were following an ANOVA.

The average score for all respondents was 2.86, which is similar to levels in 2024, 2022, 2020 and 2018 (M=2.94, 2.88, 2.93 and 2.86 respectively) and statistically significantly higher³⁶ than in 2016 and 2014 (M=2.42 and 2.49 respectively).

Those who did not experience/witness ASB or crime, those who are not worried about being a victim, those who do not think knife crime is a problem and those who do not feel unsafe were less likely (but statistically significantly) to think that ASB was a big problem in their area than those who had been a victim / were fearful of crime.

- Those who had not experienced/witnessed ASB in the last year (M=1.87) were less likely to think ASB was a big problem in their area than those who experienced/witnessed ASB (M=3.15).³⁷
- Those who had not been a victim of crime in the last year (M=2.65) were less likely to think ASB was a big problem in their area than those who had been a victim of crime (M=3.3).³⁸

³² $t = -2.624$, $df = 388.902$, $p = 0.009$

³³ $t = -4.582$, $df = 666$, $p < 0.001$

³⁴ Overall $F = 4.994$, $df = 9$, $p < 0.001$

³⁵ Overall $F = 2.337$, $df = 15$, $p = 0.003$

³⁶ Overall $F = 28.596$, $df = 6$, $p < 0.001$

³⁷ $t = -14.044$, $df = 1074$, $p < 0.001$

³⁸ $t = -7.543$, $df = 1074$, $p < 0.001$

- Those who were not worried about being a victim of crime (M=2.63) were less likely to think ASB was a big problem in their area than those who were worried (M=3.13).³⁹
- Those who did not think knife crime was a problem in Portsmouth (M=2.24) were less likely to think ASB was a big problem in their area than those who did think it was a problem (M=3.21).⁴⁰
- Those who did not feel unsafe in any areas in Portsmouth (M=2.5) were less likely to think ASB was a big problem in their area than (M=3.17).⁴¹

The following statistically significant differences were found between demographic groups:

- British White participants (M=2.97) were more likely to think that ASB was a problem than BAME participants (M=2.44).⁴²
- Participants with learning disabilities (M=3.42) and poor mental health (M=3.38) were more likely to think that ASB was a problem than those with no disability (M=2.76).⁴³
- Participants who reported being permanently sick or disabled (M=3.4) were significantly more likely to think that ASB was a big problem than stay at home parents (M=2.42), participants in full time education (M=2.71), participants working part-time (M=2.75) and retired participants (M=2.74).⁴⁴
- Participants living in Charles Dickens (M=3.22) were significantly more likely to think that ASB was a big problem than those living in Drayton & Farlington (M=1.98) and Copnor (M=2.28).⁴⁵

Personal experience of ASB

Chi Squared was used to explore significant differences for categorical data where the answers were yes or no. SPSS indicates the columns where there is a statistically significant difference between the expected and observed counts.

77% of participants reported witnessing or experiencing ASB in the last 12 months, significantly more than in 2024 (64%) and all other years except for 2020 (74%).⁴⁶

A significant association was found between witnessing and experiencing ASB and ethnicity. British white respondents were more likely to witness or experience ASB than those from other ethnic groups (80% compared with 67%).⁴⁷

No other significant differences were found.

³⁹ $t = -6.093$, $df = 1074$, $p < 0.001$

⁴⁰ $t = 10.510$, $df = 879$, $p < 0.001$

⁴¹ $t = 8.303$, $df = 1071$, $p < 0.001$

⁴² $t = 5.321$, $df = 1067$, $p < 0.001$

⁴³ $t = 3.193$, $df = 1074$, $p = 0.001$

⁴⁴ Overall $F = 2.564$, $df = 9$, $p = 0.006$

⁴⁵ Overall $F = 4.148$, $df = 15$, $p < 0.001$

⁴⁶ Chi Sqr = 111.149, $df = 6$, $p < 0.001$

⁴⁷ Chi Sqr = 18.521, $df = 1$, $p < 0.001$ - Please note that the BME group is very varied and there are likely to be differences within this group, but numbers of individual groups are too small to analyse robustly separately.

Fear of crime

Chi Squared was used to explore significant differences for categorical data where the answers were yes or no. SPSS indicates the columns where there is a statistically significant difference between the expected and observed counts

45% of respondents reported being worried about being a victim of crime, which is significantly higher than in 2024 (38%) and 2022 (36%). However, it was also significantly lower than the concern reported from 2014 to 2020.⁴⁸

Some demographic groups were significantly associated with being more likely to fear being a victim of crime:

- Women were more likely to fear being victimized than men (53% compared with 37%).⁴⁹
- Those working part time (60%) and those who are looking after their home and family (67%) were more likely to fear being victimised than other main occupations (45%), and those who were retired were less likely to fear being victimised (40%).⁵⁰
- Veterans were less likely to fear victimisation than those who were not (28% compared with 46%).⁵¹
- Those with disabilities (56%) were more likely to fear victimisation than those who do not (39%).⁵²

While not statistically significant at the 0.05 probability level using Pearson Chi-Square, SPSS picked up that that proportions differed significantly at the 0.05 level for a couple of other groups:⁵³

- Age group: participants aged 35-44 years were more likely to fear being victimized than 75years and over (53% compared with 35%).

Chi Squared was used to look for associations between fear of crime and experiencing ASB and crime - three years data was used for this (2022-2026) and the average proportion of participants reporting fear of crime across the 3 years was 40%.

- Experiencing ASB; a larger proportion of those who reported experiencing ASB were worried about being the victim of a crime than those who didn't report experiencing ASB (44% compared with 29%).⁵⁴
- Being a victim of crime; a larger proportion of those who reported experiencing at least one crime were worried about being the victim of a crime than those who didn't report being a victim (57% compared with 34%).⁵⁵

⁴⁸ Chi Sqr = 447.403, df = 6, p < 0.001

⁴⁹ Chi Sqr = 30.366, df = 2, p < 0.001

⁵⁰ Chi Sqr = 26.669, df = 9, p = 0.002

⁵¹ Chi Sqr = 9.384, df = 3, p = 0.025

⁵² Chi Sqr = 28.451, df = 1, p = <0.001

⁵³ Full details of the tests available on request

⁵⁴ Chi Sqr = 64.946, df = 2, p = <0.001

⁵⁵ Chi Sqr = 147.458, df = 1, p = <0.001

- Being a victim of online crime; a larger proportion of those who reported experiencing at least one online crime were worried about being the victim of a crime than those who didn't report being a victim (50% compared with 38%).⁵⁶
- Feeling unsafe or avoiding areas; a larger proportion of those who reported avoiding at least one area were worried about being the victim of a crime than those who didn't report feeling unsafe or avoiding areas (52% compared with 26%).⁵⁷

Victimisation

Chi Squared was used to explore significant differences for categorical data where the answers were yes or no. SPSS indicates the columns where there is a statistically significant difference between the expected and observed counts.

32% of participants reported being a victim of crime in 2026. This is statistically significantly higher than 2022 and 2024 (24%), but similar to levels in 2014 and 2018 (33-35%) and significantly lower than in 2020 (36%).⁵⁸

Some factors that were associated with being more or less likely to be a victim of crime (Q5) were:

- People who have retired (21%) were less likely to be a victim of crime than other occupations and those who were sick/disabled (47%) or unemployed (46%) were more likely to be a victim of crime.⁵⁹
- People who are 65-74 years and over 75 years old were less likely to be a victim of crime than other age groups (25% and 17% compared with the mean for all ages 32%).⁶⁰
- People who are 25-34 years (44%) were more likely to be a victim than the average for all ages (32%).⁶¹
- People with a disability were more likely to be a victim of crime and those no disabilities were slightly less likely to be a victim of crime (37% and 29%, respectively).⁶²
- Ethnic minority participants (38%) were more likely to be victims of crimes than British White participants (30%).⁶³

In 2026, 22% participants reported experiencing a cybercrime, which is significantly higher than in 2024 and 2022 (16%).⁶⁴

Factors associated with being more or less likely to be a victim of cybercrime (Q6) were:

⁵⁶ Chi Sqr = 30.118, df = 1, p = <0.001

⁵⁷ Chi Sqr = 231.265, df = 1, p = <0.001

⁵⁸ Chi Sqr = 124.433, df = 6, p = <0.001

⁵⁹ Chi Sqr = 40.179, df = 9, p < 0.001

⁶⁰ Chi Sqr = 25.517, df = 6, p < 0.001

⁶¹ Chi Sqr = 25.517, df = 6, p < 0.001

⁶² Chi Sqr = 5.970, df = 1, p < 0.015

⁶³ Chi Sqr = 5.719, df = 1, p < 0.017

⁶⁴ Chi Sqr = 18.211, df = 2, p < 0.001

- Those with disabilities were more likely to be a victim of cybercrime than those with no disabilities (26% compared with 20%).⁶⁵
- Those aged 25-34 years (36%) were more likely to be victims of cybercrime than the overall average (22%), while those aged 65-74 years (16.5%) and 75 years or over (13%) were less likely.⁶⁶
- People who have retired (19%) were less likely to be a victim of cybercrime than other occupations and those who unemployed (41%) were more likely to be a victim of cybercrime.⁶⁷

While not statistically significant at the 0.05 probability level using Pearson Chi-Square, SPSS picked up that that proportions differed significantly at the 0.05 level for a couple of other groups:⁶⁸

- Veterans were less likely to be a victim of cybercrime than those serving currently, their spouses and dependents and those not in the armed services community (12% compared with 22% - overall mean).
- Residents living in Cosham were more likely to be a victim of cybercrime (Q6) than those living in other wards (33% compared with 22%).

Chi Square was also used to compare the combined dataset for participants who had experienced either at least one crime or cybercrime type. **The proportion of participants experiencing either type of crime in 2026 (44%) is significantly higher than other years (ranges from 20% in 2016 to 36% in 2020).**⁶⁹

Knife crime

Chi Squared was used to explore significant differences for categorical data where the answers were yes or no. SPSS indicates the columns where there is a statistically significant difference between the expected and observed counts.

56% of participants said that they thought knife crime was a problem, 26% thought it was not and 18% didn't know.

Some characteristics were associated with being likely to think knife crime was a problem:

- Females were more likely to think knife crime was a problem than males (61% compared with 50%).⁷⁰
- Unemployed participants were more likely to think knife crime was a problem and students were less likely to think that it was a problem (73% compared with 42%).⁷¹

⁶⁵ Chi Sqr = 5.468, df = 1, p = 0.019

⁶⁶ Chi Sqr = 26.685, df = 6, p < 0.001

⁶⁷ Chi Sqr = 37.743, df = 9, p < 0.001

⁶⁸ Full details of the tests available on request

⁶⁹ Chi Sqr = 199.144, df = 6, p < 0.001

⁷⁰ Chi Sqr = 22.162, df = 4, p < 0.001

⁷¹ Chi Sqr = 44.275, df = 18, p < 0.001

- Veterans were less likely to think knife crime was a problem than their spouses and dependents and those not in the armed services community (38% compared with 56% - overall mean).⁷²
- White British participants were more likely to think it was a problem than BAME participants (58% compared with 47%).⁷³

Areas where people feel unsafe

Chi Squared was used to explore significant differences for categorical data where the answers were yes or no. SPSS indicates the columns where there is a statistically significant difference between the expected and observed counts.

Just over half of participants (53%) said that there were areas of Portsmouth where they felt unsafe or avoided. This is similar to most previous surveys since 2014, although it is significantly higher than 2016 (49%).⁷⁴

Some factors were associated with being likely to feel unsafe / avoid areas:

- 25-24 year olds more likely to feel unsafe / avoid areas and 45-54 years less likely (61% and 42% respectively).⁷⁵
- Females were more likely to feel unsafe / avoid areas than males (64% and 41% respectively).⁷⁶
- Veterans were less likely to feel unsafe / avoid areas than those not in the armed services community (32% compared with 55% - overall mean).⁷⁷

While not statistically significant using Chi Squared, SPSS found significant differences for some wards. Baffins residents were more likely to feel unsafe / avoid areas (74%), and those living in Charles Dickens were less likely (49%).⁷⁸

Comparison of face-to-face with online survey sample

This section compared the demographics and findings of the F2F survey with the online one using Chi Square.

⁷² Chi Sqr = 16.443, df = 6, p = 0.012

⁷³ Chi Sqr = 8.882, df = 2, p = 0.012

⁷⁴ Chi Sqr = 15.551, df = 6, p = 0.016

⁷⁵ Chi Sqr = 12.662, df = 6, p = 0.049

⁷⁶ Chi Sqr = 56.266, df = 2, p < 0.001

⁷⁷ Chi Sqr = 13.309, df = 3, p = 0.004

Demographics

The demographics for the online and F2F surveys were very different. Gender was the only characteristic with no significant difference.

There were statistically significant differences for the following demographics:

- The online survey had a **larger proportion of older age groups** answering the survey than the F2F survey; 27% compared with 15% for 55-64yrs, 31% compared with 17% for 65-74yrs and 19% compared with 10% for over 75years. The online sample had smaller proportions of younger age groups; uncalculated due to small numbers for 18-24yrs compared with 17%, 2.4% compared with 14% for 25-24yrs and 7% compared with 15% for 35-44yrs. The only age group where similar proportions were found for both samples was 24-54yrs (13% and 12% respectively).⁷⁹
- The online survey had a substantially **larger proportion of retired participants** than the F2F survey, which is consistent with the differences in age groups (51% compared with 28%). The online sample had **lower proportions of participants in full time education** (uncalculatable due to small numbers compared with 12%), **unemployed** (1.5% compared with 8%) and **carers** (uncalculatable due to small numbers compared with 2.3%).⁸⁰
- The online sample had a **larger proportion of veterans** compared with the F2F survey (11% compared with 6%).⁸¹
- The ward representation was significantly different for the two samples, most notably there being a much smaller proportion of participants from Charles Dickens in the online survey.⁸² However, while some areas which were under-represented in the F2F survey were closer to the target,⁸³ such as Cosham. Milton and Drayton and Farlington; other areas such as Charles Dickens, Nelson and Paulsgrove were under-represented instead.
- There was a smaller proportion of those with disabilities and long-term conditions participating in the online survey (27% compared with 34%).⁸⁴ However, this meant lower proportions of those with visual and learning disabilities and poor mental health, while there were higher levels of people with mobility/physical disabilities. This is likely to be due to the higher proportion of older age groups in the online sample.
- There was a smaller proportion of ethnic minority participants in the online survey (7% compared with 21%).⁸⁵

⁷⁹ Chi Sqr = 160.775, df = 6, p <0.001

⁸⁰ Chi Sqr = 114.241, df = 9, p <0.001

⁸¹ Chi Sqr = 10.84, df = 3, p = 0.011

⁸² Chi Sqr = 84.240, df = 15, p <0.001

⁸³ Targets for wards are based on the small area forecasts

⁸⁴ Chi Sqr = 6.696, df = 1, p = 0.01

⁸⁵ Chi Sqr = 34.350, df = 1, p <0.001

Ward	F2F				Online		
	Target	Survey	Survey	Difference	Survey	Survey	Difference
Baffins	7.2%	68	6.3%	-0.8%	32	9.1%	1.9%
Central Southsea	7.6%	68	6.3%	-1.3%	41	11.6%	4.0%
Charles Dickens	10.0%	235	21.9%	11.9%	20	5.7%	-4.3%
Copnor	5.9%	47	4.4%	-1.5%	25	7.1%	1.2%
Cosham	6.9%	48	4.5%	-2.4%	26	7.4%	0.5%
Drayton and Farlington	6.4%	42	3.9%	-2.5%	27	7.7%	1.2%
Eastney and Craneswater	6.6%	79	7.4%	0.8%	28	8.0%	1.3%
Fratton	7.4%	92	8.6%	1.2%	20	5.7%	-1.7%
Hilsea	6.4%	62	5.8%	-0.6%	19	5.4%	-1.0%
Milton	7.6%	56	5.2%	-2.3%	27	7.7%	0.1%
Nelson	7.2%	78	7.3%	0.0%	14	4.0%	-3.3%
Paulsgrove	6.3%	45	4.2%	-2.1%	11	3.1%	-3.1%
St. Jude	6.7%	52	4.9%	-1.9%	25	7.1%	0.4%
St. Thomas	7.7%	90	8.4%	0.7%	29	8.2%	0.5%
Homeless		4	0.4%			0.0%	
Portsmouth misc.		5	0.5%		8	2.3%	
Total		1071			352		

Key findings

Q1: **Online participants reported a lower mean quality of life** than the F2F participants (M=3.55 and 3.71 respectively).⁸⁶

Q2: **Online participants were more likely to think ASB was a problem** in their area than F2F participants (M=3.23 and M=2.86 respectively).⁸⁷

Q3: **Online participants were less likely to report experiencing ASB** than F2F (60% compared with 77%).⁸⁸

Q4: More online participants worried about being the victim of a crime (50%) compared with F2F participants (45%) but this difference was not statistically significant. However, **more online participants reported that they didn't know** (15% compared with fewer than n5 F2) and this meant **fewer reported not being worried** (36% compared with 55% of F2F participants).⁸⁹

⁸⁶ $t = -2.725$, $df = 623.862$, $p = 0.007$

⁸⁷ $t = 4.634$, $df = 1426$, $p < 0.001$

⁸⁸ Chi Sqr = 40.750, $df = 1$, $p < 0.001$

⁸⁹ Chi Sqr = 174.796, $df = 2$, $p < 0.001$

Q5: **Online participants less likely to report being the victim of a crime** (21% compared with 32%).⁹⁰

Q6: Slightly lower proportion of reported online crime from online sample but not significantly different (18% compared with 22%).

Q8a: Slightly lower proportion of online participants thought **knife crime is a problem** than F2F (51% compared with 56%), but this was not stat significant. However significantly **more reported that they didn't know** (39% compared with 18%) and **fewer thought it was not a problem** (11% compared with 27%).⁹¹

Q8c: Fewer online participants reported seeing people carry knives (7% compared with 11%) but this difference was not significant.

Q8f: **Similar proportions reporting witnessing and experiencing knife crime.**

Q9: **Larger proportion of online participants said there were areas that they found unsafe or avoided** (68% compared with 53%).⁹²

⁹⁰ Chi Sqr = 11.450, df = 1, p <0.001

⁹¹ Chi Sqr = 76.730, df = 2, p <0.001

⁹² Chi Sqr = 24.072, df = 1, p <0.001

Appendix 4 - Comparison of F2F and online samples for report.

This appendix sets out tables comparing the responses of the F2F and online participants, excluding the qualitative comments which were summarised in the main report.

Demographics:

Most of the targets have been obtained from the Office for National Statistics 2021 Census data for Portsmouth, and sources will be given if the targets are from a different source.

Gender

There was a greater difference between genders for the online sample with 55% of respondents being female, 42% male and 3% preferring not to say. This difference is not statistically significant, but the proportions are not as close to proportions observed in the Census as the F2F sample.

Gender	F2F				Online		
	Target	Survey (n)	Survey (%)	Difference	Survey (n)	Survey (%)	Difference
Male	50%	511	47.5%	-2.3%	149	42.3%	-7.5%
Female	50%	556	51.7%	1.5%	193	54.8%	4.6%
Prefer to self describe*	1%	5	0.5%			0.0%	
Prefer not to say	0%	1	0.1%	0.1%	10	2.8%	
Missing		3	0.3%				
Total		1076	100.0%		352		

Age

There were **statistically significant differences between the age profiles** for the F2F and online surveys (see Appendix 3).

Age Group	F2F				Online		
	Target	Survey (n)	Survey (%)	Difference	Survey (n)	Survey (%)	Difference
18-24	15.6%	178	16.5%	0.9%	1	0.3%	-15.3%
25-34	19.2%	151	14.0%	-5.2%	8	2.3%	-16.9%
35-44	18.2%	157	14.6%	-3.6%	23	6.5%	-11.7%
45-54	14.3%	132	12.3%	-2.0%	45	12.7%	-1.5%
55-64	14.1%	159	14.8%	0.7%	90	25.5%	11.4%
65-74	9.6%	182	16.9%	7.3%	106	30.0%	20.4%
75+	9.0%	109	10.1%	1.1%	65	18.4%	9.4%
65+	18.7%	291	27.0%	8.3%	171	48.4%	29.7%
Missing		6	0.6%				
Total	100.0%	1076	100.0%		353		

The **online survey was answered by more older people than the F2F survey**. For example, 27% of online respondents were aged 55–64 compared with 15% in the face-to-face survey, 31% compared with 17% for those aged 65–74, and 19% compared with 10% for those aged 75 and over.

The **online survey had fewer younger respondents**. Very small numbers of 18–24 year olds took part online, compared with 17% in the F2F survey. Lower proportions were also seen for those aged 25–34 (2.4% online compared with 14%) and 35–44 (7% compared with 15%).

Similar proportions were seen in both surveys for people aged 45–54 (13% online and 12% F2F).

Main occupation

The online survey included a **significantly higher proportion of retired participants** than the F2F survey (51% compared with 28%), reflecting the older age profile of online respondents. The online sample also **included fewer people in full-time education, fewer unemployed participants, and fewer carers**, with very small numbers in these groups compared with the F2F survey.

Occupation	Target	F2F			Online		
		Survey (n)	Survey (%)	Difference	Survey (n)	Survey (%)	Difference
Employed*	54.2%	438	40.9%	-13.3%	141	39.9%	-14.3%
Full time education (21,800 students UoP)	13.8%	131	12.2%	-1.6%	2	0.6%	-13.2%
Unemployed (available for work)*	2.9%	85	7.9%	5.0%	5	1.4%	-1.5%
Long term sick / disabled*	4.2%	55	5.1%	0.9%	11	3.1%	-1.1%
Retired (over 65s plus under 65s from Nomis)*	17.1%	298	27.9%	10.8%	175	49.6%	32.5%
Stay at home parent*	4.6%	24	2.2%	-2.4%	6	1.7%	-2.9%
Carer		25	2.3%		1	0.3%	0.3%
Other	3.1%	19	1.8%	-1.3%	2	0.6%	-2.5%

*Targets from Nomis⁹³

Disability

In the 2021 Census, people were asked if they had a physical or mental health condition expected to last 12 months or more. Using this definition, around 1 in 5 people in Portsmouth (19.2%) reported having a disability.

There was a **significantly smaller proportion of respondents with disabilities and long-term conditions participating in the online survey (27% compared with 34%), which is closer to the target** set by the Census.

However, when examined by the type of disability, this meant **lower proportions of those with visual and learning disabilities and poor mental health in the online survey and higher levels of people with**

⁹³ [Nomis - Official Census and Labour Market Statistics](#)

mobility/physical disabilities. This may be due to the higher proportion of older age groups in the online sample.

Disability	F2F		Online	
	Survey (n)	Survey (%)	Survey (n)	Survey (%)
Mobility / physical	156	14.5%	68	20.4%
Hearing	47	4.4%	15	4.5%
Visual	48	4.5%	8	2.4%
Learning	48	4.5%	3	0.9%
Mental Health	100	9.3%	18	5.4%
Other	89	8.3%	15	4.5%
Total participants with at least one disability	361	33.6%	88	26.4%
No disability	707	65.7%	243	73.0%
Missing	8	0.7%	22	
Total	1076		353	

Ethnicity

There was a **significantly smaller proportion of ethnic minority participants in the online survey** (7% compared with 21%).

Ethnicity	Target	F2F			Online		
		Survey (n)	Survey (%)	Difference	Survey (n)	Survey (%)	Difference
White English, Welsh, Scottish, NI or British	77.7%	841	78.6%	0.9%	314	89.0%	11.3%
White Minorities	7.5%	51	4.8%	-2.7%	12	3.4%	-4.1%
Asian, Asian British/Welsh	6.9%	81	7.6%	0.7%	5	1.4%	-5.5%
Black, Black British, Welsh, African, Caribbean	3.4%	67	6.3%	2.9%	2	0.6%	-2.8%
Mixed ethnic groups	2.6%	16	1.5%	-1.1%	7	2.0%	-0.6%
Other ethnic groups	1.8%	15	1.4%	-0.4%	8	2.3%	0.4%
Total BME groups	22.2%	230	21.5%	-0.7%	34	9.6%	-12.6%

Wards

The **ward profile was significantly different for the two samples**, most notably there being a **much smaller proportion of participants from Charles Dickens in the online survey**.

However, while some areas which were under-represented in the F2F survey were closer to the target, such as Cosham. Milton and Drayton and Farlington, other areas such as Charles Dickens, Nelson and Paulsgrove were under-represented instead.

Ward		F2F			Online		
	Target	Survey	Survey	Difference	Survey	Survey	Difference
Baffins	7.2%	68	6.3%	-0.8%	32	9.1%	1.9%
Central Southsea	7.6%	68	6.3%	-1.3%	41	11.6%	4.0%
Charles Dickens	10.0%	235	21.9%	11.9%	20	5.7%	-4.3%
Copnor	5.9%	47	4.4%	-1.5%	25	7.1%	1.2%
Cosham	6.9%	48	4.5%	-2.4%	26	7.4%	0.5%
Drayton and Farlington	6.4%	42	3.9%	-2.5%	27	7.7%	1.2%
Eastney and Craneswater	6.6%	79	7.4%	0.8%	28	8.0%	1.3%
Fratton	7.4%	92	8.6%	1.2%	20	5.7%	-1.7%
Hilsea	6.4%	62	5.8%	-0.6%	19	5.4%	-1.0%
Milton	7.6%	56	5.2%	-2.3%	27	7.7%	0.1%
Nelson	7.2%	78	7.3%	0.0%	14	4.0%	-3.3%
Paulsgrove	6.3%	45	4.2%	-2.1%	11	3.1%	-3.1%
St. Jude	6.7%	52	4.9%	-1.9%	25	7.1%	0.4%
St. Thomas	7.7%	90	8.4%	0.7%	29	8.2%	0.5%
Homeless		4	0.4%			0.0%	
Portsmouth misc.		5	0.5%		8	2.3%	
Total		1071			352		

Armed forces

The last estimate was that approximately 18% of Portsmouth's community were members of the armed forces community.⁹⁴

The **online sample had a larger proportion of respondents from the armed forces community**, driven by a **significantly higher number of veterans** (11% compared with 6%). This brings the total of armed forces community participants closer to the target of 18%.

Armed Forces	F2F		Online	
	Survey	Survey	Survey	Survey
Not armed forces	937	87.2%	295	83.8%
Spouse/partner/parent currently serves or is a veteran	71	6.6%	19	5.4%
Currently serves	6	0.6%	1	0.3%
Veteran	60	5.6%	37	10.5%
Total Armed forces (serving, vet or dependent)	137	12.7%	57	16.2%

⁹⁴ [The community - Portsmouth City Council](#)

Survey findings

Quality of life & perception of ASB

Online participants reported a significantly lower mean quality of life than the F2F participants (M=3.55 and 3.71 respectively)

Quality of Life		F2F		Online	
Strongly Disagree	1	43	4%	13	4%
Disagree	2	79	7%	46	13%
Neither	3	258	24%	63	18%
Agree	4	461	43%	195	55%
Strongly Agree	5	235	22%	35	10%
Mean		3.71		3.55	
Total		1074		352	

Online participants were significantly more likely to think ASB was a problem in their area than F2F participants (M=3.23 and M=2.86 respectively)

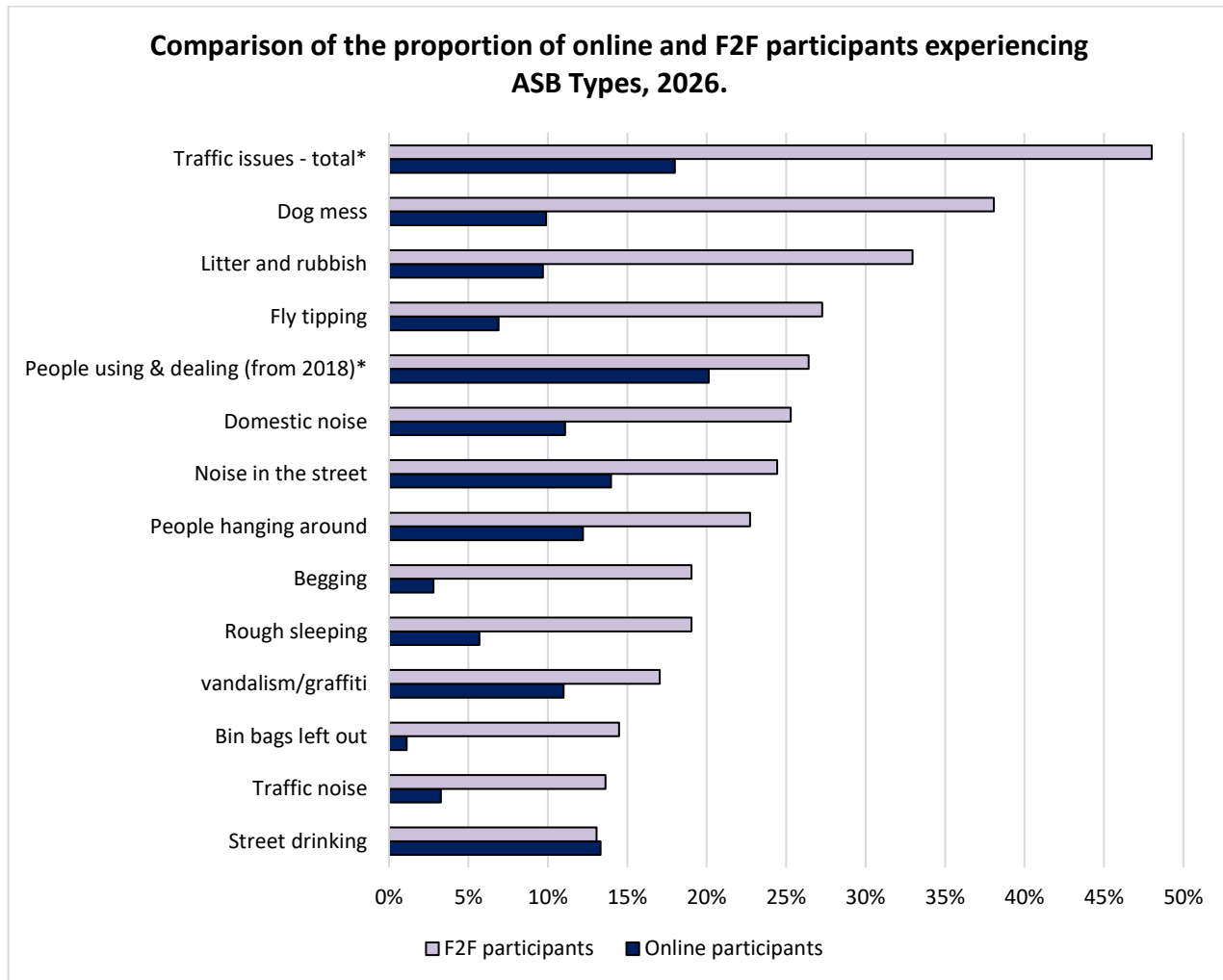
ASB is a Problem		F2F		Online	
Strongly Disagree	1	207	19%	18	5%
Disagree	2	269	25%	86	24%
Neither	3	254	24%	100	28%
Agree	4	161	15%	93	26%
Strongly Agree	5	185	17%	55	16%
Mean		2.86		3.23	
Total		1074		352	

Personal experience of ASB

Online participants were significantly less likely to report experiencing ASB than F2F (58% compared with 77%), however, when they did, they reported experiencing over three times as many ASB types.

Experience of ASB	F2F		Online	
People experiencing ASB	829	77%	205	58%
Total reports of of ASB types	2109		1920	
Av. number of ASB types (for those experiencing ASB)	2.54		9.37	

This supports the hypothesis that if people are shown a list, they are more likely to report more ASB types. It is consistent with what we know about the subjective nature of ASB and means that the two data sets are not telling us the quite the same thing. The F2F sample collected data about the issues which have the most impact on Portsmouth residents, whilst the online sample collected data about the most common ASB issues that are seen by Portsmouth residents.



Most commonly reported (top 5 for both online and F2F)	F2F		Online	
	(n)	(%)	(n)	(%)
Fly tipping	37	50%	42	45%
People dealing drugs	36	33%	27	43%
Noise from Licensed premises	2	5%	5	42%
Bullying / intimidating behaviour	32	26%	12	40%
Commercial noise	2	22%	6	33%
Neighbour disputes	22	50%	5	19%
Domestic noise	41	35%	24	28%
Vandalism/graffiti	45	39%	9	15%

Both online and F2F participants were more likely to report fly tipping and people dealing drugs than most other types of ASB. However Online participants also were more likely to report noise from licensed premises, bullying/intimidating behaviours and commercial noise.

Fear of crime

Slightly more online participants worried about being the victim of a crime (50%) compared with F2F participants (45%) but this difference was not statistically significant. However, **more online participants reported that they didn't know** (15% compared with fewer than n5 F2F) and this meant **fewer reported not being worried** (36% compared with 55% of F2F participants).

Fear of crime	F2F		Online		Comparison of % pp
	n	%	n	%	
I am not worried	589	55.0%	122	36.0%	-19.0%
Worried	484	45%	169	49.6%	4.6%
Number of crimes people are worried about	944		1166		
Av number of crimes for those who are worried	1.95		6.9		

Where participants reported being concerned about being the victim of a crime, online respondents reported being fearful of more crimes (on average 7 crimes per person) than those responding face-to-face (2 on average). Similarly to the ASB question, this is likely to be impacted by the online participants seeing a list of possible crimes and are selecting all those that apply rather than the ones they are most worried about. However, the crimes people were most worried about were similar for both samples: being mugged/robbed, being burgled and being assaulted.

Victimisation

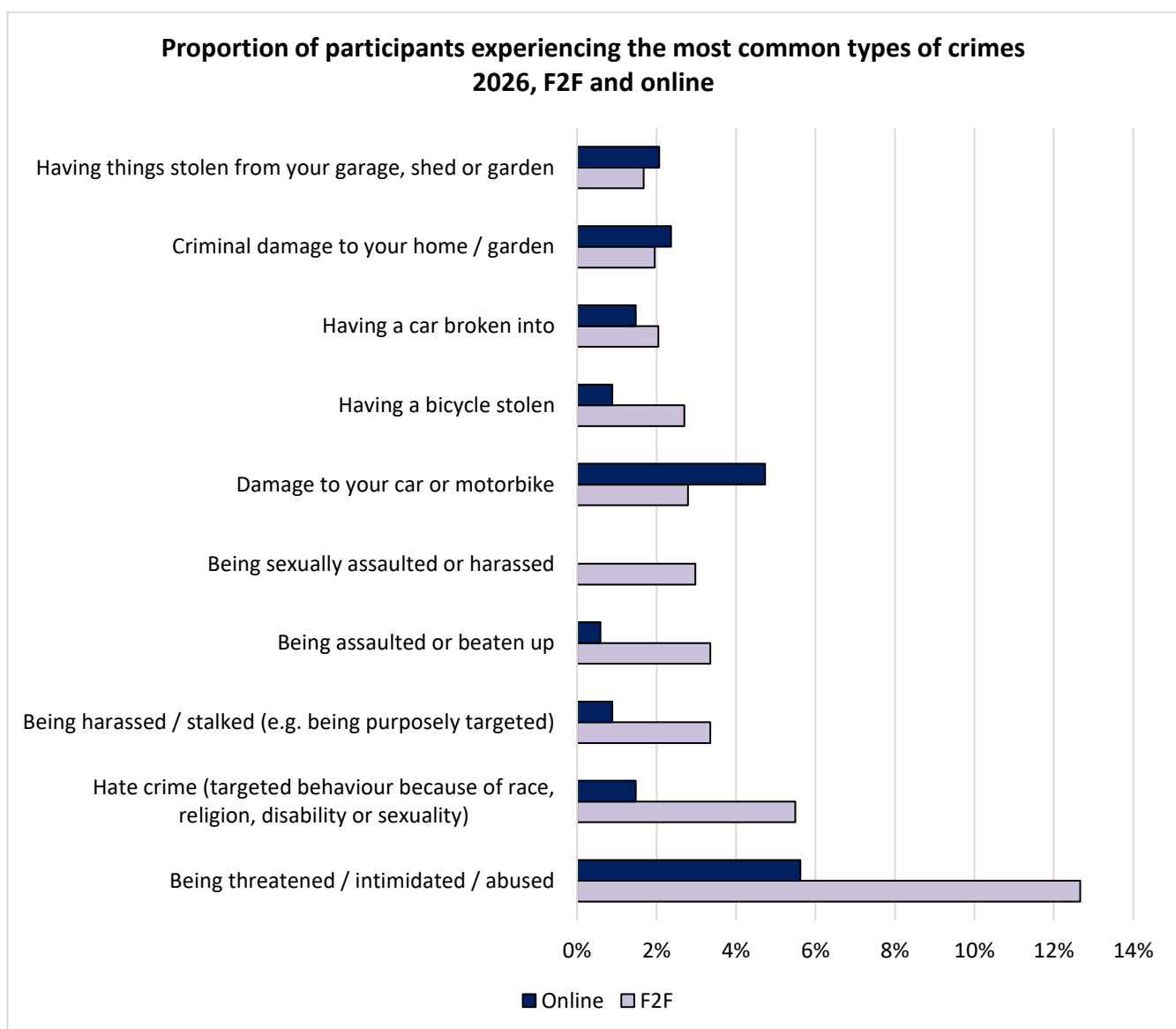
Online participants were significantly less likely to report being the victim of a crime (21% online compared with 32% F2F).

	F2F		Online		Comparison of % pp
	(n)	(%)	(n)	(%)	
Crime types experienced					
None	733	68.2%	249	78.1%	9.8%
Experienced at least one crime	340	31.7%	70	20.7%	-11.0%
How many crime types reported	528		102		
Average number of crime types per victim	1.55		1.46		

While fewer people in the online sample reported that they were victims of crime online than the F2F sample, those who did **reported a similar average number of crime types**.

The most common crime type experienced by online and F2F participants was being threatened / intimidated / abused, although a smaller proportion of online participants reported being the victim of crime (5.6% compared to 12.7%). This is likely to be at least partially due to the larger proportion of older participants in the online sample.

However, the pattern of crimes reported varied substantially; while the other common crimes for F2F participants were hate crime, being assaulted and being harassed/stalked, while for online participants they were damage to car/motorbike, damage to home and garden and having things stolen from homes and gardens.

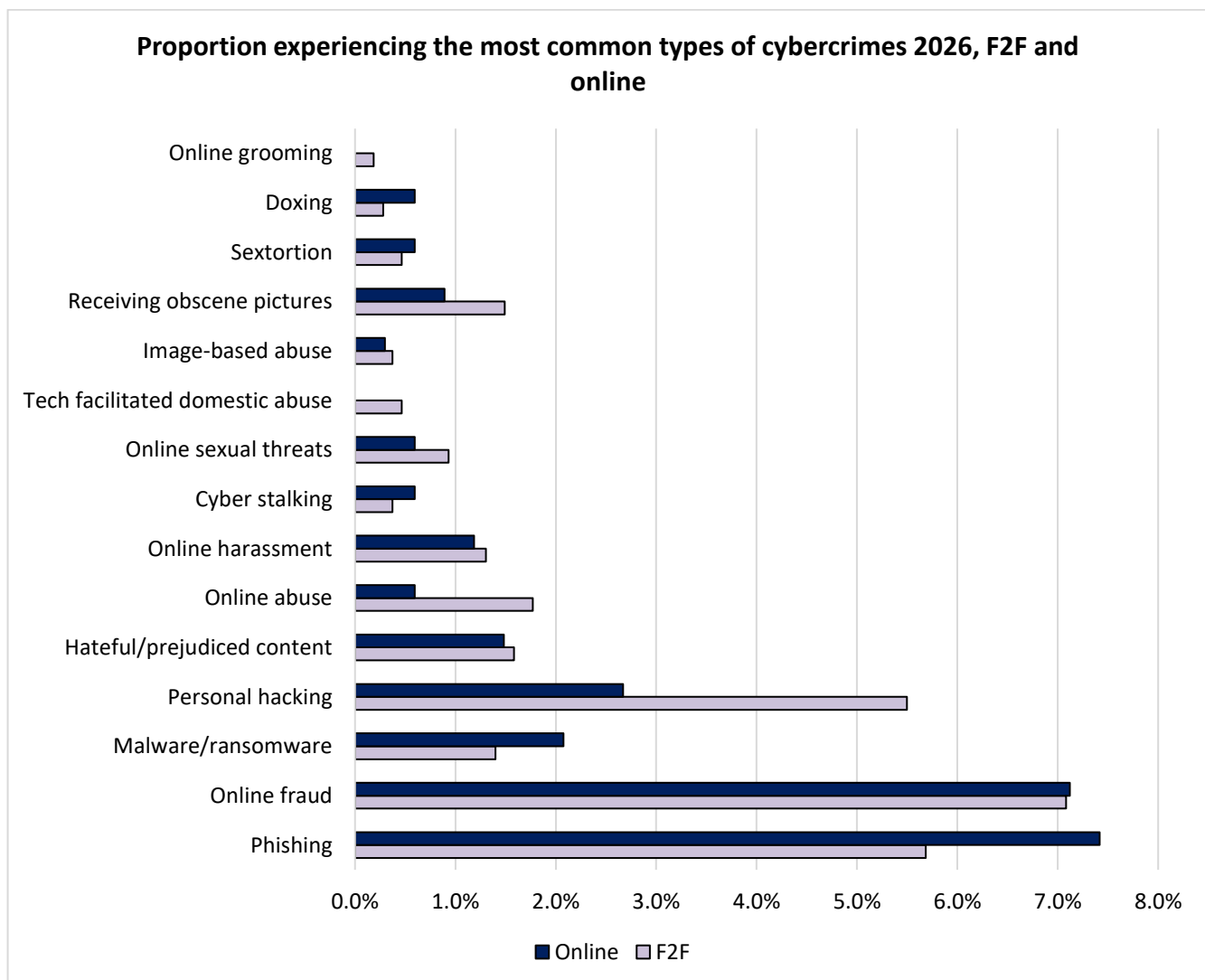


Cybercrime

There was a slightly, but not significantly, lower proportion of reported cybercrime from online sample (18% compared with 22%) and **both samples had very similar average numbers of crime types experienced** (online - 1.3 crime types and F2F - 1.5).

Cybercrime 2026	F2F		Online		Comparison of % pp
	(n)	(%)	(n)	(%)	
None	836	77.9%	254	75.37%	-2.54%
Reported being a victim of cybercrime	238	22.2%	57	16.91% ⁹⁵	-5.27%
How many crime types reported	310		88		
Average number of crime types per victim	1.3		1.5		

The most common types of crimes for both samples were online fraud, phishing and personal hacking.



⁹⁵ 7.7% of online participants answered 'don't know'

Reporting crimes

Fewer online participants reported the crimes that they had experienced (36% compared with 50% face-to-face). Almost half of those who did not report gave the reason that they did not think anything would be done if they did (47%, n=60).

If they did report crimes, similarly to face-to-face participants, they largely reported to the police or bank/credit card company. Cybercrime was largely reported to their bank/credit card company or to a social media platform.

Who were crimes reported to?	F2F				Online			
	ASB	Crime	Cyber	Total	ASB	Crime	Cyber	Total
Police	190	215	52	457	96	25		121
PCC	211	16	1	228	182	5		187
Bank / Card company		17	78	95		3	15	18
Social media (Facebook / instagram)			32	32			9	9
Landlord	26	3		29	8			8
Business / Company / Website		7	21	28	4	1	2	7
Local cllr	21			21	31			31
Social services / support worker	9	5	2	16				0
Colleagues / Employer / Manager	10	13		23				0
Email provider			9	9			2	2
School	6	1	1	8	1	1		2
Security/bouncers	6			6				0
Shop / business	6			6	1	1		2
Petition	4			4				0
University	3	1		4	1			1
Ambulance / GP / Other health	3			3				0
Insurance		3		3		1		1
Action fraud		1	2	3			4	4
Lawyer / solicitor		2	1	3				0
MP	2			2	1			1
Transport police	1			1				0
Government		1		1			2	2
CE OP (child online safety)			1	1				0
Fire service				0				0
Streetlink				0	1			1
Colas				0	9			9
VOI				0	3			3
Total	498	285	200	983	338	37	35	410

Knife crime

A slightly lower proportion of online participants thought **knife crime is a problem** than F2F (51% compared with 56%), but this was not statistically significant. However significantly **more reported that they didn't know** (39% compared with 18%) and **fewer thought it was not a problem** (11% compared with 27%).

	F2F		Online	
	(n)	(%)	(n)	(%)
Yes	597	56%	169	51%
No	283	26%	36	11%
Don't know	191	18%	129	39%
Blank	0	0%	0	0%
Total	1071	100%	334	100%

Fewer online participants reported seeing people carry knives (7% compared with 11%) but this difference was not significant.

Where online participants reported seeing people carrying knives, they were more likely to report seeing under 18s than the F2F participants (40% compared with 31%) and fewer over 25s (24% compared with 34%).

	F2F		Online	
	(n)	(%)	(n)	(%)
Yes	122	11%	25	7%
No	943	88%	271	81%
Don't know	7	1%	38	11%
Blank	1	0%	0	0%
Total	1073	100%	334	100%

	F2F		Online	
	(n)	(%)	(n)	(%)
17 or under	37	31%	10	40%
18-24	40	33%	8	32%
25+	41	34%	6	24%
18+	81	68%	14	56%
Both	0	0%	0	0%
Not sure	2	2%	1	4%
Blank		0%		0%
Total		0%	25	100%

There were similar proportions of witnessing and experiencing knife crime by both samples.

	F2F		Online	
	(n)	(%)	(n)	(%)
No	905	96%	321	96%
Experienced	8	0.8%	1	0.3%
Witnessed	31	3.3%	12	3.6%
Blank	1	0.1%		
Total		0%		0.0%

Areas people avoid or feel unsafe

A significantly larger proportion of online participants said there were areas that they found unsafe or avoided (68% compared with 53%).⁹⁶

	F2F		Online	
	(n)	(%)	(n)	(%)
Yes	569	53%	228	65%
No	504	47%	106	30%
Don't know		0%		0%
Blank		0%	18	5%
Total	1073	100%	352	100%

The areas that people said they felt unsafe or avoided were similar; the top ranked areas were the same for both: City Centre, Somerstown and Buckland. The online participants were more likely to feel unsafe in Southsea and less unsafe in Northend than the F2F participants.

Area	F2F	Area	Online
City Centre / Commercial Rd	15.2%	City Centre / Commercial Rd	29.0%
Somerstown	14.8%	Somerstown	17.9%
Buckland	9.7%	Buckland	13.4%
Fratton	7.0%	Southsea	11.1%
Northend	4.9%	Fratton	10.8%
Southsea	4.9%	Guildhall	7.1%
Guildhall	3.5%	Northend	4.3%
Paulsgrove	2.6%	Charles Dickens	3.7%
Landport	2.1%	Paulsgrove	2.8%
Portsea	1.3%	Landport	2.6%
Hilsea	0.9%	Cosham	2.0%
Stamshaw	1.1%	Portsea	1.7%
Milton	0.7%	Stamshaw	1.4%
Cosham	0.7%	Hilsea	1.1%

⁹⁶ Chi Sqr = 24.072, df = 1, p <0.001

Eastney	0.3%	Drayton	1.1%
Baffins	0.2%	Milton	0.3%
Charles Dickens	0.1%	Eastney	0.3%
Whole City	7.1%	Whole City	20.7%

The reasons given for feeling unsafe or avoiding the City Centre, Fratton and Southsea were similar for both the online and F2F participants:

- City Centre: visible presence of rough sleeping and related support needs, drug and alcohol-related issues and ASB, and gangs⁹⁷ or groups of people hanging around.
- Fratton: gangs or groups of people hanging around, individuals perceived as 'dodgy' and feelings of unease linked to unfamiliar people, including references to immigrants. No specific behaviours or incidents were described in relation to these perceptions.
- Southsea: alcohol and drug-related ASB.

However online participants cited different reasons to the F2F participants for why they felt unsafe in Somerstown, Buckland and Northend. Online participants were less likely to mention that these areas had a bad reputation or describe the area as 'rough', a term used by respondents to express general feelings of unease rather than specific incidents or behaviours.

Somerstown	F2F		Online	
Why	2026 (n)	2026%	2026 (n)	2026%
Reputation	29	18%	6	10%
Rough area	16	10%	2	3%
Alcohol-related	11	7%	4	6%
Youth ASB	11	7%	3	5%
Crime levels	11	7%	6	10%
Gangs/groups	5	3%	11	17%
Drug-related ASB	7	4%	10	16%
Total responses	159		63	

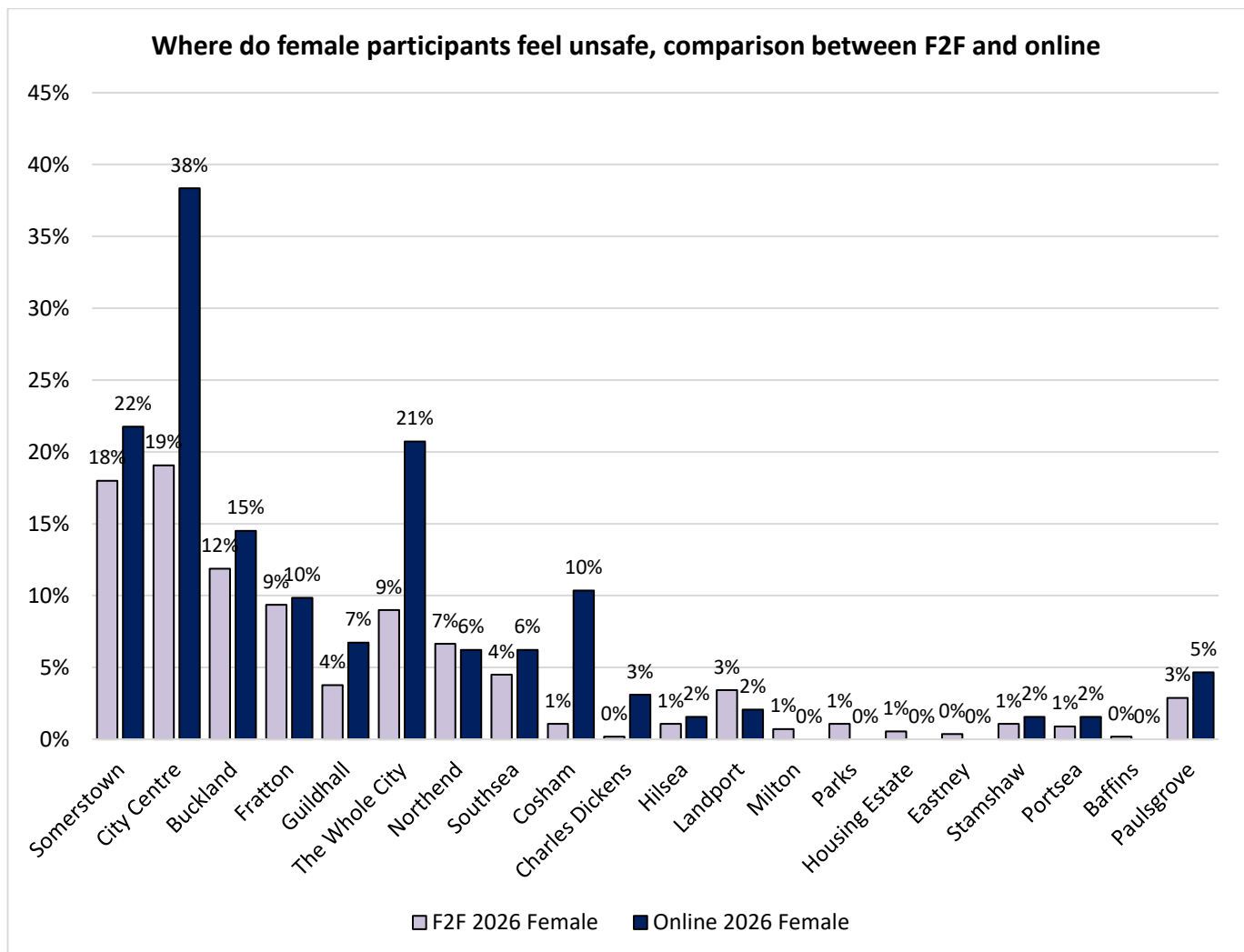
Buckland	F2F		Online	
Why	2026 (n)	2026%	2026 (n)	2026%
Reputation	18	17%	3	6%
Rough area	16	15%	2	4%
Youth ASB	14	13%	7	15%
Bad experience	11	11%	0	0%
Gangs/groups	9	9%	6	13%
Drug-related ASB	8	8%	5	11%
Total responses	104		47	

⁹⁷ Where participants referred to 'gangs' comments typically did not distinguish between organised criminal gangs and informal groups of people hanging around.

Northend	F2F		Online	
Why	2026 (n)	2026%	2026 (n)	2026%
Reputation	10	19%	0	0%
Dodgy people	7	13%	1	7%
Alcohol-related	6	11%	2	13%
Gangs/groups	5	9%	2	13%
Total responses	53		15	

Where do women feel unsafe?

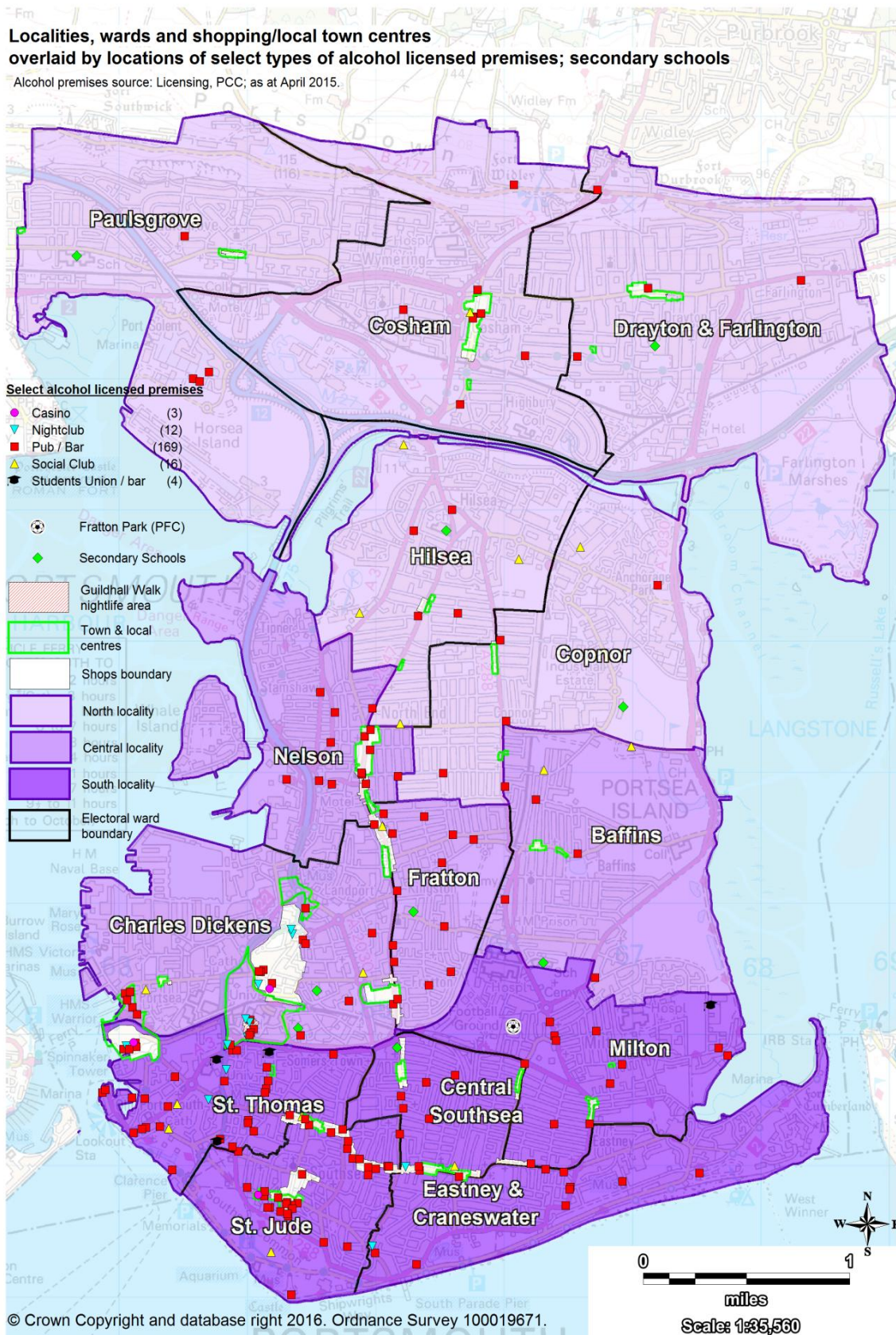
Women who participated online generally **reported feeling unsafe and avoiding the same areas** as those who completed the survey in person, **although the proportion feeling unsafe in the city centre** (38% compared with 19%), Cosham (10% and 1%) and Portsmouth overall (21% and 9%) **was higher**.



Appendix 5: Participants by ethnicity.

Ethnicity	Survey		Census 2021	Difference
White British	840	78.5%	77.7%	0.8%
White Irish	5	0.5%	0.5%	0.0%
White Gypsy or Irish Traveller	3	0.3%	0.6%	-0.3%
Any other White background	42	3.9%	6.8%	-2.9%
White and Black Caribbean	6	0.6%	0.6%	0.0%
White and Black African	4	0.4%	0.6%	-0.2%
White and Asian	6	0.6%	0.8%	-0.2%
Any other multiple ethnic group	4	0.4%	0.7%	-0.4%
Asian or Asian British Indian	29	2.7%	1.5%	1.2%
Asian or Asian British Pakistani	9	0.8%	0.3%	0.6%
Asian or Asian British Bangladeshi	17	1.6%	2.3%	-0.7%
Asian or Asian British Chinese	10	0.9%	1.0%	-0.1%
Any other Asian background	16	1.5%	1.8%	-0.3%
Black or Black British African	51	4.8%	2.6%	2.2%
Black or Black British Caribbean	9	0.8%	0.5%	0.4%
Any other Black background	3	0.3%	0.1%	0.1%
Other ethnic group Arab	8	0.7%	0.5%	0.3%
Any other ethnic group	7	0.7%	1.3%	-0.7%
Total ethnic minorities	229	21.4%	22.4%	-1%
Total	1076			

Appendix 6: ward map



Appendix 7: Areas where residents felt unsafe or avoided

Rank	2004	2007	2009	2012	2014	2016	2018	2020	2022	2024	2026
1	Somerstown	Somerstown	Somerstown	Somerstown	Somerstown	Somerstown	Somerstown	Somerstown	Somerstown	Commercial Rd	Commercial Rd
2	Buckland	Buckland	Buckland	Fratton	Buckland	Buckland	Buckland	Buckland	Buckland	Somerstown	Somerstown
3	Paulsgrove	Paulsgrove	Paulsgrove	Buckland	Guildhall	Fratton	Commercial Rd	Fratton	Commercial Rd	Buckland	Buckland
4	Portsea	Guildhall	Guildhall	Guildhall	Fratton	Commercial Rd	Fratton	Commercial Rd	Fratton	Southsea	Fratton
5	Landport	Portsea	Landport	Paulsgrove	Paulsgrove	Southsea	Guildhall	Guildhall	Southsea	Fratton	Northend (5)
6	Guildhall	Landport	Portsea	Portsea	Portsea	Guildhall	Southsea	Southsea	Guildhall	Guildhall	Southsea (5)
7	Southsea	Commercial Rd	Southsea	Landport	Landport	Paulsgrove	Paulsgrove	Northend	Northend	Paulsgrove	Guildhall
8	Commercial Rd	Fratton	Fratton		Southsea	Portsea	Portsea	Portsea	Paulsgrove	Northend	Paulsgrove
9	Fratton	Southsea	Commercial Rd		Commercial Rd	Northend	Northend	Paulsgrove	Portsea	Landport	Landport
10	Cosham	Cosham	Stamshaw		Northend	Landport	Landport	Landport	Landport	Portsea	Portsea

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Agenda Item 11



Title of meeting:	Health & Wellbeing Board
Date of meeting:	23 September 2026
Subject:	Approval of the Portsmouth Neighbourhood Health Strategic Plan 2026–2029
Report by:	Helen Atkinson, Director of Public Health and Chair of Health and Care Portsmouth Andy Biddle, Director of Adult Social Care and Chair of Portsmouth Provider Partnership Bernie Allen, Partnerships Director, Portsmouth, NHS Hampshire and Isle of Wight and Programme Lead for the National Neighbourhood Health Integration Programme
Cabinet Member:	Councillor Matthew Winnington, Cabinet Member for Community Wellbeing, Health and Care
Wards affected:	All
Key decision:	No
Full Council decision:	No

1. Purpose of report

- 1.1 To present the Portsmouth Neighbourhood Health Strategic Plan 2026–2029 and seek Health and Wellbeing Board approval of the strategic framework for neighbourhood health across Portsmouth.
- 1.2 The Plan brings together the proposed neighbourhood geographies, population health and community evidence, strategic priorities, delivery approach, governance arrangements and phased implementation to March 2029.

2. Recommendations

- 2.1 The Board is asked to:
- 2.2 **Approve** the Portsmouth Neighbourhood Health Strategic Plan 2026–2029, attached at Appendix 1, including:
 - the seven Neighbourhood Health Areas set out within the Plan as the common population geographies for neighbourhood health planning in Portsmouth
 - the initial priorities identified for each of the Neighbourhood Health Areas.



- 2.4 **Agree** the proposed approach to neighbourhood delivery, comprising the neighbourhood organising function, community connection layer and delivery through existing provider and professional arrangements.
- 2.4 **Confirm** that implementation will continue through existing Portsmouth partnership and statutory governance, with Health and Care Portsmouth providing Place leadership and oversight and P3 coordinating neighbourhood delivery, while individual organisations retain their statutory and formal decision-making responsibilities.
- 3. Background**
- 3.1 The Health and Wellbeing Board has received regular updates on the development of Portsmouth's approach to neighbourhood health. In June 2026, the Board noted progress and agreed that the final neighbourhood geographies, locally defined outcomes and measures, and draft neighbourhood health plan would return for consideration in September.
- 3.2 Since that meeting, partners have completed the principal evidence and development work required to bring forward the strategic plan. This has included finalising the proposed seven neighbourhood geographies; completing neighbourhood population health profiles; incorporating resident and community insight; developing the delivery and governance framework; and setting out the phased approach to implementation.
- 3.3 The Strategic Plan has been considered and endorsed by the Health and Care Portsmouth Partnership Board and is now presented to the Health and Wellbeing Board for formal approval.
- 4. The proposed Strategic Plan**
- 4.1 The Plan covers the period to March 2029 and sits beneath the Portsmouth Health and Wellbeing Strategy 2022–2030. It does not create a parallel strategy or transfer the statutory responsibilities of individual organisations. Its purpose is to provide a common population, priority and delivery framework around which partners can increasingly align their contribution.
- 4.2 The Plan proposes seven Neighbourhood Health Areas as the common population basis for understanding need, inequalities, outcomes, service use and community assets. The neighbourhoods are organising geographies rather than rigid service boundaries, recognising that residents, communities and services routinely operate across them.
- 4.3 As shown in table 1, Population health analysis confirms substantial variation between neighbourhoods. Some areas experience markedly greater deprivation, poorer health outcomes and higher use of urgent and emergency care, while others have comparatively positive current outcomes but different future challenges, including population ageing or specific prevention needs. This



supports a common citywide framework with priorities and interventions differentiated according to local need.

Table 1: Population health analysis as at September 2026

Neighbourhood	Population	Life expectancy M/F(years)	Premature mortality (per 100,000)	Preventable mortality (per 100,000)	All-cause emergency admissions (per 100,000)	Living with 5+ LTC	Poor self-reported health
Paulsgrove and Cosham	21k	77.9 / 81.4	417.2	211.2	14,152	3.2%	7.5%
Drayton & Farlington	23k	80.8 / 85.5	246.0	103.8	9,631	1.8%	3.8%
North Island	40k	79.4 / 83.4	344.9	154.9	11,876	2.4%	5.3%
Central	35k	74.5 / 80.0	581.2	316.4	15,368	3.7%	8.7%
Portsea and Somerstown	22k	72.4 / 78.2	693.4	347.2	17,351	3.9%	10.7%
South East	35k	78.9 / 84.3	329.7	166.5	10,910	2.2%	5.0%
South Coast	39k	78.9 / 82.2	362.2	159.4	10,327	1.8%	5.1%

- 4.4 Community engagement reinforces that health is shaped by wider social, economic and environmental factors as well as formal health and care services. Residents emphasise the need for all partners to be improving practical access, transport, community safety, local environments, social connection, affordability and trusted local support. The evidence supports neighbourhood approaches that connect existing community assets and professional services rather than creating an additional parallel service layer.

5. Priorities and delivery

- 5.1 The Plan confirms three overarching citywide priorities to be tackled at a neighbourhood level:
1. improving healthy life expectancy and reducing inequalities;
 2. supporting independence and reducing avoidable deterioration; and
 3. improving access to coordinated health, care and community support.
- 5.2 These priorities will be applied differently across the seven neighbourhoods according to population need and resident insight. The intention is therefore not to provide an identical neighbourhood offer across Portsmouth, but to pursue common outcomes through locally appropriate priorities and action. Table 2 summarises the initial priorities by neighbourhood.

Table 2: Initial Neighbourhood Health Priorities as at September 2026

Neighbourhood	Initial Neighbourhood Priority
Paulsgrove and Cosham	Consistent, trusted local access to prevention and coordinated support, particularly for children, families and people with long-term conditions, with fewer hand-offs and better transport, sensory and navigation support.
Drayton & Farlington	Helping an older population stay healthy and independent through accessible local support, with shorter journeys, strong primary care links, transport and community connection.

Neighbourhood	Initial Neighbourhood Priority
North Island	Healthy ageing and targeted prevention in communities where poorer outcomes are hidden by neighbourhood averages, supported by accessible services and strong community connections.
Central	Earlier, easier-to-access prevention and long-term condition support, tackling practical barriers such as transport, affordability, safety and navigation that contribute to poorer outcomes and avoidable deterioration.
Portsea and Somerstown	Accessible prevention and early intervention for long-term conditions through trusted community routes, with better coordination and practical support around transport, digital access and wider social needs.
South East	Healthy ageing with targeted prevention for alcohol-related risk and asthma, supported by accessible local services and community-based prevention.
South Coast	Targeted prevention around alcohol and mental wellbeing, connected to accessible community support and action on safety, affordability and housing-related pressures.

5.3 Delivery will be organised through three connected elements:

- a neighbourhood organising function, providing the capability to turn priorities into coordinated action;
- a community connection layer, strengthening access, navigation and links between residents, communities and services; and
- provider and professional delivery through the existing organisations, services and teams responsible for health, care and wider support.

6. Governance and implementation

6.1 The proposed approach uses existing Portsmouth governance:

- The Health and Wellbeing Board provides strategic accountability;
- Health and Care Portsmouth provides Place partnership leadership and oversight; and
- P3 coordinates neighbourhood delivery and the organising function.
- Existing organisations retain their statutory, financial, commissioning, professional and operational accountabilities.

6.2 Implementation will be phased:

- The remainder of 2026/27 will focus on mobilising governance and delivery, developing the organising capability and establishing initial outcome baselines.
- During 2027/28 partners will extend delivery where evidence supports it and strengthen neighbourhood-informed commissioning, service planning and resource alignment.
- By 2028/29 the focus will be on embedding the approach and demonstrating impact.

6.3 The Plan is deliberately strategic. Detailed service models, workforce, commissioning, contractual and resource arrangements will continue to be developed through implementation and will be subject to the relevant organisational governance and impact assessment where material changes are proposed.

7. Reasons for recommendations

7.1 The proposed approach is recommended because it:



- provides the single strategic framework for neighbourhood health in Portsmouth;
- is grounded in population health evidence, the JSNA and resident insight;
- establishes common geographies while allowing delivery to reflect local need;
- strengthens the focus on prevention, inequalities and earlier intervention;
- uses existing partnership and statutory governance rather than creating additional structures; and
- provides a phased route from strategic priorities to measurable delivery.

8. Integrated impact assessment

- 8.1 A detailed Integrated Impact Assessment (IIA) has been undertaken alongside the NHS HIOW Equality Impact Assessment and both are attached at Appendix 2
- 8.2 Both assessments identify the potential for positive impact through stronger use of population intelligence, greater focus on inequalities, improved accessibility and coordination, and proportionate targeting of support according to need.
- 8.3 The Plan includes safeguards relating to accessibility and reasonable adjustments, language and communication, non-digital access, transport and practical accessibility, culturally appropriate and trusted routes, targeted outreach and continuity of support.
- 8.4 The Strategic Plan does not itself make material changes to service eligibility, locations, workforce or individual commissioning arrangements. Where subsequent implementation proposals result in such changes, further equality and other relevant impact assessment will be undertaken through the governance of the organisation responsible.

9. Legal implications

- 9.1 The statutory responsibilities of the Health and Wellbeing Board and individual partner organisations are unchanged by the Strategic Plan.
- 9.2 The Plan provides a partnership framework for neighbourhood health and does not transfer statutory functions, commissioning responsibilities or formal accountability between organisations.

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Signed by:



Appendices:

Appendix 1: Portsmouth Neighbourhood Health Strategic Plan 2026 to 2029 (contains 8 appendices including Combined findings from Drayton, Cosham and Paulsgrove; Drayton / PASCO neighbourhood health consultation; Cosham / Community Kettle; Paulsgrove / St Michael's Church)

Appendix 2: Integrated Impact Assessment (IIA) & Equality Impact Assessment

Appendix 3: Portsmouth Neighbourhood Health Strategic Plan 2026 to 2029 (Powerpoint presentation for meeting on 23 September 2026)

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
<i>Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies</i> , Department of Health, March 2013. <i>Portsmouth Health and Wellbeing Strategy 2022-2030</i> January 2022 <i>Health and Wellbeing Boards – Guidance</i> , Department of Health and Social Care, November 2022. <i>Fit for the Future: 10-Year Health Plan for England</i> (accessible GOV.UK version), DHSC / NHS England. <i>Planning Framework for the NHS in England</i> , NHS England, September 2025. <i>Medium-Term Planning Framework – Delivering Change Together 2026/27 to 2028/29</i> , NHS England. <i>Strategic Commissioning Framework</i> , NHS England, November 2025. <i>Arrangements for Delegation and Joint Exercise of Statutory Functions</i> , NHS England, November 2025. <i>Neighbourhood Health Guidelines 2025/26</i> , NHS England, 26 January 2025. <i>NHS Social Value Playbook</i> , NHS England, July 2025. <i>Better Care Fund framework 2026 to 2027</i> , February 2026 <i>Neighbourhood health framework</i> , March 2026 <i>Fit for the future: towards population health delivery models</i> , March 2026 <i>1 April 2026 next steps on planning and priorities for 2026/27</i> , April 2026 <i>Neighbourhood health centre guidance for regions and integrated care boards</i> , April 2026	Published on NHSE and DHSC websites

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



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Signed by:

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Portsmouth Neighbourhood Health Strategic Plan 2026 to 2029

September 2026

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1. Foreword

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 they work and we know that they will make a measurable difference to their lives.

A short joint partnership foreword to be drafted and co- signed by HCP/HWBB leadership.

2. Executive summary

- 2.1 The Portsmouth Neighbourhood Health Strategic Plan 2026–2029 sets out the shared approach through which partners will develop neighbourhood health across the city. It sits beneath the Portsmouth Health and Wellbeing Strategy and provides a common framework for translating population need, inequalities and national neighbourhood health requirements into local priorities and coordinated action. The ambition is to enable people in Portsmouth to live healthier, safer and more independent lives, with support organised around people and communities rather than organisational boundaries.
- 2.2 Portsmouth faces significant and persistent health challenges. Healthy life expectancy remains low, inequalities between communities are substantial, the population is ageing and there are opportunities to identify need and intervene earlier. At the same time, health and care services are managing sustained demand. Portsmouth is not starting from an absence of services or partnership working; the challenge is that existing resources are not yet consistently organised around the same populations, priorities and outcomes. Neighbourhood health provides a way to strengthen prevention, reduce fragmentation and make better use of the collective resources already available across the city.
- 2.3 The Plan proposes neighbourhood geographies as the common population basis for understanding need, inequalities, outcomes, service use and community assets. These are not new organisations or rigid service boundaries. They provide a shared place-based framework while retaining flexibility for communities and population groups whose needs cross neighbourhood boundaries. Priorities will be informed by the JSNA, population health and service-use intelligence, professional knowledge, resident and community insight and existing community assets.
- 2.4 The initial citywide priorities are to improve healthy life expectancy and reduce health inequalities; support independence and reduce avoidable deterioration; and improve access to coordinated health, care and community support. Priority populations include people who may benefit particularly from prevention, earlier intervention or more coordinated support, while the balance of priorities will vary between neighbourhoods according to local evidence. The approach is explicitly all-age and inclusive, combining a universal neighbourhood offer with proportionate and targeted responses where people experience poorer outcomes, greater barriers to access or increased risk of deterioration.
- 2.5 Delivery will be organised through three connected elements:
 - a **neighbourhood organising function** to turn agreed priorities into coordinated action;

- a **community connection layer** to strengthen access, navigation and connections between residents, communities and services; and
 - **provider and professional delivery** through the existing organisations and services responsible for health, care and wider support.
- 2.6 The intention is not to create a new provider organisation or duplicate existing provision, but to align existing contributions more effectively around shared populations, priorities and outcomes.
- 2.6 Governance will operate through existing Portsmouth partnership and statutory arrangements:
- The **Health and Wellbeing Board** will provide strategic accountability;
 - **Health and Care Portsmouth** will provide Place partnership leadership and oversight; and
 - The **Portsmouth Provider Partnership** (P3) will coordinate neighbourhood delivery and the organising function.
- 2.7 Existing organisations will retain their statutory, financial, commissioning, professional and operational responsibilities.
- 2.8 Success will be assessed through population health and inequality outcomes, resident experience and relevant service measures.
- 2.9 Implementation will be phased to March 2029: mobilising governance and delivery in 2026/27; extending neighbourhood approaches and strengthening alignment of commissioning, services and resources in 2027/28; and embedding the model and demonstrating impact in 2028/29.

3. Purpose of the plan

- 3.1 The Portsmouth Neighbourhood Health Plan sets out the shared approach for developing neighbourhood health across the city. It provides the single place-based framework through which partners will translate national neighbourhood health requirements into local priorities and delivery arrangements, grounded in the needs and inequalities of Portsmouth's population. National policy expects locally owned neighbourhood health plans to confirm the geographies partners will work within, the organisations responsible for delivery and the governance and operational arrangements that will support implementation.
- 3.2 The plan is owned collectively through the Portsmouth Health and Wellbeing Board (HWB). Health and Care Portsmouth (HCP), working with the Portsmouth Provider Partnership (P3) and other established partnerships, has coordinated its development on behalf of the HWB under existing local arrangements. This reflects the HWB's role in setting the strategic direction for health and wellbeing in the city and HCP's role in translating that direction into integrated planning and delivery.
- 3.3 The plan covers the period September 2026 to March 2029, aligning with the longer-term reform period set out in the national Neighbourhood Health Framework. It builds on work already underway during 2026/27 to establish the foundations for delivery, including neighbourhood geographies, population profiles and priorities, community-based approaches and the development of neighbourhood delivery arrangements.

- 3.4 The plan sits beneath and supports delivery of the Portsmouth Health and Wellbeing Strategy 2022–2030. It does not replace that strategy or create a parallel set of health and wellbeing priorities. The Health and Wellbeing Strategy remains the primary strategic framework for improving health and wellbeing in Portsmouth, with its focus on the wider factors that shape health, including poverty, education, housing, positive relationships, active travel and air quality. The Neighbourhood Health Plan provides a more detailed framework for how partners will use neighbourhood approaches to contribute to those ambitions, improve health outcomes and reduce inequalities.
- 3.5 In particular, the plan:
- confirms the neighbourhood geographies that partners will use for neighbourhood health planning;
 - establishes how population health intelligence, the JSNA and local insight will be used to identify neighbourhood health priorities;
 - sets out the functions and partnership arrangements required to translate those priorities into delivery;
 - provides a common framework within which NHS, Local Authority, VCSE and provider plans can increasingly align; and
 - provides a basis for monitoring neighbourhood outcomes and adapting priorities as population need changes.
- 3.6 This reflects the national expectation that the neighbourhood health plan becomes the ‘single story’ at place, connecting national objectives, local population need and clear accountability for delivery.
- 3.7 The plan does not replace the statutory responsibilities, commissioning responsibilities or accountability of individual organisations. It does not prescribe that every service should be organised or delivered at neighbourhood level, nor does it seek to determine the detailed operating model, workforce or contractual arrangements for individual services. These will continue to be determined through the appropriate NHS, Local Authority and provider governance arrangements. Instead, the plan establishes the shared populations, priorities and delivery framework around which those arrangements should increasingly align.

4. Portsmouth’s ambition for neighbourhood health

- 4.1 Portsmouth’s approach to neighbourhood health builds on the vision and principles already established through Health and Care Portsmouth. The ambition remains for everyone in Portsmouth to be enabled to live healthy, safe and independent lives, with care and support integrated around the needs of the individual, at the right time and in the right setting. The existing approach also commits partners to doing things because they matter to local people, are supported by evidence and make a measurable difference to their lives.
- 4.2 Neighbourhood health provides a way of applying this ambition more consistently at a local level. Portsmouth’s ambition is to improve outcomes for residents by putting people at the centre of decisions and organising relevant and effective support around the needs of communities. This will build on existing partnerships, services,

networks and community assets, changing or adding to them where evidence shows that a different approach would better meet local need.

4.3 The approach recognises that neighbourhood health is wider than healthcare alone. Differences in health and wellbeing are influenced by wider social, economic and environmental factors, as well as access to and experience of services. Neighbourhood working therefore needs to connect health and care services across the NHS, social care, public health, wider local government, the voluntary and community sector and the assets and relationships that already exist within communities. It also needs to recognise that neighbourhoods are not simply administrative boundaries: natural communities, local infrastructure and the way people identify with place are important in determining how support should be organised.

4.4 The following principles will guide the development and delivery of neighbourhood health in Portsmouth:

- **Improving outcomes:** improving outcomes for Portsmouth residents will remain the starting point for neighbourhood working. Organisational structures, existing service models and professional boundaries should not determine the response where there is evidence that working differently would improve outcomes.
- **Reducing inequalities:** neighbourhood health will deliberately identify differences in need, access and outcomes within the city and target action where the potential to reduce inequality is greatest. This includes proactively identifying people and communities whose needs may not be met through existing routes, rather than relying solely on those who already access services.
- **Prevention and earlier intervention:** neighbourhood working will support a shift towards prevention, early identification and proactive support. Population segmentation and risk stratification will be used where appropriate to identify people at greater risk of deterioration and enable support to be provided earlier, while action on wider determinants and community resilience will support prevention across the whole population.
- **Residents and communities as partners:** individuals and communities will be treated as equal partners in creating health, rather than solely as recipients of services. Resident insight and co-production will help shape both the outcomes being pursued and the interventions used to achieve them, building on the strengths, relationships and assets already present within Portsmouth communities.
- **Integration around people and communities:** partners will organise around the needs of residents rather than requiring residents to navigate organisational boundaries. The aim is to strengthen connections between existing services, reduce unnecessary interactions and hand-offs, and make support easier to find and use. Integration does not require every service to operate at neighbourhood level; services should be provided as locally as is effective, with delivery at city or wider system level where this produces better outcomes.
- **Evidence-led decisions:** neighbourhood priorities will be informed by the JSNA, population health intelligence, service data, professional knowledge and qualitative insight from residents and communities. This will include identifying

unmet need and groups who may not currently be accessing services, rather than relying solely on existing patterns of service use.

- **Local accountability:** decisions about neighbourhood priorities and the use of resources should be transparent and locally accountable. Clear arrangements will be required for partners to understand who is responsible for delivery, what outcomes are expected and how progress will be assessed.
- **Best use of collective resources:** neighbourhood health should make better use of the resources Portsmouth already has. This may require activity, resource and risk to be aligned or shared differently across partners, formally or informally, supported by greater transparency and collective leadership. Financial constraint should reinforce the need to use collective resources effectively rather than prevent partners from organising them differently where this will improve outcomes.

- 4.5 These principles are intended to provide consistency across Portsmouth without requiring every neighbourhood or population group to have the same response. Different communities and cohorts will require different combinations of support, and the scale at which services are organised will vary. The common requirement is that decisions start with population need and the outcomes to be achieved, rather than with existing organisational arrangements.

5. The case for change

- 5.1 Portsmouth has significant and persistent health challenges. The latest ONS estimate puts the resident population at around 214,300. Although the overall population is not expected to grow substantially, its age profile will change: the number of residents aged 65 and over is projected to increase by around 18% between 2022 and 2032, with the number aged 80 and over increasing by around 26%. This will increase the number of people likely to be living with frailty, multiple long-term conditions and needs that span health, care and wider community support.
- 5.2 People in Portsmouth also spend a significant part of their lives in poorer health. In 2021–23, healthy life expectancy was estimated at 57.6 years for men and 58.2 years for women. Male life expectancy in 2023 was 78.1 years, significantly below the England average of 79.3 years. Premature mortality for Portsmouth men also remained significantly higher than England in 2023.
- 5.3 These outcomes are closely associated with inequalities in the conditions in which people live. The Index of Multiple Deprivation 2025 ranks Portsmouth as the 64th most deprived of 296 Local Authority areas in England, with 15 of the city's 125 Lower Super Output Areas falling within the most deprived 10% nationally. There are also marked inequalities in health within Portsmouth: in 2021–23, male life expectancy in the most deprived tenth of the city was 8.5 years shorter than in the least deprived tenth, with a corresponding gap of 6.0 years for women.
- 5.4 The causes of poorer health extend well beyond access to healthcare. Portsmouth's Health and Wellbeing Strategy identifies poverty, educational attainment, housing, positive relationships, and active travel and air quality as key underlying factors affecting health and wellbeing. The strategy deliberately focuses on these 'causes of the causes', recognising that improving population health requires action on the circumstances in which people live as well as effective health and care services. A

neighbourhood approach provides an opportunity to connect these wider determinants more directly with health, care and community responses around defined populations.

- 5.5 There remains significant scope to identify need earlier and prevent avoidable deterioration. In 2023/24, almost 30,000 patients were recorded on Portsmouth GP hypertension registers, while modelling suggests there could be approximately a further 13,400 residents aged 16 and over with undiagnosed hypertension. Uptake of some preventative interventions is also below national levels: 31.5% of eligible people offered an NHS Health Check received one over the five years to 2023/24 compared with 40.6% nationally, while cervical and bowel screening coverage remain below national rates.
- 5.6 Some of this unmet or escalating need is reflected in avoidable use of health services. For example, recorded COPD prevalence in Portsmouth was 2.7% in 2023/24 compared with 1.9% nationally, and the emergency admission rate for COPD has remained significantly higher than England. Around 450 emergency COPD admissions were recorded for Portsmouth-registered patients in 2022/23. This reinforces the potential value of identifying people at risk earlier and combining prevention, supported self-management, proactive care and timely specialist input before needs escalate.
- 5.7 Published indicators show that preventable deterioration extends beyond respiratory disease. In 2024/25, emergency readmissions within 30 days of discharge were 18.1% in Portsmouth compared with 14.7% nationally. Emergency hospital admissions for intentional self-harm were 177.1 per 100,000 in 2023/24 compared with 117.0 nationally, while alcohol-related admission episodes were also higher than England, at 558 compared with 504 per 100,000. These indicators reinforce the opportunity for earlier identification, prevention and coordinated support across physical and mental health needs.
- 5.8 At the same time, health and care services are managing sustained demand across primary care, community services, urgent and emergency care, hospitals, mental health and social care. A predominantly reactive model, in which organisations respond separately once need has reached the threshold for an individual service, will not on its own improve healthy life expectancy or reduce inequalities. The national direction towards neighbourhood health reflects the need to move care closer to home, strengthen prevention and organise services more proactively around defined populations. Primary care activity in Portsmouth continued to grow during 2025/26, averaging 5,295 appointments each day. A further 178,772 appointments were delivered compared with 2024/25, a 4% year-on-year increase, while 51% of appointments were for patients seen on the same or following day.
- 5.9 Portsmouth is not starting from an absence of services or partnership working. The city already has established primary care, community, acute, mental health, social care, public health and voluntary and community provision, alongside a long history of integrated working. The issue is that these resources are not yet consistently organised around the same populations, priorities or outcomes. Portsmouth's earlier work on integrated neighbourhood working identified the need to increase coordination, alignment and awareness between existing services, strengthen connections, reduce unnecessary interactions and hand-offs, and use resources more effectively across organisational boundaries.

- 5.10 Neighbourhood health therefore provides a means of addressing a combination of challenges: persistent inequalities, increasing complexity of need, opportunities for earlier intervention, sustained service pressure and fragmentation between different parts of the system. It enables partners to use a common understanding of defined populations, identify where different or earlier action is required and align their collective contribution around shared outcomes.
- 5.11 The case for neighbourhood health in Portsmouth is not that every neighbourhood requires a new set of services. It is that the city needs a more systematic way of understanding population need, identifying opportunities for prevention and earlier intervention, and bringing together the collective resources of partners around the people and populations they serve. More detailed analysis of how need varies across Portsmouth, and what residents and communities have told us, is set out in the following sections.

6. What residents and communities have told us

- 6.1 **‘Doing with’ our communities, not ‘doing to’:** Understanding our residents, their communities and what matters most to them is central to Portsmouth’s approach to neighbourhood health. Our approach is to ‘do with’ communities rather than ‘do to’ them, building on a significant body of existing resident and community insight rather than starting again.
- 6.2 In 2021, residents across the city took part in Imagine Portsmouth, a resident-led citywide vision and engagement initiative that set out long-term aspirations for Portsmouth to 2040. A central theme is a “healthy and happy city”, where people have the education, care and support needed for good physical and mental health. The work also provides important insight into what matters to Portsmouth communities: wellbeing, belonging, strong communities, good homes, partnership working and action on the wider determinants of health.
- 6.3 In 2023, two programmes of asset-based community development (ABCD) began in Paulsgrove and Portsea, providing a much deeper understanding of what matters to residents in those communities. Access to healthcare was important in both areas, alongside community spaces and activities, transport, access to food and shopping, opportunities to develop skills and volunteer, and digital inclusion. Residents and community organisations worked with partners to identify local priorities and develop locally owned action plans. This has led directly to practical changes, including community Help Desks, targeted wellbeing and prevention activity and, in Portsea, the reopening of John Pounds Medical Centre.
- 6.4 Further insight comes from the Healthwatch Portsmouth and University of Portsmouth Health Inequalities Research Project, published in 2024, which explored the experiences and unmet needs of residents living in some of Portsmouth’s more deprived communities. The study reinforced the importance of addressing the wider determinants of health, improving access to services and designing support around people’s lived experience. These findings complement the learning from Paulsgrove and Portsea and inform the development of this Neighbourhood Health Plan.
- 6.5 **Local identity and trusted relationships:** Residents identify strongly with the places where they live, the people they know and the relationships they trust.

Portsmouth has a strong sense of local identity, and different neighbourhoods have distinct identities of their own.

- 6.6 The ABCD work highlights the importance of familiar faces, local organisations and trusted community leaders. People value being known, welcomed and listened to, and often place as much importance on trusted relationships as on formal services. Residents want support that is local, approachable and joined up, without having to repeat their story across multiple organisations.
- 6.7 **Existing community strengths:** Engagement also challenges deficit-based assumptions about communities. Paulsgrove, Portsea and other Portsmouth neighbourhoods have significant strengths, including active residents, community groups, faith organisations, schools, voluntary organisations, local businesses and informal networks of support.
- 6.8 The ABCD approach demonstrates the value of building on these existing assets to strengthen community resilience, develop sustainable local responses and improve trust between residents and services. Portsmouth's neighbourhood model therefore works alongside communities, recognising and mobilising local strengths rather than focusing solely on need.
- 6.9 **Learning from engagement:** Residents consistently identify the wider determinants of health as being as important as healthcare itself. Cost of living, housing, transport, social isolation, employment opportunities, community safety and access to local facilities often feature more prominently than clinical services. In both Paulsgrove and Portsea, engagement shows that people are concerned not only with health and care services, but with the conditions that enable them to live healthy, independent and connected lives.
- 6.10 The consistent message is that people do not necessarily want more services. They want support that is easier to access, better coordinated, closer to home and shaped around the realities of their daily lives.
- 6.11 Residents have also told us that they are tired of being repeatedly consulted without seeing change. Portsmouth's Neighbourhood Health Plan therefore builds on existing insight rather than creating another generic engagement exercise. Existing learning informs neighbourhood priorities, neighbourhood footprints, community wellbeing hubs and service development.
- 6.12 **What residents have told us about neighbourhoods in 2026:** During 2026, HIVE Portsmouth, the Health Determinants Research Collaboration and Community Researchers undertook targeted engagement specifically to understand how Portsmouth residents define and experience their neighbourhoods. This tested the proposed approach against lived experience rather than assuming that administrative or service boundaries reflect how people see their communities.
- 6.13 The engagement involved over 1,000 residents across the whole of the city and explored where people say they live, the names and boundaries they associate with their neighbourhood, how far they are willing or able to travel, what they expect to access locally and what they value about the places in which they live.
- 6.14 The findings highlight five consistent themes:
- **Place and environment matter to health:** residents repeatedly identified transport, traffic and parking, cleanliness and the public realm, green space,

housing and environmental quality as factors affecting their health and wellbeing. Transport, traffic, parking and active travel were the most frequently identified theme in the community responses.

- **Access is about whether support can actually be used:** residents identified access to GPs, dentistry, pharmacy and mental health support alongside transport, mobility, opening times, affordability, information and digital exclusion. The relevant issue is therefore not simply whether a service or asset exists locally, but whether residents can realistically access and use it.
- **Community connection and local infrastructure are valued:** community centres and hubs, groups, clubs, activities, youth provision and opportunities for social connection were repeatedly identified as important to wellbeing, independence and reducing isolation.
- **Safety affects health and participation:** antisocial behaviour, crime, drugs and feeling unsafe were prominent concerns and affect whether residents feel able to walk, use local spaces and participate in community life.
- **Affordability shapes people's ability to benefit from what is available:** residents referred to the cost of activities, food, transport, housing, bills and heating, reinforcing the importance of considering practical and financial barriers alongside formal service provision.

- 6.15 These findings provide the community evidence used alongside population health intelligence and the JSNA to test the proposed neighbourhood footprints described in section 8.
- 6.16 Resident voice is therefore not an addition to neighbourhood health. It is part of how neighbourhoods are understood, how priorities are set, how support is designed and how success is measured.

7. What Portsmouth means by neighbourhood health

- 7.1 Neighbourhood health is an approach to organising health, care and wider support around the needs of defined populations and communities. It is intended to make it easier for partners to understand local need, identify opportunities for prevention and earlier intervention, and coordinate the contribution of different services and organisations around the outcomes that matter for residents. It is not, in itself, a new service, organisation or organisational tier.
- 7.2 For the purposes of this plan, a **neighbourhood** provides is a defined population within a geographical area around which partners can understand need, inequalities, outcomes, services and community assets. Geography provides an important common reference point, but it does not define every community or every population with which partners need to work. Portsmouth's existing approach has consistently recognised that natural communities, local infrastructure, transport and existing community assets are more important than imposing standardised boundaries solely for organisational convenience.
- 7.3 People may also identify with communities or population groups that extend across, or sit within, geographical neighbourhoods. These may reflect age, health need,

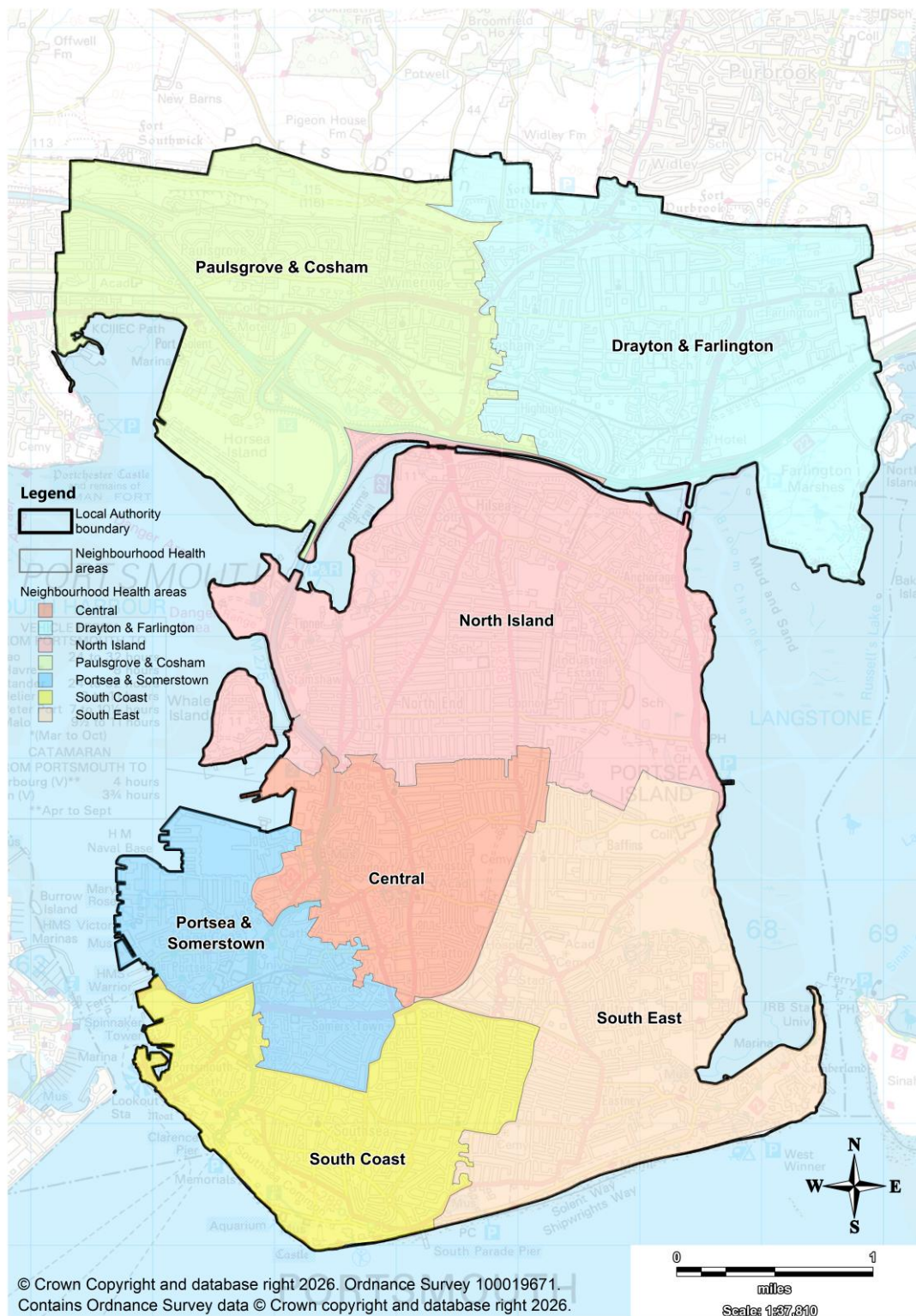
disability, culture, faith, shared experience or other characteristics. Similarly, population health analysis may identify particular cohorts whose needs require a coordinated response across more than one neighbourhood. Portsmouth will therefore use neighbourhood geography as an organising framework, while retaining the flexibility to identify and work with populations according to need. This is consistent with the existing Portsmouth principle that neighbourhood working should align with how people identify and should not be determined solely by geography or existing organisational structures.

- 7.4 **Neighbourhood health** describes what partners do with that shared understanding of population and place. It brings together population health intelligence, prevention, proactive care, health and social care services, and the contribution of communities and the voluntary and community sector. Different populations will require different responses: population segmentation and risk stratification may identify cohorts requiring more proactive or coordinated support, while other action may focus on the wider population, prevention or strengthening community capacity.
- 7.5 Portsmouth's neighbourhoods are also distinct from existing Primary Care Network (PCN) footprints. General practice and PCNs remain a core part of neighbourhood health delivery, organised around practices and their registered patient populations. The neighbourhoods described in this plan are place-based populations agreed through the wider Portsmouth partnership. The two need to work together and should be aligned wherever practical, but one does not replace the other. General practice and PCNs will work with wider neighbourhood services around shared priorities and outcomes, with contractual arrangements evolving in line with national policy.
- 7.6 Neighbourhoods are not organisational structures. NHS organisations, Portsmouth City Council, primary care, VCSE organisations and other partners retain their respective statutory, contractual and professional responsibilities. National policy is explicit that neighbourhoods do not need to become single organisations and that the focus should be on outcomes rather than organisational form. Services will continue to operate at different scales according to their purpose: some will be most appropriately organised around a neighbourhood, others across several neighbourhoods, across Portsmouth as a whole, or at Hampshire and Isle of Wight level.
- 7.7 The practical principle is that the response should organise around the needs of people and populations, rather than requiring people to organise themselves around services. Residents should not need to understand organisational boundaries in order to find the right support. Portsmouth's existing neighbourhood approach commits partners to designing services from the perspective of the person using them, reducing barriers to access and making services more seamless across organisational boundaries.
- 7.8 Neighbourhood health in Portsmouth is therefore both place-based and population-based: geography provides a common framework for understanding communities, inequalities, assets and accountability, while the response within and across those geographies is shaped by the needs of the people concerned. The aim is not to make every service fit the same boundary, but to create sufficient alignment around shared populations and outcomes for partners to work together more effectively.

8. Portsmouth's neighbourhood boundaries

- 8.1 Portsmouth has agreed seven Neighbourhood Health Areas as the common geographic basis for neighbourhood health planning. They are intended to represent meaningful local populations around which partners can understand need, inequalities, community assets and outcomes, and coordinate action.
- 8.2 The boundaries have been developed using the following principles:
- **Natural communities:** reflecting how people live, identify and connect, rather than organisational boundaries alone.
 - **A common geographic reference point:** giving partners a shared basis for understanding population need, inequalities, assets and outcomes.
 - **Locally meaningful scale:** generally working towards populations of around 50,000, while allowing smaller neighbourhoods where deprivation or poorer health outcomes support more targeted action.
 - **Flexible application:** recognising that some priorities will apply across a whole neighbourhood, while others may focus on particular communities or cohorts within or across neighbourhoods.
 - **Practical partnership working:** providing geographies that residents can recognise and within which NHS, local authority and VCSE partners can organise collectively while retaining their existing responsibilities.
 - **Consistent analytical geography:** neighbourhoods are mutually exclusive, sit wholly within the Portsmouth Health and Wellbeing Board area and are constructed from 2021 Census Lower Super Output Areas, enabling consistent population analysis, trend monitoring and comparison over time.
- 8.3 The seven neighbourhoods are shown below. Their size varies deliberately, reflecting differences in population density, deprivation, health outcomes and local community identity.

Figure 1: Neighbourhood boundaries



- 8.4 **Paulsgrove & Cosham Neighbourhood Health Area (NHA)** has a lower population density and an older population profile than Portsmouth overall, circa 21k. The area experiences significant deprivation, particularly affecting children and families. However, fuel poverty, overcrowding and air quality are better than the Portsmouth average.
- 8.5 Child poverty, Year 6 obesity prevalence, emergency hospital admissions among children aged under five years and admissions for self-harm among young people are all higher than across Portsmouth overall. Adult recorded prevalence of smoking, obesity, diabetes and multiple long-term conditions are also higher than the city average.
- 8.6 Emergency hospital admissions for all causes and COPD are significantly higher than the Portsmouth average. However, life expectancy and most mortality indicators remain broadly similar to Portsmouth overall despite the area's levels of deprivation and poorer behavioural risk factors.
- 8.7 Overall, Paulsgrove & Cosham NHA presents important opportunities for prevention and early intervention. Although many mortality indicators are similar to the Portsmouth average at NHA level, some communities within the area experience greater disadvantage and poorer outcomes, highlighting the importance of targeted neighbourhood health approaches.
- 8.8 The initial neighbourhood priority will be creating consistent, trusted local access to prevention and coordinated support, particularly for children, families and people with long-term conditions, with fewer hand-offs and enabling transport, sensory and navigation support.
- 8.9 **Drayton & Farlington Neighbourhood Health Area (NHA)** with headcount circa 23k, has a much older population than Portsmouth, including twice the city proportion aged 85 years and over. Its population is less densely concentrated and less ethnically diverse.
- 8.10 The NHA has a comparatively positive socioeconomic profile, with lower deprivation, child low income, unemployment, fuel poverty and overcrowding. The air quality indicator is slightly worse than Portsmouth.
- 8.11 Adult recorded prevalence of smoking, obesity and unhealthy alcohol use is lower than the city average. Recorded prevalence of COPD, diabetes, severe mental illness and 5+ long-term conditions is also lower. All-cause emergency admissions and several condition-specific admission rates compare favourably to the city average.
- 8.12 Life expectancy is higher for both males and females, while all-cause, premature, preventable, cancer and cardiovascular mortality are lower.
- 8.13 Overall, healthy ageing and maintaining independence are important considerations because of the area's older population, despite its comparatively positive current health profile.
- 8.14 The initial neighbourhood priority will be helping an older population stay healthy and independent through accessible local support, with shorter journeys, strong primary care links and community connection.

- 8.15 **North Island Neighbourhood Health Area (NHA)** with circa 40k people has higher proportions of children and older residents than Portsmouth overall. Population forecasts indicate particularly strong growth among people aged 65 and over and aged 85 and over.
- 8.16 Overall deprivation, child low income, unemployment, crime, fuel poverty and overcrowding compare favourably with Portsmouth. However, the Children and Young People deprivation sub-domain score and the air quality indicator are worse than the city average.
- 8.17 Adult recorded prevalence of smoking and obesity is similar to Portsmouth, while unhealthy alcohol use is lower. Most recorded long-term conditions are similar, and a lower proportion of residents report bad or very bad health. COPD emergency admissions and all-cause admissions among children aged under five are lower, while most other emergency admission measures are similar. Life expectancy and mortality are also broadly comparable with Portsmouth.
- 8.18 Overall, North Island NHA has a favourable socioeconomic profile and health outcomes that are broadly similar to Portsmouth. However, NHA-level averages may mask variation between communities, with evidence from some smaller neighbourhoods indicating poorer outcomes than are apparent from the overall profile.
- 8.19 Considering the NHA as a whole, population forecasts indicate substantial growth in older residents, highlighting the importance of healthy ageing and community support. Although child low-income measures compare favourably with Portsmouth, the Children and Young People deprivation sub-domain score is worse than the city average, indicating broader challenges affecting children and young people. The poorer air quality indicator also warrants further consideration.
- 8.20 The initial neighbourhood priority will focus on healthy ageing and targeted prevention in communities where poorer outcomes are hidden by neighbourhood averages, supported by accessible services and strong community connections.
- 8.21 **Central Neighbourhood Health Area (NHA)** is a young, diverse and densely populated urban area experiencing some of the highest levels of deprivation in Portsmouth with circa 35k people. Nearly half of residents live within the most deprived national decile, while child poverty, unemployment, crime, fuel poverty and overcrowding are all worse than the city average.
- 8.22 Adult recorded prevalence of smoking, obesity, asthma, COPD, diabetes and multiple long-term conditions are higher than the Portsmouth average, while self-reported poor health is also higher. Year 6 obesity prevalence is significantly higher than across the city.
- 8.23 Emergency hospital admissions are consistently higher than the Portsmouth average across a wide range of conditions. Life expectancy is lower than the city average, while mortality from all causes, premature mortality, preventable mortality, cardiovascular disease, respiratory disease and COPD are all significantly worse than across Portsmouth overall.
- 8.24 Overall, Central NHA combines very high levels of deprivation with poorer health outcomes and higher rates of emergency hospital admission, highlighting the

importance of prevention, early intervention and action on the wider determinants of health.

- 8.25 The initial neighbourhood priority will be earlier, easier-to-access prevention and long-term condition support, tackling practical barriers such as transport, affordability, safety and navigation that contribute to poorer outcomes and avoidable deterioration.
- 8.26 **Portsea & Somerstown Neighbourhood Health Area (NHA)** is a young, ethnically diverse and densely populated urban area of around 22k people, with a substantial student population and significant high-rise housing. The area experiences high levels of deprivation, including child poverty, income deprivation, employment deprivation and deprivation affecting older people.
- 8.27 Adult recorded prevalence of current smokers, obesity, diabetes, COPD, severe mental illness and five or more long-term conditions are all higher than the Portsmouth average. The proportion of residents reporting bad or very bad health is also higher than across the city.
- 8.28 Emergency hospital admissions for all causes and several specific conditions are significantly higher than the Portsmouth average. Life expectancy is lower than the city average, while mortality from all causes, premature mortality, preventable mortality, cardiovascular disease, cancer, COPD and alcohol-related causes are all worse than across Portsmouth overall.
- 8.29 Overall, Portsea & Somerstown NHA experiences poorer health outcomes and a greater burden of chronic disease than Portsmouth overall, making it an important focus for prevention, early intervention and neighbourhood health approaches.
- 8.30 The initial neighbourhood priority will be accessible prevention and early intervention for long-term conditions through trusted community routes, with better coordination and practical support around transport, digital access and wider social needs.
- 8.31 **South Coast Neighbourhood Health Area (NHA)** is a densely populated (roughly 39k people) and ethnically diverse part of Portsmouth with a substantial student population, many of whom live in shared accommodation. Its overall deprivation, income and employment profiles are more favourable, and fewer children live in low-income families. However, crime, fuel poverty and overcrowding compare less favourably than the city average.
- 8.32 Adult recorded prevalence of smoking and obesity is lower than Portsmouth, while adult recorded prevalence of unhealthy alcohol use is higher. Recorded prevalence indicators for several long-term conditions are lower, although adult recorded prevalence of severe mental illness is higher.
- 8.33 All-cause emergency hospital admissions, COPD admissions and emergency admissions following self-harm are lower than the Portsmouth average. Life expectancy and most mortality indicators are similar to the city, while COPD mortality is lower.
- 8.34 Overall, priorities include prevention relating to unhealthy alcohol use, appropriate support for severe mental illness, and action addressing fuel poverty, overcrowding and crime.

- 8.35 The initial neighbourhood priority is targeted prevention around alcohol and mental wellbeing, connected to accessible community support and action on safety, affordability and housing-related pressures.
- 8.36 **South East Neighbourhood Health Area (NHA)** has around 35k people and a higher proportion of older residents than Portsmouth overall, with further growth forecast among people aged 65 years and over and particularly those aged 85 years and over. The NHA is also home to St Mary's Community Health Campus.
- 8.37 The area has a comparatively positive socioeconomic profile. Overall deprivation, child poverty, unemployment, fuel poverty and overcrowding are lower than the Portsmouth average, while the Children and Young People deprivation sub-domain score and air quality indicator are also better.
- 8.38 Adult recorded prevalence of smoking and obesity is lower than across Portsmouth, although adult recorded prevalence of unhealthy alcohol use and recorded prevalence of asthma are higher. All-cause and COPD emergency hospital admission rates are lower, while most other admission indicators are similar. Female life expectancy is better than the Portsmouth average, all-cause and premature mortality are lower, and most cause-specific mortality measures are similar.
- 8.39 Overall, South East NHA has a comparatively positive socioeconomic and health profile. Adult recorded prevalence of unhealthy alcohol use is higher than the Portsmouth average and represents a potential area for prevention and health improvement activity. Recorded prevalence of asthma is also higher than the city average, while most other long-term condition indicators are similar to Portsmouth overall. These findings highlight the importance of supporting healthy ageing, prevention and community-based services.
- 8.40 The initial neighbourhood priority will focus on healthy ageing with targeted prevention for alcohol-related risk and asthma, supported by accessible local services and community-based prevention.

9. Understanding neighbourhood need and setting priorities

- 9.1 Neighbourhood priorities are based on a shared assessment of population need, inequality, service use and local insight. The aim is to identify where action is most likely to improve outcomes, reduce inequalities or prevent deterioration.
- 9.2 The assessment draws on six main sources of evidence:
- Population health intelligence and the JSNA, including demographic trends, health outcomes, long-term conditions, wider determinants and inequalities.
 - Neighbourhood-level data, to identify variation within Portsmouth that may be masked by citywide averages.
 - Resident insight, including experience of access, barriers, local priorities and what people value within their communities.
 - Professional and frontline knowledge, including intelligence from primary care, community services, social care, public health, acute and mental health services and the voluntary and community sector.

- Service-utilisation information, including patterns of access, activity, avoidable deterioration and use of urgent or higher-intensity services.
 - Community assets and existing provision, including services, organisations, networks and community capacity already available within or accessible to each neighbourhood.
- 9.3 These sources are considered together. No single dataset determines a neighbourhood priority. High service use may indicate significant need, but low use may also indicate poor access or unmet need. Equally, an identified health need does not automatically require a new service if existing resources can be better connected, targeted or organised.
- 9.4 Priority-setting gives particular weight to inequalities and unmet need. This includes identifying populations experiencing poorer outcomes, groups who face barriers to accessing support and needs that are not adequately reflected in existing service activity.
- 9.5 Population segmentation and risk stratification are used where appropriate to identify cohorts at greater risk of deterioration or where earlier intervention could improve outcomes. This supports a more proactive approach to prevention and care.
- 9.6 The resulting evidence is used to agree a small number of priorities for each neighbourhood and, where appropriate, priorities that apply across several neighbourhoods or the whole city. These priorities then inform the delivery response, rather than being constrained by existing organisational or service boundaries.
- 9.7 Neighbourhood priorities will be reviewed periodically as population need, service use and resident experience change. This allows priorities to be updated without repeatedly redesigning the overall neighbourhood framework.

10. Initial neighbourhood health priorities

- 10.1 The initial neighbourhood priorities reflect both the health needs shared across Portsmouth and the different needs of individual neighbourhood populations. They are not expected to be identical across the city.
- 10.2 **Citywide priorities:** The existing Portsmouth and NHS Hampshire and Isle of Wight strategies identify a number of priorities that apply across all neighbourhoods:
- improving healthy life expectancy and reducing health inequalities;
 - supporting independence and reducing avoidable deterioration; and
 - improving access to coordinated health, care and community support.
- 10.3 **Priority populations:** Existing neighbourhood and Place work also identifies populations where more proactive or coordinated support is likely to have particular benefit. These include:
- people living with frailty – to support healthy ageing, independence and reduce avoidable deterioration;
 - people at risk of or living with cardiovascular disease – to prevent ill health and reduce premature mortality;

- people with multiple long-term conditions – to improve health, self-management and coordination of care;
- people with complex health and social needs – to improve independence, wellbeing and experience of joined-up support;
- people who are housebound or living in care homes – to improve access to proactive and preventative support;
- people approaching the end of life – to support personalised care in the place that is right for them; and
- people with repeated or potentially avoidable use of urgent and emergency care – to identify unmet need earlier and reduce avoidable escalation.

10.4 **Neighbourhood priorities:** The balance between these priorities varies by neighbourhood. The Portsmouth evidence base shows that:

- levels and patterns of health need and inequality differ across the city, including variation in deprivation, long-term conditions, avoidable hospital use and premature mortality;
- population profiles differ, affecting the relative importance of issues affecting children and families, working-age adults and older people;
- residents consistently identify wider neighbourhood conditions as important to health and wellbeing, particularly transport and practical access, safety, cleanliness and the public realm, affordability, community connection and opportunities to participate locally;
- access depends on more than whether a service exists, with mobility, transport, cost, information, digital exclusion and the ability to navigate support all influencing whether people can use what is available; and
- community assets, relationships and local infrastructure vary between neighbourhoods, creating different opportunities to build on existing strengths and support.

10.5 Neighbourhood priorities are informed by the combined evidence from the JSNA neighbourhood profiles, population health intelligence, service-use and access information, resident and community insight, and existing services and community assets.

10.6 Each neighbourhood profile sets out the population or need requiring focus, the outcome sought and the principal local factors that need to change.

11. What residents should experience differently

11.1 Neighbourhood health should make a practical difference to the way Portsmouth residents experience health, care and wider support. The precise support available will vary according to individual need and neighbourhood priorities, but residents should increasingly experience:

- help earlier, with greater emphasis on prevention, identifying need before it escalates and supporting people to remain well;
- support that is easier to find and access, with barriers identified and addressed and without needing to understand organisational boundaries;

- better coordinated and more seamless care and support, with fewer unnecessary hand-offs and greater continuity where needs involve more than one organisation;
- appropriate support as locally as possible, through neighbourhood, community, primary care, home-based or digital routes where these are effective and accessible, while recognising that some specialist services will appropriately operate at a wider scale;
- support organised around the person and what matters to them, rather than around individual organisations, services or conditions;
- greater involvement in decisions about their own care and support, including greater confidence and capability to manage their health and wellbeing and maintain independence;
- better connection to the relationships, activities and community support that contribute to health and wellbeing, as well as access to formal services;
- more equitable access, experience and outcomes, with additional attention to people and communities experiencing poorer health, disadvantage or barriers to support; and
- a stronger voice in how neighbourhood health develops, with residents and communities involved in shaping priorities, services and improvement rather than being treated solely as recipients of support.

12. The neighbourhood health delivery framework

- 12.1 Portsmouth's neighbourhood health model is designed around a simple principle: residents should experience a coordinated response organised around their needs rather than a series of disconnected organisational interactions. This builds on the established Health and Care Portsmouth commitment to design services from the perspective of the person using them, remove barriers to access and make support as seamless as possible across organisational boundaries. The model brings together three connected elements:
- a **neighbourhood organising function**, providing the capability to turn agreed priorities into coordinated action;
 - a **community connection layer**, providing accessible routes into support and connection between residents, communities and services; and
 - **provider and professional delivery**, through the existing organisations, services and teams responsible for health, care and wider support.
- 12.2 **How the framework works:** Neighbourhood priorities are identified through the approach described in sections 9 and 10, drawing together population health intelligence, the JSNA, neighbourhood-level data, resident insight, professional knowledge, service use and community assets.
- 12.3 Once a priority has been agreed, the organising function brings together the partners, intelligence, existing services and community assets relevant to that population or issue and supports agreement on the appropriate response.
- 12.4 The response will depend on the nature of the priority. It may involve:
- direct delivery, where an organisation or service already holds responsibility and can act;

- better connection and coordination, where the main opportunity is to align existing services, pathways or community support more effectively; or
 - influence and escalation, where the principal policy or delivery lever sits elsewhere, for example within housing, transport, employment, community safety or another existing partnership.
- 12.5 Neighbourhood health does not transfer responsibility for these functions. Its role is to ensure that their impact on health and wellbeing is visible and that the appropriate partners are connected around the population concerned.
- 12.6 **Neighbourhood organising function:** Commonly referred to as an “*Integrator*”, the organising function provides the capability needed to translate strategic priorities into delivery. It does not replace statutory commissioners or providers and is not a new provider organisation. It provides the infrastructure through which partners can organise their collective contribution around agreed neighbourhood populations, priorities and outcomes.
- 12.7 This will be delivered through existing Health and Care Portsmouth arrangements and will be coordinated by the Portsmouth Provider Partnership (P3). Its core functions are to:
- bring together population health intelligence, neighbourhood insight, service-utilisation information and community intelligence;
 - support the identification and segmentation of priority populations and opportunities for prevention and earlier intervention;
 - convene the organisations and partners relevant to each agreed priority;
 - translate priorities into coordinated neighbourhood action;
 - identify opportunities to strengthen existing provision, reduce unnecessary interactions and hand-offs and improve pathways across organisational boundaries;
 - support partners to align existing activity, services, resources and investment around agreed priorities, with formal financial, commissioning or contractual decisions remaining subject to the governance of the responsible organisation;
 - support decisions about the appropriate scale of delivery, recognising that some responses will be neighbourhood-based while others will be delivered across several neighbourhoods, citywide or at Hampshire and Isle of Wight level;
 - identify barriers that cannot be resolved through neighbourhood delivery and escalate these through the organisation or partnership holding the relevant authority or delivery lever;
 - monitor agreed outcomes and benefits across organisational boundaries; and
 - use learning from delivery to support continuing improvement and future priority-setting.
- 12.8 The organising function therefore does not require a standing multidisciplinary team containing every partner for every neighbourhood priority. The combination of organisations, professionals and community partners involved will vary according to the population, outcome and intervention concerned.

- 12.9 **Community connection layer:** The community connection layer provides a trusted and accessible bridge between residents, communities and formal health and care services. Residents should not need to understand organisational structures, service boundaries or funding arrangements in order to find appropriate support. Its role extends beyond signposting. It has three connected functions:
- access and navigation – helping residents find, access and move between appropriate health, care and community support;
 - connection and activation – connecting people with the relationships, activities, community assets and opportunities that support health, wellbeing, independence and participation; and
 - community intelligence – identifying recurring barriers, unmet needs and changing community concerns and feeding these back into neighbourhood planning and improvement.

This reflects Portsmouth's existing emphasis on community assets, trusted relationships and working with residents as partners in creating health.

- 12.10 Portsmouth will build on the community infrastructure already in place, including Help Desks, Community Connectors, Community Champions, social prescribing and other trusted community roles. The citywide community connection offer will include:
- consistent face-to-face, telephone and digital routes into neighbourhood support, including neighbourhood Help Desks and drop-in access;
 - accessible non-digital routes for residents who cannot or do not wish to use digital channels;
 - improved alignment between Community Connectors, social prescribing, Community Champions and related functions;
 - navigation and follow-up where residents need additional help to access or move between support;
 - comprehensive and accessible information about health, care, VCSE services and community assets;
 - clear connections into primary care, social care, NHS and VCSE services; and
 - routine feedback of community intelligence into neighbourhood priority-setting, planning and improvement.
- 12.11 A consistent citywide offer does not mean identical provision in every neighbourhood. Consistency relates to the core functions and routes available to residents. The scale, location, intensity and combination of support will reflect population need, inequalities, accessibility, existing community assets and local circumstances.
- 12.12 The community connection layer will therefore combine universal, self-directed access with additional targeted outreach, navigation and support for populations experiencing poorer health outcomes, greater barriers to access or increased risk of deterioration.
- 12.13 It is not a new clinical service, a single mandatory front door or an additional referral or assessment tier. Nor does it replace Public Health, social care, primary care, NHS providers or VCSE provision. Its purpose is to connect these resources more effectively around residents.
- 12.14 **Provider and professional delivery:** Neighbourhood health will continue to be delivered through the existing organisations, services and professionals working with

Portsmouth residents. It does not create a separate provider model. The intention is to align existing provision more effectively around agreed neighbourhood populations, priorities and outcomes.

12.15 The contribution of partners includes:

- **Public Health** – population health intelligence, prevention, health improvement, reducing inequalities and action on the wider determinants of health.
- **Adult Social Care** – supporting independence, prevention, reablement, safeguarding and coordinated support for people with care and support needs.
- **Children's Services** – supporting children, young people and families through early help, safeguarding and links with education and wider family support.
- Other Local Authority services – contributing to the wider determinants of health, including housing, employment, community development and other services that influence people's health and wellbeing.
- **VCSE organisations and community partners** – contributing as delivery and co-design partners, providing community-based support, prevention, social connection, specialist provision, resident engagement and local knowledge.
- **Primary care** – providing generalist clinical care, continuity, prevention, population health management, case finding and clinical leadership within neighbourhood delivery.
- **Community health services** – providing proactive, specialist, urgent and ongoing care closer to home, including rehabilitation, frailty and support for people with complex needs.
- **Mental health services** – providing prevention, early intervention, community-based support, specialist care and integration with wider health, care and community provision.
- **Acute services** – contributing specialist expertise, identifying people who may benefit from earlier neighbourhood support, and strengthening admission avoidance, discharge, elective and other pathways across organisational boundaries.

12.16 Providers retain responsibility for the quality, safety, workforce and operational delivery of their services. Neighbourhood health strengthens the expectation that these contributions are coordinated around shared populations and outcomes, with clearer connections between services and fewer avoidable hand-offs.

12.17 Detailed service, clinical, professional and workforce models will continue to develop through the relevant commissioning and provider arrangements within this common neighbourhood framework.

13. Prevention, community capacity and resident activation

13.1 Prevention is a core function of neighbourhood health and applies across life course of our population and recognises inequalities within and across our communities. Portsmouth's approach combines action to prevent ill health, identify risk and disease earlier, prevent deterioration for people with existing conditions, and support people to remain healthy, independent and connected for as long as possible. This reflects existing HCP priorities on cardiovascular disease prevention, smoking cessation, drugs and alcohol, diet and physical activity, healthy ageing and the wider determinants of health, alongside the shift from treating ill-health to prevention.

13.2 Prevention within neighbourhoods includes:

- **primary prevention** – improving health and reducing the likelihood of disease through action on risk factors, healthy behaviours and the wider determinants of health;
 - **secondary prevention and early intervention** – identifying risk, unmet need and emerging illness earlier and acting before needs become more complex;
 - **proactive support** – identifying people at greater risk of deterioration and connecting them with appropriate health, care and community support; and
 - **supported self-management** – helping people with existing health conditions to build the knowledge, skills and confidence to manage their health and maintain their independence.
- 13.3 This means prevention is not a separate service or programme. It is part of the contribution of Public Health, adults and children's and wider Local Authority services, VCSE organisations, primary care and NHS providers within each neighbourhood.
- 13.4 **Resident activation:** An important aim of neighbourhood health is to increase residents' confidence and capability to look after their own health and wellbeing. This includes access to understandable information, support to make informed choices, opportunities to manage existing conditions and practical help to act before needs escalate. Portsmouth's neighbourhood work already identifies health confidence and resident activation as outcomes alongside health, wellbeing and independence.
- 13.5 Neighbourhood health is therefore not only concerned with whether people receive a service, but whether they are better able to manage their health and wellbeing as a result. The common resident measures described in section 16 provide a consistent way of tracking this across neighbourhoods.
- 13.6 **Community capacity:** Healthy neighbourhoods depend on the strengths and capabilities that already exist within communities as well as formal health and care provision. Community organisations, local groups, social networks, faith organisations, schools, businesses, volunteers and residents themselves all contribute to health, wellbeing, independence and belonging.
- 13.7 Portsmouth's approach builds on these assets through community development and co-production, strengthening local capacity rather than treating communities solely as recipients of services. HIVE Portsmouth, VCSE organisations and residents already contribute to identifying local priorities, understanding barriers to access and shaping neighbourhood approaches.
- 13.8 Social prescribing, Community Connectors, Community Champions, peer support and other trusted community roles form part of this preventative approach. Their contribution is broader than navigation between services: they connect people to local opportunities and relationships, support confidence and participation, and help statutory partners understand changing community needs. Portsmouth already has established Community Champion and community development capacity on which to build.
- 13.9 Prevention also requires action on the circumstances that shape people's health: 'the causes of the causes'. Neighbourhood priorities therefore consider housing, employment, poverty, income and cost of living, social connection, education, physical activity, community safety and other wider determinants alongside clinical need. The balance of action differs between neighbourhoods according to deprivation

levels and population need, local assets and the priorities identified through the JSNA and community insight.

- 13.10 The approach combines a universal offer, supporting the whole population to remain healthy and access preventative support, with targeted action for communities and populations experiencing poorer health outcomes, greater inequality or increased risk of deterioration. This allows preventative responses to reflect differences in local need and risk.

14. All-age and inclusive neighbourhood health

- 14.1 Neighbourhood health in Portsmouth is an all-age approach. It applies across the life course and is intended to improve health and wellbeing, reduce inequalities and support earlier intervention for children, young people and families, working-age adults and older people. It is not an older-person, frailty or urgent-care model, although these populations may be priorities where local evidence demonstrates particular need.
- 14.2 The response within each neighbourhood will reflect its population profile, inequalities, resident insight and identified priorities rather than assuming that the same populations or interventions should be prioritised everywhere.
- 14.3 Portsmouth will combine a universal neighbourhood offer with proportionate and targeted responses. Core routes to information, community connection, prevention and support should be available to the whole population, while additional outreach, coordination or specialist input will be directed towards populations experiencing poorer outcomes, greater barriers to access or increased risk of deterioration. Equal provision will not necessarily produce equitable outcomes.
- 14.4 Particular consideration will be given to populations whose needs may not be adequately met through standard routes, including:
- **children, young people and families**, recognising the importance of prevention, early intervention, healthy development and coordinated support across health, education, social care, Public Health and community services;
 - **working-age adults**, including people living with long-term conditions, mental ill health or circumstances that affect their ability to remain healthy, independent or economically active;
 - **older people and people living with frailty**, including people who are housebound or living in care homes and those who may benefit from proactive support to maintain independence and prevent avoidable deterioration;
 - **people with mental health needs**, recognising that mental and physical health needs frequently overlap and that fragmented pathways can create additional barriers to accessing support;
 - **neurodivergent people and people with learning disabilities**, including people whose needs cross traditional organisational or diagnostic boundaries;
 - **disabled people**, including people requiring physical accessibility, communication support or reasonable adjustments;

- **people experiencing complex lives or multiple disadvantage**, whose needs may involve health, social care, housing, substance misuse, safeguarding and other services; and
 - **inclusion health populations**, including people experiencing homelessness and other groups who may face substantial barriers to accessing mainstream health and care.
- 14.5 The equality evidence supporting the plan identifies particular access risks affecting, among others, disabled and housebound people, neurodivergent people, people requiring interpreters or alternative communication methods, digitally excluded residents and people whose needs span several services.
- 14.6 Inclusion therefore needs to be designed into neighbourhood delivery rather than treated as a separate workstream. This includes considering:
- physical accessibility and reasonable adjustments;
 - language, communication and interpretation requirements;
 - digital exclusion and the continued availability of non-digital routes;
 - transport and the practical ability to reach support;
 - cultural appropriateness and trusted community routes;
 - targeted outreach where people are unlikely to access services through conventional routes; and
 - continuity and coordination where needs cross more than one service or organisation.
- 14.7 This is consistent with the neighbourhood model described in section 12, in which universal access is combined with additional support according to need and barriers to access.
- 14.8 Neighbourhood geography will not be applied rigidly where this would disadvantage a particular population. Some services, specialist pathways and population groups will appropriately operate across several neighbourhoods, across Portsmouth as a whole or at Hampshire and Isle of Wight level. Neighbourhood working should improve connections into those services rather than require every form of provision to be recreated locally.
- 14.9 Consistent with the priority-setting approach in section 9, neighbourhood priorities will not be determined solely by existing service activity. Population health intelligence, equality information, resident insight and professional knowledge will be used together to identify populations who may be under-represented in existing data or services.
- 14.10 As detailed neighbourhood delivery arrangements develop, equality and inclusion impacts will continue to be reviewed. Any future material changes to service locations, eligibility, commissioning arrangements, workforce or access routes will be subject to the appropriate further impact assessment through the organisation responsible for that change.

15. Data, information and intelligence

- 15.1 The neighbourhood health approach brings together existing Local Authority, NHS and VCSE data and intelligence to provide a shared understanding of population need, service use and outcomes.
- 15.2 Cross-system intelligence already uses the core elements of population health segmentation and risk stratification to support:
- neighbourhood population profiles;
 - identification and segmentation of priority populations and cohorts;
 - understanding inequalities, unmet need and patterns of service use;
 - proactive identification of people at greater risk of deterioration;
 - monitoring agreed neighbourhood outcomes; and
 - evaluation of the impact of changes in services and use of resources.
- 15.3 Place of residence will provide the common population basis for neighbourhood analysis, supplemented where relevant by registered-population and service-use information so that commissioning and delivery can be understood in relation to the communities they serve.
- 15.4 Over the life of this Plan, partners will continue to align existing data and analytical capability around agreed neighbourhood populations, priorities and outcomes, supporting a consistent approach to planning, delivery and evaluation.

16. Outcomes and how success will be measured

- 16.1 The Portsmouth neighbourhood outcomes framework comprises of:
- The overarching population outcome of increasing healthy life expectancy;
 - Resident activation;
 - Population health outcomes, the local outcomes framework and HCP measures relevant to each neighbourhood's priorities; and
 - Service contribution – relevant NHS and partner measures showing the impact of neighbourhood delivery.
- 16.2 The main outcomes for neighbourhood health in Portsmouth are improved healthy life expectancy and reduced inequality in healthy life expectancy between communities.
- 16.3 Two resident measures provide a consistent view across all neighbourhoods:
- How good or bad is your health today?
 - How good or bad are you at taking care of your health?
- 16.4 Population health outcomes reflect the priorities of each neighbourhood. Measures are drawn from the Public Health Outcomes Framework (PHOF), Portsmouth Local Outcomes Framework (LOF) and Health and Care Portsmouth priorities. The measures used therefore vary between neighbourhoods according to identified need.
- 16.5 HCP priorities cover children and young people; health improvement and inequalities; adults with the most complex lives and needs; integrated community care; and person-centred care.

16.6 The NHS contribution is measured through the outcomes and measures set out in the national Neighbourhood Health Framework, aligned with NHS Hampshire and Isle of Wight strategic objectives:

- improving personalised neighbourhood care;
- greater prevention;
- smarter use of technology and data;
- better value; and
- a thriving workforce.

17. Governance and accountability

17.1 Neighbourhood health is governed through existing Portsmouth partnership and statutory arrangements. It does not create a new statutory body or transfer statutory responsibilities between organisations.

- **Portsmouth Health and Wellbeing Board:** provides strategic accountability for neighbourhood health in Portsmouth. It agrees the neighbourhood health plan, neighbourhood geographies, population health priorities and outcomes, and oversees progress in improving health and reducing inequalities.
- **NHS Hampshire and Isle of Wight:** provides the statutory NHS strategic commissioning role, aligning NHS priorities, resources and commissioning with the Portsmouth neighbourhood health plan. It retains accountability for NHS commissioning, contracts, finance, quality assurance and the NHS contribution to delivery of the national Neighbourhood Health Framework.
- **Health and Care Portsmouth:** provides Place partnership leadership and oversight. It aligns partners around the priorities agreed through the Health and Wellbeing Board, oversees delivery of the neighbourhood health plan and provides the principal partnership accountability for delivery.
- **Portsmouth Provider Partnership (P3):** coordinates neighbourhood delivery across providers and wider partners on behalf of HCP. It oversees delivery against agreed priorities, supports resolution of issues that cross organisational boundaries and coordinates the neighbourhood organising function.
- **Neighbourhood organising function:** operates beneath P3 to turn agreed priorities and decisions into coordinated action. It brings together the intelligence, partners, improvement activity and delivery support needed to progress neighbourhood priorities, address barriers across organisational boundaries and track delivery and outcomes. Initially hosted by NHS Hampshire and Isle of Wight, the detailed scope, capability and resource arrangements for the function will be developed through implementation.
- **Individual statutory organisations:** Portsmouth City Council, NHS Hampshire and Isle of Wight and individual NHS providers retain the statutory, financial, professional and operational accountabilities that sit with them. Neighbourhood governance enables collective action but does not transfer those responsibilities.
- **Resident and VCSE participation:** residents, Healthwatch, HIVE and the wider VCSE sector contribute to neighbourhood priorities, local intelligence, service development, delivery and evaluation. Their participation forms part of the governance and delivery model rather than a separate consultation process.

17.2 **Reporting and escalation:** Progress against neighbourhood priorities and outcomes will be reviewed through P3 and HCP, with strategic progress reported to the Health

and Wellbeing Board. Issues that cannot be resolved through P3 will be escalated to HCP or the statutory organisation holding the relevant authority.

18. Delivery roadmap

- 18.1 Following approval of the Neighbourhood Health Plan, implementation will be phased over the remainder of the Plan period. The roadmap below sets out the principal stages of governance and delivery. Detailed actions and milestones will be managed through the relevant partnership and organisational arrangements:
- 18.2 **2026/27 Mobilise governance and delivery.** During the remainder of 2026/27 partners will:
- establish the governance, decision-making and reporting arrangements required to support neighbourhood delivery through HCP and P3;
 - further develop the neighbourhood organising function, including its initial scope, capability and resource requirements;
 - translate agreed neighbourhood priorities into initial coordinated programmes of action;
 - continue to test and develop the community connection layer, building on Help Desks, Health Hubs, Community Connectors and other existing community infrastructure;
 - progress alignment between existing access, navigation and community-support arrangements, including exploration of a shared health and community directory;
 - use neighbourhood intelligence, service information and community insight to identify opportunities for better coordination and earlier intervention; and
 - establish the initial outcome baselines and reporting arrangements for neighbourhood delivery.
- 18.3 **2027/28 Extend delivery and align resources.** During 2027/28 partners will:
- build on learning from existing neighbourhood pilots and priority areas;
 - extend Help Desks, Health Hubs and other community connection arrangements across the city where evidence demonstrates benefit and subject to available resources;
 - establish a more consistent citywide community connection offer while retaining flexibility to reflect local need and community assets;
 - implement and develop interventions for agreed priority populations;
 - strengthen the role of the organising function in coordinating delivery across organisational boundaries;
 - introduce a more neighbourhood-informed approach to commissioning, service planning and resource alignment, while retaining formal organisational accountabilities; and
 - use emerging evidence on outcomes, access, inequalities and resident experience to refine neighbourhood priorities and delivery.

18.4 **2028/29: Embed and demonstrate impact.** During 2028/29 partners will:

- embed neighbourhood population, priorities and outcomes within routine partnership, commissioning and service-planning cycles;
- consolidate the P3 and organising-function arrangements and increase local flexibility where evidence and governance support this;
- demonstrate progress against the Plan's population health, inequality, resident and service outcomes;
- assess whether neighbourhood approaches are improving access, prevention, coordination, independence and use of health and care services;
- identify which approaches should be sustained, adapted, expanded or discontinued based on evidence; and
- refresh neighbourhood priorities and the delivery model in preparation for the next planning period.

19. Risks, dependencies and learning

19.1 Delivery of the Neighbourhood Health Plan will take place within a changing health and care environment. The approach is therefore intended to develop over time, using evidence and learning from implementation while retaining the agreed principles, neighbourhood populations and focus on improving outcomes and reducing inequalities.

19.2 **Major dependencies:** Successful delivery will depend on:

- sustained commitment from NHS, Local Authority, primary care, provider, VCSE and community partners to work around shared neighbourhood priorities and outcomes;
- effective governance through HCP and P3, with clear relationships between partnership decision-making, the neighbourhood organising function and the statutory responsibilities of individual organisations;
- sufficient capacity and resource to develop the organising function, community connection arrangements and priority interventions;
- continued access to timely population, service-use, equality and community intelligence;
- the ability of commissioning, service and organisational plans to increasingly align around neighbourhood populations and priorities; and
- national policy, commissioning and contractual developments remaining sufficiently flexible to support Portsmouth's place-based approach.

19.3 **Implementation risks:** The principal strategic risks are that:

- neighbourhood working becomes an additional layer rather than changing how existing partners organise around populations and outcomes;
- organisational or service boundaries continue to take precedence over population need;
- neighbourhood geography is applied too rigidly, creating barriers for populations whose needs or trusted services cross neighbourhood boundaries;

- implementation develops unevenly because of differences in capacity, resources or engagement between partners and neighbourhoods;
 - pressure on existing services limits the ability to shift towards prevention and earlier intervention;
 - insufficient resident and community involvement weakens local relevance, accessibility or trust; and
 - delivery activity develops without sufficiently clear evidence of impact on outcomes, inequalities and resident experience.
- 19.4 These risks will be managed through the governance, equality safeguards and phased implementation arrangements described in this Plan.
- 19.5 **Evaluation and learning:** Evaluation will be proportionate to the stage of implementation and will use the outcomes framework described in section 16. This will bring together progress in healthy life expectancy and inequalities, resident activation, neighbourhood-specific population health outcomes and relevant service measures. Evaluation will consider not only whether activity has been delivered, but whether access, experience and outcomes are improving and whether benefits are being experienced equitably across neighbourhoods and population groups.
- 19.6 **Review and refresh:** Neighbourhood profiles, priorities, outcomes and delivery arrangements will be reviewed at least annually using updated population intelligence, resident and community insight, service-use information and learning from implementation. This is not intended to require annual redesign of the neighbourhood model; priorities and delivery approaches should change where the evidence demonstrates that population need, inequalities or the effectiveness of the response have changed.
- 19.7 **Sharing learning:** Learning will be shared across neighbourhoods and partner organisations through P3 and HCP, with strategic progress reported to the Health and Wellbeing Board. Residents, communities and the VCSE sector will also contribute to understanding what is working, where barriers remain and how neighbourhood approaches should develop. Learning from individual neighbourhoods and priority interventions will be used to inform improvement elsewhere in the city rather than remaining confined to the area in which it originated.

Appendices

Neighbourhood Health Profiles

Appendix 1 Paulsgrove & Cosham neighbourhood health area profile as at 26th August 2026

Legend	Meaning
*	Comparison uses confidence intervals
†	Comparison uses values only and is not statistically tested
Better*	Statistically better than Portsmouth
Worse*	Statistically worse than Portsmouth
Higher*	Statistically higher than Portsmouth
Lower*	Statistically lower than Portsmouth
Similar*	Not statistically different from Portsmouth
Better†	Better than Portsmouth based on a value-only comparison; not statistically tested
Worse†	Worse than Portsmouth based on a value-only comparison; not statistically tested
Higher†	Higher than Portsmouth based on a value-only comparison; not statistically tested
Lower†	Lower than Portsmouth based on a value-only comparison; not statistically tested
Not compared	A comparison was not available

Indicator	Reporting period	Value	Statistic type (see Value)	Value Portsmouth	NH compared to Portsmouth
% population aged 0-4 years (latest year)	2024	5.4%	%	5.3%	Highest†
% population aged 0-15 years (latest year)	2024	20.9%	%	17.9%	Highest†
% population aged 65+ years (latest year)	2024	15.6%	%	14.9%	Highest†
% population aged 85+ years (latest year)	2024	1.6%	%	2.0%	Lower†
Population density (people per square km)	2024	2755.67	People per square km	5306.22	Lower†
HCC SAPP: Population change aged 0-4 years forecast in 2031	2024 to 2031	-1.8%	%	-1.8%	Lower†
HCC SAPP: Population change aged 0-15 years forecast in 2031	2024 to 2031	-11.8%	%	-6.2%	Lower†
HCC SAPP: Population change aged 65+ years forecast in 2031	2024 to 2031	17.1%	%	17.1%	Lower†
HCC SAPP: Population change aged 85+ years forecast in 2031	2024 to 2031	28.5%	%	18.7%	Highest†
% of population of ethnic minorities	2021 Census	13.8%	%	22.3%	Lower†
% of households with no cars or vans	2021 Census	27.1%	%	30.3%	Lower†
% population in most deprived decile (latest year)	2024	23.3%	%	12.2%	Highest†
IMD 2025 average score	IoD 2025	36.09	Score	26.38	Worse†
Income domain average score	IoD 2025	34.7%	%	25.9%	Worse†
Children aged under 16 years in absolute low-income families (Before Housing Costs)	2024/25	26.6%	%	20.7%	Worse*
Children aged under 16 years in relative low-income families (Before Housing Costs)	2024/25	26.6%	%	20.7%	Worse*
IDAOP average score	IoD 2025	27.4%	%	21.4%	Worse†
Employment domain average score	IoD 2025	20.0%	%	14.0%	Worse†
Unemployment: people claiming out of work benefit (aged 16 to 64 years)	Mar 2026	43.6 per 1,000	Rate per 1,000	45.4 per 1,000	Similar*
Crime domain average score	IoD 2025	0.68	Score	0.55	Worse†
% of households fuel poor	2026 (2024 data)	8.7%	%	10.9%	Better†
% of households overcrowded (occupancy rating of rooms is -1 or less)	2021 Census	6.4%	%	7.1%	Better†
Air quality indicator average value	IoD 2025	2.79	Score	2.82	Better†
Live birth rate	2024	9.6 per 1,000	Rate per 1,000	9.5 per 1,000	Similar*
General fertility rate	2024	46.5 per 1,000	Rate per 1,000	42.7 per 1,000	Similar*
% of low birth weight babies (out of live births)	2018 - 22	7.7%	%	7.7%	Similar*
Children and Young People Sub-domain average score	IoD 2025	1.50	Score	0.62	Worse†
Reception prevalence of obesity (including severe obesity)	2022/23 to 2024/25	13.2%	%	11.1%	Similar*
Year 6 prevalence of obesity (including severe obesity)	2022/23 to 2024/25	32.1%	%	24.8%	Worse*
Emergency hospital admissions: all causes (aged under 5)	2021/22 to 2024/25	151.3 per 1,000	Rate per 1,000	129.1 per 1,000	Worse†
Unintentional and deliberate injuries: hospital admissions in children aged under 5 years	2021/22 to 2024/25	62.4 per 10,000	Rate per 10,000	69.3 per 10,000	Similar*
Unintentional and deliberate injuries: hospital admissions in children aged under 15 years	2021/22 to 2024/25	70.1 per 10,000	Rate per 10,000	62.8 per 10,000	Similar*
Hospital admissions as a result of self-harm (aged 10-24 years)	2021/22 to 2024/25	484.1 per 100,000	DSR	343.7 per 100,000	Worse*
% of people aged 5 and over providing 50+ hours unpaid care (age-standardised)	2021 Census	4.0%	%	2.7%	Highest†
Recorded prevalence of current smokers (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	19.1%	%	15.8%	Worse*
Recorded prevalence of obese (including severely obese) adults (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	33.1%	%	26.6%	Worse*
Recorded prevalence of unhealthy alcohol use (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	9.3%	%	11.5%	Better*
Recorded prevalence of Asthma (age-standardised, all ages)	29 Oct 2025 snapshot	10.3%	%	10.4%	Similar*
Recorded prevalence of COPD (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	5.7%	%	5.1%	Similar*
Recorded prevalence of CHD (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	6.4%	%	6.4%	Similar*
Recorded prevalence of hypertension (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	29.1%	%	30.2%	Similar*
Recorded prevalence of diabetes (age-standardised, all ages)	29 Oct 2025 snapshot	12.2%	%	10.0%	Worse*

Paulsgrove & Cosham Neighbourhood Health Area (NHA) has a lower population density, lower ethnic diversity and a slightly older population profile than Portsmouth overall. The NHA includes Queen Alexandra Hospital and population forecasts suggest a decline in younger age groups alongside growth in the older population, particularly among those aged 85 years and over.

The area experiences significant deprivation. Around one quarter of residents live within the most deprived national decile and measures of overall deprivation, income deprivation, employment deprivation and crime are all worse than the Portsmouth average. Child poverty is also significantly higher than across the city. However, fuel poverty, overcrowding and air quality are better than the Portsmouth average.

Children and young people face a number of challenges. The Children and Young People deprivation sub-domain score is substantially worse than Portsmouth overall. Year 6 obesity prevalence, emergency hospital admissions among children aged under five years and admissions for self-harm among young people are all higher than the city average. Several other indicators, including low birth weight, reception obesity prevalence and injury-related admissions, are similar to the Portsmouth average.

Adult recorded prevalence of smoking, obesity, diabetes and five or more long-term conditions are higher than the Portsmouth average. The proportion of residents reporting bad or very bad health is also higher than across the city. In contrast, recorded prevalence of severe mental illness is lower than Portsmouth overall and several other long-term conditions are similar to the city average.

Emergency hospital admissions for all causes and COPD are significantly higher than the Portsmouth average, although many other admission indicators are similar to the city average. Life expectancy and most mortality indicators are also broadly similar to Portsmouth overall.

Overall, Paulsgrove & Cosham NHA experiences significant deprivation and prevention challenges, particularly affecting children and families. Although many mortality indicators are similar to the Portsmouth average at NHA level, variation within the area means that some communities experience poorer outcomes than others, highlighting opportunities for targeted prevention and support.

Appendix 2 Drayton & Farlington neighbourhood health area profile as at 26th August 2026

Legend	Meaning
*	Comparison uses confidence intervals
†	Comparison uses values only and is not statistically tested
Better*	Statistically better than Portsmouth
Worse*	Statistically worse than Portsmouth
Higher*	Statistically higher than Portsmouth
Lower*	Statistically lower than Portsmouth
Similar*	Not statistically different from Portsmouth
Better†	Better than Portsmouth based on a value-only comparison; not statistically tested
Worse†	Worse than Portsmouth based on a value-only comparison; not statistically tested
Higher†	Higher than Portsmouth based on a value-only comparison; not statistically tested
Lower†	Lower than Portsmouth based on a value-only comparison; not statistically tested
Not compared	A comparison was not available

Indicator	Reporting period	Value	Statistic type (see Value)	Value Portsmouth	NH compared to Portsmouth
% population aged 0-4 years (latest year)	2024	4.6%	%	5.3%	Lower†
% population aged 0-15 years (latest year)	2024	18.2%	%	17.9%	Higher†
% population aged 65+ years (latest year)	2024	21.5%	%	14.9%	Higher†
% population aged 85+ years (latest year)	2024	4.0%	%	2.0%	Higher†
Population density (people per square km)	2024	2957.29	People per square km	5306.22	Lower†
HCC SAPP: Population change aged 0-4 years forecast in 2031	2024 to 2031	-3.5%	%	-1.8%	Lower†
HCC SAPP: Population change aged 0-15 years forecast in 2031	2024 to 2031	-9.6%	%	-6.2%	Lower†
HCC SAPP: Population change aged 65+ years forecast in 2031	2024 to 2031	5.7%	%	17.1%	Lower†
HCC SAPP: Population change aged 85+ years forecast in 2031	2024 to 2031	3.4%	%	18.7%	Lower†
% of population of ethnic minorities	2021 Census	10.4%	%	22.3%	Lower†
% of households with no cars or vans	2021 Census	15.3%	%	30.3%	Lower†
% population in most deprived decile (latest year)	2024	0.0%	%	12.2%	Lower†
IMD 2025 average score	IoD 2025	9.66	Score	26.38	Better†
Income domain average score	IoD 2025	11.9%	%	25.9%	Better†
Children aged under 16 years in absolute low-income families (Before Housing Costs)	2024/25	9.4%	%	20.7%	Better*
Children aged under 16 years in relative low-income families (Before Housing Costs)	2024/25	9.4%	%	20.7%	Better*
IDAOP average score	IoD 2025	7.6%	%	21.4%	Better†
Employment domain average score	IoD 2025	7.6%	%	14.0%	Better†
Unemployment: people claiming out of work benefit (aged 16 to 64 years)	Mar 2026	17.6 per 1,000	Rate per 1,000	45.4 per 1,000	Better*
Crime domain average score	IoD 2025	-0.46	Score	0.55	Better†
% of households fuel poor	2026 (2024 data)	7.1%	%	10.9%	Better†
% of households overcrowded (occupancy rating of rooms is -1 or less)	2021 Census	2.5%	%	7.1%	Better†
Air quality indicator average value	IoD 2025	2.87	Score	2.82	Worse†
Live birth rate	2024	7.5 per 1,000	Rate per 1,000	9.5 per 1,000	Lower*
General fertility rate	2024	42.4 per 1,000	Rate per 1,000	42.7 per 1,000	Similar*
% of low birth weight babies (out of live births)	2018 - 22	7.7%	%	7.7%	Similar*
Children and Young People Sub-domain average score	IoD 2025	-0.17	Score	0.62	Better†
Reception prevalence of obesity (including severe obesity)	2022/23 to 2024/25	9.3%	%	11.1%	Similar*
Year 6 prevalence of obesity (including severe obesity)	2022/23 to 2024/25	19.1%	%	24.8%	Better*
Emergency hospital admissions: all causes (aged under 5)	2021/22 to 2024/25	125.1 per 1,000	Rate per 1,000	129.1 per 1,000	Similar*
Unintentional and deliberate injuries: hospital admissions in children aged under 5 years	2021/22 to 2024/25	68.6 per 10,000	Rate per 10,000	69.3 per 10,000	Similar*
Unintentional and deliberate injuries: hospital admissions in children aged under 15 years	2021/22 to 2024/25	47.3 per 10,000	Rate per 10,000	62.8 per 10,000	Similar*
Hospital admissions as a result of self-harm (aged 10-24 years)	2021/22 to 2024/25	341.9 per 100,000	DSR	343.7 per 100,000	Similar*
% of people aged 5 and over providing 50+ hours unpaid care (age-standardised)	2021 Census	2.6%	%	2.7%	Lower†
Recorded prevalence of current smokers (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	10.3%	%	15.8%	Better*
Recorded prevalence of obese (including severely obese) adults (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	25.0%	%	26.6%	Better*
Recorded prevalence of unhealthy alcohol use (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	9.7%	%	11.5%	Better*
Recorded prevalence of Asthma (age-standardised, all ages)	29 Oct 2025 snapshot	10.9%	%	10.4%	Similar*
Recorded prevalence of COPD (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	3.4%	%	5.1%	Better*
Recorded prevalence of CHD (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	6.1%	%	6.4%	Similar*
Recorded prevalence of hypertension (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	28.8%	%	30.2%	Similar*
Recorded prevalence of diabetes (age-standardised, all ages)	29 Oct 2025 snapshot	8.9%	%	10.0%	Better*
Recorded prevalence of Severe Mental Illness (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	0.8%	%	1.4%	Better*
Recorded prevalence of dementia excluding care homes (age-standardised, aged 65+ years)	29 Oct 2025 snapshot	6.3%	%	6.5%	Similar*
Recorded prevalence of 5+ long-term conditions (age-standardised, aged under 75 years)	29 Oct 2025 snapshot	1.8%	%	2.5%	Better*
% of people with bad or very bad self-reported health (age-standardised)	2021 Census	3.8%	%	6.0%	Better†
Emergency hospital admissions: all causes	2021/22 to 2024/25	9630.6 per 100,000	DSR	12025.5 per 100,000	Better*
COPD: emergency hospital admissions (aged 35 and over)	2021/22 to 2024/25	236.3 per 100,000	DSR	478.9 per 100,000	Better*
Coronary heart disease: emergency hospital admissions	2021/22 to 2024/25	151.3 per 100,000	DSR	194.8 per 100,000	Better*
MI (Heart attack): emergency hospital admissions	2021/22 to 2024/25	107.7 per 100,000	DSR	135.9 per 100,000	Similar*
Stroke: emergency hospital admissions	2021/22 to 2024/25	132.2 per 100,000	DSR	173.3 per 100,000	Better*
Emergency hospital admissions as a result of self-harm (all ages)	2021/22 to 2024/25	118.0 per 100,000	DSR	179.3 per 100,000	Better*
Emergency hospital admissions due to falls in people aged 65 and over	2021/22 to 2024/25	1469.8 per 100,000	DSR	1630.2 per 100,000	Similar*
Hip fractures in people aged 65 and over	2021/22 to 2024/25	484.5 per 100,000	DSR	545.2 per 100,000	Similar*
Life expectancy at birth (males)	2022-2024	80.79 years	Years	78.06 years	Better*
Life expectancy at birth (females)	2022-2024	85.50 years	Years	82.55 years	Better*
Life expectancy at age 65 (males)	2022-2024	19.57 years	Years	17.71 years	Better*
Life expectancy at age 65 (females)	2022-2024	22.35 years	Years	20.63 years	Better*
Mortality from all causes, all ages	2022-2024	844.7 per 100,000	DSR	1059.7 per 100,000	Better*
Mortality from all causes aged under 75	2022-2024	246.0 per 100,000	DSR	394.2 per 100,000	Better*
Mortality from causes considered preventable, aged under 75	2022-2024	103.8 per 100,000	DSR	191.8 per 100,000	Better*
Mortality from cancer, all ages	2022-2024	202.7 per 100,000	DSR	273.7 per 100,000	Better*
Mortality from cancer aged under 75	2022-2024	97.9 per 100,000	DSR	142.5 per 100,000	Better*
Mortality from CVD, all ages	2022-2024	194.6 per 100,000	DSR	264.4 per 100,000	Better*
Mortality from CVD aged under 75	2022-2024	49.3 per 100,000	DSR	88.5 per 100,000	Better*
Mortality from CHD, all ages	2022-2024	68.7 per 100,000	DSR	96.7 per 100,000	Similar*
Mortality from Stroke, all ages	2022-2024	37.4 per 100,000	DSR	53.4 per 100,000	Similar*
Mortality from respiratory diseases, all ages	2022-2024	94.9 per 100,000	DSR	126.6 per 100,000	Similar*
Mortality from COPD, all ages	2022-2024	54.7 per 100,000	DSR	66.4 per 100,000	Similar*
Alcohol-related mortality	2022-2024	23.0 per 100,000	DSR	53.1 per 100,000	Better*

Drayton & Farlington Neighbourhood Health Area (NHA) has a substantially older population than the Portsmouth average. More than one in five residents is aged 65 years and over, while 4% are aged 85 years and over. The NHA is less densely populated and less ethnically diverse than the city average. Population forecasts indicate decreasing number of children and modest growth in older residents, although growth among those aged 65 years and over is forecast to be slower than across Portsmouth.

The socioeconomic circumstances of residents are generally better than the Portsmouth average. None of the population is recorded within the most deprived national decile. Overall deprivation, income, employment, unemployment, crime, fuel poverty and overcrowding all compare favourably. Air quality is slightly worse than the city average.

Children are significantly less likely to live in absolute or relative low-income families, and the Children and Young People deprivation sub-domain score is better than Portsmouth's. The live birth rate is lower, while the general fertility rate and low birth weight are similar. Year 6 obesity prevalence is significantly lower, and most child hospital admission measures are similar to the city average.

Adult recorded prevalence of current smoking, obesity and unhealthy alcohol use is significantly lower than Portsmouth. Recorded prevalence of COPD, diabetes, severe mental illness and five or more long-term conditions is also lower. Several other long-term conditions are similar to the city average, while fewer residents report bad or very bad health.

All-cause emergency hospital admissions and admissions for COPD, coronary heart disease, stroke and self-harm are significantly lower than the Portsmouth average. Emergency admissions for heart attack, falls and hip fractures are similar to the city average.

Life expectancy at birth and at age 65 is significantly higher for both males and females. All-cause, premature, preventable, cancer and cardiovascular mortality are lower, as is alcohol-related mortality.

Overall, Drayton & Farlington NHA has a relatively good health profile. Its large existing older population means that healthy ageing, independence and community support remain important, while the poorer air quality indicator warrants separate consideration.

Appendix 3 North Island neighbourhood health area profile as at 26th August 2026

Legend	Meaning
*	Comparison uses confidence intervals
†	Comparison uses values only and is not statistically tested
Better*	Statistically better than Portsmouth
Worse*	Statistically worse than Portsmouth
Higher*	Statistically higher than Portsmouth
Lower*	Statistically lower than Portsmouth
Similar*	Not statistically different from Portsmouth
Better†	Better than Portsmouth based on a value-only comparison; not statistically tested
Worse†	Worse than Portsmouth based on a value-only comparison; not statistically tested
Higher†	Higher than Portsmouth based on a value-only comparison; not statistically tested
Lower†	Lower than Portsmouth based on a value-only comparison; not statistically tested
Not compared	A comparison was not available

Indicator	Reporting period	Value	Statistic type (see Value)	Value Portsmouth	NH compared to Portsmouth
▲					
% population aged 0-4 years (latest year)	2024	5.9%	%	5.3%	Higher†
% population aged 0-15 years (latest year)	2024	19.5%	%	17.9%	Higher†
% population aged 65+ years (latest year)	2024	15.3%	%	14.9%	Higher†
% population aged 85+ years (latest year)	2024	1.7%	%	2.0%	Lower†
Population density (people per square km)	2024	4647.07	People per square km	5306.22	Lower†
HCC SAPF: Population change aged 0-4 years forecast in 2031	2024 to 2031	-1.7%	%	-1.8%	Higher†
HCC SAPF: Population change aged 0-15 years forecast in 2031	2024 to 2031	-7.5%	%	-6.2%	Lower†
HCC SAPF: Population change aged 65+ years forecast in 2031	2024 to 2031	22.1%	%	17.1%	Higher†
HCC SAPF: Population change aged 85+ years forecast in 2031	2024 to 2031	34.6%	%	18.7%	Higher†
% of population of ethnic minorities	2021 Census	17.5%	%	22.3%	Lower†
% of households with no cars or vans	2021 Census	23.5%	%	30.3%	Lower†
% population in most deprived decile (latest year)	2024	0.0%	%	12.2%	Lower†
IMD 2025 average score	IoD 2025	22.09	Score	26.38	Better†
Income domain average score	IoD 2025	22.1%	%	25.9%	Better†
Children aged under 16 years in absolute low-income families (Before Housing Costs)	2024/25	16.7%	%	20.7%	Better*
Children aged under 16 years in relative low-income families (Before Housing Costs)	2024/25	16.7%	%	20.7%	Better*
IDAQPI average score	IoD 2025	16.8%	%	21.4%	Better†
Employment domain average score	IoD 2025	12.0%	%	14.0%	Better†
Unemployment: people claiming out of work benefit (aged 16 to 64 years)	Mar 2026	41.3 per 1,000	Rate per 1,000	45.4 per 1,000	Better*
Crime domain average score	IoD 2025	0.36	Score	0.55	Better†
% of households fuel poor	2026 (2024 data)	9.6%	%	10.9%	Better†
% of households overcrowded (occupancy rating of rooms is -1 or less)	2021 Census	4.8%	%	7.1%	Better†
Air quality indicator average value	IoD 2025	3.04	Score	2.82	Worse†
Live birth rate	2024	9.8 per 1,000	Rate per 1,000	9.5 per 1,000	Similar*
General fertility rate	2024	47.7 per 1,000	Rate per 1,000	42.7 per 1,000	Similar*
% of low birth weight babies (out of live births)	2018 - 22	7.7%	%	7.7%	Similar*
Children and Young People Sub-domain average score	IoD 2025	0.70	Score	0.62	Worse†
Reception prevalence of obesity (including severe obesity)	2022/23 to 2024/25	11.0%	%	11.1%	Similar*
Year 6 prevalence of obesity (including severe obesity)	2022/23 to 2024/25	22.9%	%	24.8%	Similar*
Emergency hospital admissions: all causes (aged under 5)	2021/22 to 2024/25	115.7 per 1,000	Rate per 1,000	129.1 per 1,000	Better*
Unintentional and deliberate injuries: hospital admissions in children aged under 5 years	2021/22 to 2024/25	68.6 per 10,000	Rate per 10,000	69.3 per 10,000	Similar*
Unintentional and deliberate injuries: hospital admissions in children aged under 15 years	2021/22 to 2024/25	57.1 per 10,000	Rate per 10,000	62.8 per 10,000	Similar*
Hospital admissions as a result of self-harm (aged 10-24 years)	2021/22 to 2024/25	301.0 per 100,000	DSR	343.7 per 100,000	Similar*
% of people aged 5 and over providing 50+ hours unpaid care (age-standardised)	2021 Census	2.7%	%	2.7%	Higher†
Recorded prevalence of current smokers (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	15.2%	%	15.8%	Similar*
Recorded prevalence of obese (including severely obese) adults (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	27.6%	%	26.6%	Similar*
Recorded prevalence of unhealthy alcohol use (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	10.6%	%	11.5%	Better*
Recorded prevalence of Asthma (age-standardised, all ages)	29 Oct 2025 snapshot	10.8%	%	10.4%	Similar*
Recorded prevalence of COPD (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	5.6%	%	5.1%	Similar*
Recorded prevalence of CHD (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	6.5%	%	6.4%	Similar*
Recorded prevalence of hypertension (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	32.6%	%	30.2%	Similar*
Recorded prevalence of diabetes (age-standardised, all ages)	29 Oct 2025 snapshot	10.6%	%	10.0%	Similar*
Recorded prevalence of Severe Mental Illness (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	1.0%	%	1.4%	Similar*
Recorded prevalence of dementia excluding care homes (age-standardised, aged 65+ years)	29 Oct 2025 snapshot	6.2%	%	6.5%	Similar*
Recorded prevalence of 5+ long-term conditions (age-standardised, aged under 75 years)	29 Oct 2025 snapshot	2.4%	%	2.5%	Similar*
% of people with bad or very bad self-reported health (age-standardised)	2021 Census	5.3%	%	6.0%	Better†
Emergency hospital admissions: all causes	2021/22 to 2024/25	11875.6 per 100,000	DSR	12025.5 per 100,000	Similar*
COPD: emergency hospital admissions (aged 35 and over)	2021/22 to 2024/25	377.7 per 100,000	DSR	478.9 per 100,000	Better*
Coronary heart disease: emergency hospital admissions	2021/22 to 2024/25	184.1 per 100,000	DSR	194.8 per 100,000	Similar*
MI (Heart attack): emergency hospital admissions	2021/22 to 2024/25	129.6 per 100,000	DSR	135.9 per 100,000	Similar*
Stroke: emergency hospital admissions	2021/22 to 2024/25	171.3 per 100,000	DSR	173.3 per 100,000	Similar*
Emergency hospital admissions as a result of self-harm (all ages)	2021/22 to 2024/25	151.7 per 100,000	DSR	179.3 per 100,000	Similar*
Emergency hospital admissions due to falls in people aged 65 and over	2021/22 to 2024/25	1427.5 per 100,000	DSR	1630.2 per 100,000	Similar*
Hip fractures in people aged 65 and over	2021/22 to 2024/25	436.4 per 100,000	DSR	545.2 per 100,000	Similar*
Life expectancy at birth (males)	2022-2024	79.43 years	Years	78.06 years	Similar*
Life expectancy at birth (females)	2022-2024	83.38 years	Years	82.55 years	Similar*
Life expectancy at age 65 (males)	2022-2024	17.94 years	Years	17.71 years	Similar*
Life expectancy at age 65 (females)	2022-2024	21.32 years	Years	20.63 years	Similar*
Mortality from all causes, all ages	2022-2024	1005.8 per 100,000	DSR	1059.7 per 100,000	Similar*
Mortality from all causes aged under 75	2022-2024	344.9 per 100,000	DSR	394.2 per 100,000	Similar*
Mortality from causes considered preventable, aged under 75	2022-2024	154.9 per 100,000	DSR	191.8 per 100,000	Similar*
Mortality from cancer, all ages	2022-2024	273.4 per 100,000	DSR	273.7 per 100,000	Similar*
Mortality from cancer aged under 75	2022-2024	129.2 per 100,000	DSR	142.5 per 100,000	Similar*
Mortality from CVD, all ages	2022-2024	261.3 per 100,000	DSR	264.4 per 100,000	Similar*
Mortality from CVD aged under 75	2022-2024	81.6 per 100,000	DSR	88.5 per 100,000	Similar*
Mortality from CHD, all ages	2022-2024	109.5 per 100,000	DSR	96.7 per 100,000	Similar*
Mortality from Stroke, all ages	2022-2024	41.5 per 100,000	DSR	53.4 per 100,000	Similar*
Mortality from respiratory diseases, all ages	2022-2024	119.1 per 100,000	DSR	126.6 per 100,000	Similar*
Mortality from COPD, all ages	2022-2024	45.3 per 100,000	DSR	66.4 per 100,000	Similar*
Alcohol-related mortality	2022-2024	43.6 per 100,000	DSR	53.1 per 100,000	Similar*

North Island Neighbourhood Health Area (NHA) has higher proportions of children and people aged 65 years and over than the Portsmouth average, but a lower proportion aged 85 years and over. Its population is less ethnically diverse and less densely concentrated than the city overall. Population forecasts indicate a decrease in the number of children aged under 16 years alongside greater growth in residents aged 65 and over and aged 85 and over than forecast across Portsmouth.

The NHA's socioeconomic profile is generally more positive than the city average. None of its population is recorded within the most deprived national decile, while overall deprivation, income, employment, unemployment, crime, fuel poverty and overcrowding compare favourably with the Portsmouth average. The air quality indicator is worse than the city average.

Children are significantly less likely to live in absolute or relative low-income families. In contrast, the Children and Young People deprivation sub-domain score is worse than the Portsmouth average, indicating a less favourable position across that broader measure. Childhood obesity, low birth weight, injury admissions and admissions following self-harm among young people are similar to the city average. Emergency hospital admissions among children aged under five years are lower than the city average.

Adult recorded prevalence of current smoking and obesity is similar to the Portsmouth average, while adult recorded prevalence of unhealthy alcohol use is lower. Recorded prevalence of asthma, COPD, coronary heart disease, hypertension, diabetes, severe mental illness, dementia and multiple long-term conditions is also similar. The proportion of residents reporting bad or very bad health is lower than the city average.

All-cause emergency hospital admissions and most condition-specific admission measures are similar to the Portsmouth average. COPD emergency admissions are lower, as are all-cause admissions among children aged under five years. Life expectancy and all of the mortality indicators included in the profile are similar to the city average.

Overall, North Island NHA has a generally positive socioeconomic profile and a health profile that is largely similar to Portsmouth. However, variation exists between communities within the NHA and evidence from smaller geographies indicates that some neighbourhoods experience poorer health outcomes than are apparent from NHA-level averages. This highlights the importance of understanding local variation when identifying priorities and targeting support.

Looking at the NHA overall, population forecasts show substantial growth in older residents, making healthy ageing, prevention and community support important future priorities. Although children are less likely to live in low-income families than across Portsmouth overall, the Children and Young People deprivation sub-domain score is worse than the city average. Poorer air quality is also a distinct consideration for the area.

Appendix 4 Central neighbourhood health area profile as at 26th August 2026

Legend	Meaning
*	Comparison uses confidence intervals
†	Comparison uses values only and is not statistically tested
Better*	Statistically better than Portsmouth
Worse*	Statistically worse than Portsmouth
Higher*	Statistically higher than Portsmouth
Lower*	Statistically lower than Portsmouth
Similar*	Not statistically different from Portsmouth
Better†	Better than Portsmouth based on a value-only comparison; not statistically tested
Worse†	Worse than Portsmouth based on a value-only comparison; not statistically tested
Higher†	Higher than Portsmouth based on a value-only comparison; not statistically tested
Lower†	Lower than Portsmouth based on a value-only comparison; not statistically tested
Not compared	A comparison was not available

Indicator	Reporting period	Value	Statistic type (see Value)	Value Portsmouth	NH compared to Portsmouth
% population aged 0-4 years (latest year)	2024	6.5%	%	5.3%	Higher†
% population aged 0-15 years (latest year)	2024	21.8%	%	17.9%	Higher†
% population aged 65+ years (latest year)	2024	11.0%	%	14.9%	Lower†
% population aged 85+ years (latest year)	2024	1.0%	%	2.0%	Lower†
Population density (people per square km)	2024	10616.51	People per square km	5306.22	Higher†
HCC SAPF: Population change aged 0-4 years forecast in 2031	2024 to 2031	-13.6%	%	-1.8%	Lower†
HCC SAPF: Population change aged 0-15 years forecast in 2031	2024 to 2031	-14.8%	%	-6.2%	Lower†
HCC SAPF: Population change aged 65+ years forecast in 2031	2024 to 2031	26.6%	%	17.1%	Higher†
HCC SAPF: Population change aged 85+ years forecast in 2031	2024 to 2031	22.9%	%	18.7%	Higher†
% of population of ethnic minorities	2021 Census	28.2%	%	22.3%	Higher†
% of households with no cars or vans	2021 Census	41.2%	%	30.3%	Higher†
% population in most deprived decile (latest year)	2024	44.9%	%	12.2%	Higher†
IMD 2025 average score	IoD 2025	42.81	Score	26.38	Worse†
Income domain average score	IoD 2025	42.6%	%	25.9%	Worse†
Children aged under 16 years in absolute low-income families (Before Housing Costs)	2024/25	29.1%	%	20.7%	Worse†
Children aged under 16 years in relative low-income families (Before Housing Costs)	2024/25	29.1%	%	20.7%	Worse†
IDAOP average score	IoD 2025	40.7%	%	21.4%	Worse†
Employment domain average score	IoD 2025	22.1%	%	14.0%	Worse†
Unemployment: people claiming out of work benefit (aged 16 to 64 years)	Mar 2026	70.0 per 1,000	Rate per 1,000	45.4 per 1,000	Worse†
Crime domain average score	IoD 2025	1.12	Score	0.55	Worse†
% of households fuel poor	2026 (2024 data)	12.2%	%	10.9%	Worse†
% of households overcrowded (occupancy rating of rooms is -1 or less)	2021 Census	10.6%	%	7.1%	Worse†
Air quality indicator average value	IoD 2025	3.03	Score	2.82	Worse†
Live birth rate	2024	13.0 per 1,000	Rate per 1,000	9.5 per 1,000	Higher†
General fertility rate	2024	54.9 per 1,000	Rate per 1,000	42.7 per 1,000	Higher†
% of low birth weight babies (out of live births)	2018 - 22	8.1%	%	7.7%	Similar*
Children and Young People Sub-domain average score	IoD 2025	0.94	Score	0.62	Worse†
Reception prevalence of obesity (including severe obesity)	2022/23 to 2024/25	11.8%	%	11.1%	Similar*
Year 6 prevalence of obesity (including severe obesity)	2022/23 to 2024/25	28.7%	%	24.8%	Worse†
Emergency hospital admissions: all causes (aged under 5)	2021/22 to 2024/25	132.5 per 1,000	Rate per 1,000	129.1 per 1,000	Similar*
Unintentional and deliberate injuries: hospital admissions in children aged under 5 years	2021/22 to 2024/25	77.7 per 10,000	Rate per 10,000	69.3 per 10,000	Similar*
Unintentional and deliberate injuries: hospital admissions in children aged under 15 years	2021/22 to 2024/25	67.1 per 10,000	Rate per 10,000	62.8 per 10,000	Similar*
Hospital admissions as a result of self-harm (aged 10-24 years)	2021/22 to 2024/25	434.9 per 100,000	DSR	343.7 per 100,000	Similar*
% of people aged 5 and over providing 50+ hours unpaid care (age-standardised)	2021 Census	3.2%	%	2.7%	Higher†
Recorded prevalence of current smokers (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	20.9%	%	15.8%	Worse*
Recorded prevalence of obese (including severely obese) adults (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	30.3%	%	26.6%	Worse*
Recorded prevalence of unhealthy alcohol use (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	10.0%	%	11.5%	Better*
Recorded prevalence of Asthma (age-standardised, all ages)	29 Oct 2025 snapshot	11.5%	%	10.4%	Worse*
Recorded prevalence of COPD (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	7.2%	%	5.1%	Worse*
Recorded prevalence of CHD (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	7.5%	%	6.4%	Similar*
Recorded prevalence of hypertension (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	32.4%	%	30.2%	Similar*
Recorded prevalence of diabetes (age-standardised, all ages)	29 Oct 2025 snapshot	12.1%	%	10.0%	Worse*

Recorded prevalence of Severe Mental Illness (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	1.7%	%	1.4%	Similar*
Recorded prevalence of dementia excluding care homes (age-standardised, aged 65+ years)	29 Oct 2025 snapshot	6.3%	%	6.5%	Similar*
Recorded prevalence of 5+ long-term conditions (age-standardised, aged under 75 years)	29 Oct 2025 snapshot	3.7%	%	2.5%	Worse*
% of people with bad or very bad self-reported health (age-standardised)	2021 Census	8.7%	%	6.0%	Worse*
Emergency hospital admissions: all causes	2021/22 to 2024/25	15368.3 per 100,000	DSR	12025.5 per 100,000	Worse*
COPD: emergency hospital admissions (aged 35 and over)	2021/22 to 2024/25	878.4 per 100,000	DSR	478.9 per 100,000	Worse*
Coronary heart disease: emergency hospital admissions	2021/22 to 2024/25	255.1 per 100,000	DSR	194.8 per 100,000	Worse*
MI (Heart attack): emergency hospital admissions	2021/22 to 2024/25	177.3 per 100,000	DSR	135.9 per 100,000	Worse*
Stroke: emergency hospital admissions	2021/22 to 2024/25	219.1 per 100,000	DSR	173.3 per 100,000	Worse*
Emergency hospital admissions as a result of self-harm (all ages)	2021/22 to 2024/25	251.4 per 100,000	DSR	179.3 per 100,000	Worse*
Emergency hospital admissions due to falls in people aged 65 and over	2021/22 to 2024/25	2233.0 per 100,000	DSR	1630.2 per 100,000	Worse*
Hip fractures in people aged 65 and over	2021/22 to 2024/25	816.8 per 100,000	DSR	545.2 per 100,000	Worse*
Life expectancy at birth (males)	2022-2024	74.51 years	Years	78.06 years	Worse*
Life expectancy at birth (females)	2022-2024	80.02 years	Years	82.55 years	Worse*
Life expectancy at age 65 (males)	2022-2024	15.41 years	Years	17.71 years	Worse*
Life expectancy at age 65 (females)	2022-2024	18.42 years	Years	20.63 years	Worse*
Mortality from all causes, all ages	2022-2024	1351.8 per 100,000	DSR	1059.7 per 100,000	Worse*
Mortality from all causes aged under 75	2022-2024	581.2 per 100,000	DSR	394.2 per 100,000	Worse*
Mortality from causes considered preventable, aged under 75	2022-2024	316.4 per 100,000	DSR	191.8 per 100,000	Worse*
Mortality from cancer, all ages	2022-2024	315.9 per 100,000	DSR	273.7 per 100,000	Similar*
Mortality from cancer aged under 75	2022-2024	197.4 per 100,000	DSR	142.5 per 100,000	Worse*
Mortality from CVD, all ages	2022-2024	328.5 per 100,000	DSR	264.4 per 100,000	Worse*
Mortality from CVD aged under 75	2022-2024	131.1 per 100,000	DSR	88.5 per 100,000	Worse*
Mortality from CHD, all ages	2022-2024	119.7 per 100,000	DSR	96.7 per 100,000	Similar*
Mortality from Stroke, all ages	2022-2024	70.7 per 100,000	DSR	53.4 per 100,000	Worse*
Mortality from respiratory diseases, all ages	2022-2024	234.0 per 100,000	DSR	126.6 per 100,000	Worse*
Mortality from COPD, all ages	2022-2024	153.3 per 100,000	DSR	66.4 per 100,000	Worse*
Alcohol-related mortality	2022-2024	75.2 per 100,000	DSR	53.1 per 100,000	Similar*

Central Neighbourhood Health Area (NHA) is a young, diverse and densely populated urban area. The NHA has higher proportions of children and young people than Portsmouth overall, lower proportions of older residents and one of the highest population densities in the city. Population forecasts suggest declining numbers of children and young people alongside growth in older age groups over the coming years.

The NHA experiences some of the highest levels of deprivation in Portsmouth. Nearly half of residents live within the most deprived national decile. Income deprivation, employment deprivation, deprivation affecting older people and crime are all substantially worse than the Portsmouth average. Child poverty is also significantly higher, while fuel poverty, overcrowding and households without access to a car or van are more common than across the city.

Children and young people face several challenges. The Children and Young People deprivation sub-domain score is worse than Portsmouth overall, while Year 6 obesity prevalence is significantly higher. Birth rates and fertility rates are also higher than city averages. However, several other indicators, including low birth weight babies, reception obesity prevalence, injury-related admissions and self-harm admissions among young people, are similar to the Portsmouth average.

Adult recorded prevalence of smoking, obesity, asthma, COPD, diabetes and five or more long-term conditions are all higher than the Portsmouth average. Self-reported poor health is also higher. Adult recorded prevalence of unhealthy alcohol use is lower than the city average.

Emergency hospital admissions are consistently higher than the Portsmouth average across a wide range of conditions, including all-cause admissions, COPD, coronary heart disease, heart attacks, stroke, self-harm, falls and hip fractures. Life expectancy is lower than the city average and mortality from all causes, premature mortality, preventable mortality, cardiovascular disease, respiratory disease and COPD are all significantly worse than across Portsmouth overall.

Overall, Central NHA experiences very high levels of deprivation, poorer health outcomes and consistently higher rates of emergency hospital admission than Portsmouth overall, making it an important focus for prevention and neighbourhood health approaches.

Appendix 5 Portsea & Somerstown neighbourhood health area profile as at 26th August 2026

Legend	Meaning
*	Comparison uses confidence intervals
†	Comparison uses values only and is not statistically tested
Better*	Statistically better than Portsmouth
Worse*	Statistically worse than Portsmouth
Higher*	Statistically higher than Portsmouth
Lower*	Statistically lower than Portsmouth
Similar*	Not statistically different from Portsmouth
Better†	Better than Portsmouth based on a value-only comparison; not statistically tested
Worse†	Worse than Portsmouth based on a value-only comparison; not statistically tested
Higher†	Higher than Portsmouth based on a value-only comparison; not statistically tested
Lower†	Lower than Portsmouth based on a value-only comparison; not statistically tested
Not compared	A comparison was not available

Indicator	Reporting period	Value	Statistic type (see Value)	Value Portsmouth	NH compared to Portsmouth
▲					
% population aged 0-4 years (latest year)	2024	4.1%	%	5.3%	Lower†
% population aged 0-15 years (latest year)	2024	14.7%	%	17.9%	Lower†
% population aged 65+ years (latest year)	2024	8.0%	%	14.9%	Lower†
% population aged 85+ years (latest year)	2024	0.9%	%	2.0%	Lower†
Population density (people per square km)	2024	8167.57	People per square km	5306.22	Higher†
HCC SAPF: Population change aged 0-4 years forecast in 2031	2024 to 2031	43.0%	%	-1.8%	Higher†
HCC SAPF: Population change aged 0-15 years forecast in 2031	2024 to 2031	25.8%	%	-6.2%	Higher†
HCC SAPF: Population change aged 65+ years forecast in 2031	2024 to 2031	33.1%	%	17.1%	Higher†
HCC SAPF: Population change aged 85+ years forecast in 2031	2024 to 2031	17.7%	%	18.7%	Lower†
% of population of ethnic minorities	2021 Census	40.6%	%	22.3%	Higher†
% of households with no cars or vans	2021 Census	54.9%	%	30.3%	Higher†
% population in most deprived decile (latest year)	2024	24.5%	%	12.2%	Higher†
IMD 2025 average score	IoD 2025	42.27	Score	26.38	Worse†
Income domain average score	IoD 2025	38.0%	%	25.9%	Worse†
Children aged under 16 years in absolute low-income families (Before Housing Costs)	2024/25	36.7%	%	20.7%	Worse†
Children aged under 16 years in relative low-income families (Before Housing Costs)	2024/25	36.7%	%	20.7%	Worse†
IDAOPI average score	IoD 2025	53.0%	%	21.4%	Worse†
Employment domain average score	IoD 2025	16.9%	%	14.0%	Worse†
Unemployment: people claiming out of work benefit (aged 16 to 64 years)	Mar 2026	59.4 per 1,000	Rate per 1,000	45.4 per 1,000	Worse†
Crime domain average score	IoD 2025	1.11	Score	0.55	Worse†
% of households fuel poor	2026 (2024 data)	12.2%	%	10.9%	Worse†
% of households overcrowded (occupancy rating of rooms is -1 or less)	2021 Census	15.3%	%	7.1%	Worse†
Air quality indicator average value	IoD 2025	2.91	Score	2.82	Worse†
Live birth rate	2024	7.1 per 1,000	Rate per 1,000	9.5 per 1,000	Lower*
General fertility rate	2024	23.1 per 1,000	Rate per 1,000	42.7 per 1,000	Lower*
% of low birth weight babies (out of live births)	2018 - 22	11.5%	%	7.7%	Worse*
Children and Young People Sub-domain average score	IoD 2025	1.11	Score	0.62	Worse†
Reception prevalence of obesity (including severe obesity)	2022/23 to 2024/25	13.6%	%	11.1%	Similar*
Year 6 prevalence of obesity (including severe obesity)	2022/23 to 2024/25	24.8%	%	24.8%	Similar*
Emergency hospital admissions: all causes (aged under 5)	2021/22 to 2024/25	147.4 per 1,000	Rate per 1,000	129.1 per 1,000	Worse*
Unintentional and deliberate injuries: hospital admissions in children aged under 5 years	2021/22 to 2024/25	76.1 per 10,000	Rate per 10,000	69.3 per 10,000	Similar*
Unintentional and deliberate injuries: hospital admissions in children aged under 15 years	2021/22 to 2024/25	75.0 per 10,000	Rate per 10,000	62.8 per 10,000	Similar*
Hospital admissions as a result of self-harm (aged 10-24 years)	2021/22 to 2024/25	311.2 per 100,000	DSR	343.7 per 100,000	Similar*
% of people aged 5 and over providing 50+ hours unpaid care (age-standardised)	2021 Census	3.0%	%	2.7%	Higher†
Recorded prevalence of current smokers (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	21.3%	%	15.8%	Worse*
Recorded prevalence of obese (including severely obese) adults (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	28.6%	%	26.6%	Worse*
Recorded prevalence of unhealthy alcohol use (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	10.0%	%	11.5%	Better*
Recorded prevalence of Asthma (age-standardised, all ages)	29 Oct 2025 snapshot	9.9%	%	10.4%	Similar*
Recorded prevalence of COPD (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	7.2%	%	5.1%	Worse*
Recorded prevalence of CHD (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	7.5%	%	6.4%	Similar*
Recorded prevalence of hypertension (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	31.7%	%	30.2%	Similar*
Recorded prevalence of diabetes (age-standardised, all ages)	29 Oct 2025 snapshot	12.3%	%	10.0%	Worse*

Recorded prevalence of Severe Mental Illness (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	2.3%	%	1.4%	Worse*
Recorded prevalence of dementia excluding care homes (age-standardised, aged 65+ years)	29 Oct 2025 snapshot	8.8%	%	6.5%	Similar*
Recorded prevalence of 5+ long-term conditions (age-standardised, aged under 75 years)	29 Oct 2025 snapshot	3.9%	%	2.5%	Worse*
% of people with bad or very bad self-reported health (age-standardised)	2021 Census	10.7%	%	6.0%	Worse*
Emergency hospital admissions: all causes	2021/22 to 2024/25	17351.2 per 100,000	DSR	12025.5 per 100,000	Worse*
COPD: emergency hospital admissions (aged 35 and over)	2021/22 to 2024/25	1104.4 per 100,000	DSR	478.9 per 100,000	Worse*
Coronary heart disease: emergency hospital admissions	2021/22 to 2024/25	260.7 per 100,000	DSR	194.8 per 100,000	Worse*
MI (Heart attack): emergency hospital admissions	2021/22 to 2024/25	201.6 per 100,000	DSR	135.9 per 100,000	Worse*
Stroke: emergency hospital admissions	2021/22 to 2024/25	223.6 per 100,000	DSR	173.3 per 100,000	Similar*
Emergency hospital admissions as a result of self-harm (all ages)	2021/22 to 2024/25	319.4 per 100,000	DSR	179.3 per 100,000	Worse*
Emergency hospital admissions due to falls in people aged 65 and over	2021/22 to 2024/25	2094.7 per 100,000	DSR	1630.2 per 100,000	Worse*
Hip fractures in people aged 65 and over	2021/22 to 2024/25	644.4 per 100,000	DSR	545.2 per 100,000	Similar*
Life expectancy at birth (males)	2022-2024	72.42 years	Years	78.06 years	Worse*
Life expectancy at birth (females)	2022-2024	78.15 years	Years	82.55 years	Worse*
Life expectancy at age 65 (males)	2022-2024	14.19 years	Years	17.71 years	Worse*
Life expectancy at age 65 (females)	2022-2024	18.24 years	Years	20.63 years	Worse*
Mortality from all causes, all ages	2022-2024	1585.7 per 100,000	DSR	1059.7 per 100,000	Worse*
Mortality from all causes aged under 75	2022-2024	693.4 per 100,000	DSR	394.2 per 100,000	Worse*
Mortality from causes considered preventable, aged under 75	2022-2024	347.2 per 100,000	DSR	191.8 per 100,000	Worse*
Mortality from cancer, all ages	2022-2024	430.8 per 100,000	DSR	273.7 per 100,000	Worse*
Mortality from cancer aged under 75	2022-2024	206.0 per 100,000	DSR	142.5 per 100,000	Worse*
Mortality from CVD, all ages	2022-2024	438.3 per 100,000	DSR	264.4 per 100,000	Worse*
Mortality from CVD aged under 75	2022-2024	192.9 per 100,000	DSR	88.5 per 100,000	Worse*
Mortality from CHD, all ages	2022-2024	173.4 per 100,000	DSR	96.7 per 100,000	Worse*
Mortality from Stroke, all ages	2022-2024	78.8 per 100,000	DSR	53.4 per 100,000	Similar*
Mortality from respiratory diseases, all ages	2022-2024	177.5 per 100,000	DSR	126.6 per 100,000	Similar*
Mortality from COPD, all ages	2022-2024	129.8 per 100,000	DSR	66.4 per 100,000	Worse*
Alcohol-related mortality	2022-2024	104.7 per 100,000	DSR	53.1 per 100,000	Worse*

Portsea & Somerstown Neighbourhood Health Area (NHA) is a young, ethnically diverse and densely populated urban area. The NHA has higher proportions of children and young people than Portsmouth overall, lower proportions of older residents and a population density that is substantially higher than the city average. The area also contains a substantial student population and significant high-rise housing. Population forecasts suggest future growth in both younger and older age groups.

The NHA experiences significant deprivation. Around one quarter of residents live within the most deprived national decile. Income deprivation, deprivation affecting older people, employment deprivation and crime are all worse than the Portsmouth average. Children are more likely to be living in both absolute and relative low-income families, while fuel poverty and overcrowded housing are also more common than across the city.

Children and young people experience a mixed picture. Child poverty and the Children and Young People deprivation sub-domain are both worse than the Portsmouth average. Low birth weight babies and emergency hospital admissions among children aged under five years are also higher. However, childhood obesity, injury-related admissions and self-harm admissions among young people are similar to the Portsmouth average.

Several behavioural risk factors are more common within the NHA. Adult recorded prevalence of current smokers and adult recorded prevalence of obesity are significantly higher than the Portsmouth average, while adult recorded prevalence of unhealthy alcohol use is lower. Adult recorded prevalence of diabetes, COPD, severe mental illness and five or more long-term conditions are also higher than across Portsmouth overall, while self-reported poor health is more common.

Emergency hospital admissions are higher than across Portsmouth, particularly for all causes, COPD, coronary heart disease, heart attacks, self-harm and falls among older people. Health outcomes are also poorer, with lower life expectancy and higher rates of premature mortality, preventable mortality, cardiovascular mortality, cancer mortality, COPD mortality and alcohol-related mortality.

Overall, Portsea & Somerstown NHA experiences poorer health outcomes, a greater burden of long-term conditions and higher rates of emergency hospital admission than Portsmouth

overall. The profile highlights the importance of prevention, support for children and families, smoking cessation and effective management of long-term conditions.

Appendix 6 South Coast neighbourhood health area profile as at 26th August 2026

Legend	Meaning
*	Comparison uses confidence intervals
†	Comparison uses values only and is not statistically tested
Better*	Statistically better than Portsmouth
Worse*	Statistically worse than Portsmouth
Higher*	Statistically higher than Portsmouth
Lower*	Statistically lower than Portsmouth
Similar*	Not statistically different from Portsmouth
Better†	Better than Portsmouth based on a value-only comparison; not statistically tested
Worse†	Worse than Portsmouth based on a value-only comparison; not statistically tested
Higher†	Higher than Portsmouth based on a value-only comparison; not statistically tested
Lower†	Lower than Portsmouth based on a value-only comparison; not statistically tested
Not compared	A comparison was not available

Indicator	Reporting period	Value	Statistic type (see Value)	Value Portsmouth	NH compared to Portsmouth
▲					
% population aged 0-4 years (latest year)	2024	4.4%	%	5.3%	Lower†
% population aged 0-15 years (latest year)	2024	12.7%	%	17.9%	Lower†
% population aged 65+ years (latest year)	2024	14.9%	%	14.9%	Lower†
% population aged 85+ years (latest year)	2024	2.4%	%	2.0%	Higher†
Population density (people per square km)	2024	9592.31	People per square km	5306.22	Higher†
HCC SAPF: Population change aged 0-4 years forecast in 2031	2024 to 2031	-5.9%	%	-1.8%	Lower†
HCC SAPF: Population change aged 0-15 years forecast in 2031	2024 to 2031	-2.9%	%	-6.2%	Higher†
HCC SAPF: Population change aged 65+ years forecast in 2031	2024 to 2031	11.2%	%	17.1%	Lower†
HCC SAPF: Population change aged 85+ years forecast in 2031	2024 to 2031	10.4%	%	18.7%	Lower†
% of population of ethnic minorities	2021 Census	28.4%	%	22.3%	Higher†
% of households with no cars or vans	2021 Census	33.7%	%	30.3%	Higher†
% population in most deprived decile (latest year)	2024	0.0%	%	12.2%	Lower†
IMD 2025 average score	IoD 2025	19.13	Score	26.38	Better†
Income domain average score	IoD 2025	17.7%	%	25.9%	Better†
Children aged under 16 years in absolute low-income families (Before Housing Costs)	2024/25	15.7%	%	20.7%	Better*
Children aged under 16 years in relative low-income families (Before Housing Costs)	2024/25	15.7%	%	20.7%	Better*
IDAOP1 average score	IoD 2025	17.7%	%	21.4%	Better†
Employment domain average score	IoD 2025	10.2%	%	14.0%	Better†
Unemployment: people claiming out of work benefit (aged 16 to 64 years)	Mar 2026	42.1 per 1,000	Rate per 1,000	45.4 per 1,000	Similar*
Crime domain average score	IoD 2025	0.67	Score	0.55	Worse†
% of households fuel poor	2026 (2024 data)	14.6%	%	10.9%	Worse†
% of households overcrowded (occupancy rating of rooms is -1 or less)	2021 Census	8.5%	%	7.1%	Worse†
Air quality indicator average value	IoD 2025	2.59	Score	2.82	Better†
Live birth rate	2024	9.3 per 1,000	Rate per 1,000	9.5 per 1,000	Similar*
General fertility rate	2024	39.7 per 1,000	Rate per 1,000	42.7 per 1,000	Similar*
% of low birth weight babies (out of live births)	2018 - 22	7.7%	%	7.7%	Similar*
Children and Young People Sub-domain average score	IoD 2025	-0.07	Score	0.62	Better†
Reception prevalence of obesity (including severe obesity)	2022/23 to 2024/25	10.6%	%	11.1%	Similar*
Year 6 prevalence of obesity (including severe obesity)	2022/23 to 2024/25	21.5%	%	24.8%	Similar*
Emergency hospital admissions: all causes (aged under 5)	2021/22 to 2024/25	129.6 per 1,000	Rate per 1,000	129.1 per 1,000	Similar*
Unintentional and deliberate injuries: hospital admissions in children aged under 5 years	2021/22 to 2024/25	72.9 per 10,000	Rate per 10,000	69.3 per 10,000	Similar*
Unintentional and deliberate injuries: hospital admissions in children aged under 15 years	2021/22 to 2024/25	64.7 per 10,000	Rate per 10,000	62.8 per 10,000	Similar*
Hospital admissions as a result of self-harm (age 10-24 years)	2021/22 to 2024/25	319.3 per 100,000	DSR	343.7 per 100,000	Similar*
% of people aged 5 and over providing 50+ hours unpaid care (age-standardised)	2021 Census	1.8%	%	2.7%	Lower†
Recorded prevalence of current smokers (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	14.1%	%	15.8%	Better*
Recorded prevalence of obese (including severely obese) adults (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	21.1%	%	26.6%	Better*
Recorded prevalence of unhealthy alcohol use (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	14.6%	%	11.5%	Worse*
Recorded prevalence of Asthma (age-standardised, all ages)	29 Oct 2025 snapshot	8.8%	%	10.4%	Better*
Recorded prevalence of COPD (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	4.0%	%	5.1%	Better*
Recorded prevalence of CHD (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	5.9%	%	6.4%	Similar*
Recorded prevalence of hypertension (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	27.2%	%	30.2%	Better*
Recorded prevalence of diabetes (age-standardised, all ages)	29 Oct 2025 snapshot	7.5%	%	10.0%	Better*
Recorded prevalence of Severe Mental Illness (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	1.8%	%	1.4%	Worse*
Recorded prevalence of dementia excluding care homes (age-standardised, aged 65+ years)	29 Oct 2025 snapshot	5.5%	%	6.5%	Similar*
Recorded prevalence of 5+ long-term conditions (age-standardised, aged under 75 years)	29 Oct 2025 snapshot	1.8%	%	2.5%	Better*
% of people with bad or very bad self-reported health (age-standardised)	2021 Census	5.1%	%	6.0%	Better†
Emergency hospital admissions: all causes	2021/22 to 2024/25	10326.5 per 100,000	DSR	12025.5 per 100,000	Better*
COPD: emergency hospital admissions (aged 35 and over)	2021/22 to 2024/25	267.2 per 100,000	DSR	478.9 per 100,000	Better*
Coronary heart disease: emergency hospital admissions	2021/22 to 2024/25	170.1 per 100,000	DSR	194.8 per 100,000	Similar*
MI (Heart attack): emergency hospital admissions	2021/22 to 2024/25	112.9 per 100,000	DSR	135.9 per 100,000	Similar*
Stroke: emergency hospital admissions	2021/22 to 2024/25	168.6 per 100,000	DSR	173.3 per 100,000	Similar*
Emergency hospital admissions as a result of self-harm (all ages)	2021/22 to 2024/25	148.2 per 100,000	DSR	179.3 per 100,000	Better*
Emergency hospital admissions due to falls in people aged 65 and over	2021/22 to 2024/25	1603.4 per 100,000	DSR	1630.2 per 100,000	Similar*
Hip fractures in people aged 65 and over	2021/22 to 2024/25	479.0 per 100,000	DSR	545.2 per 100,000	Similar*
Life expectancy at birth (males)	2022-2024	78.88 years	Years	78.06 years	Similar*
Life expectancy at birth (females)	2022-2024	82.20 years	Years	82.55 years	Similar*
Life expectancy at age 65 (males)	2022-2024	18.14 years	Years	17.71 years	Similar*
Life expectancy at age 65 (females)	2022-2024	20.23 years	Years	20.63 years	Similar*
Mortality from all causes, all ages	2022-2024	1062.1 per 100,000	DSR	1059.7 per 100,000	Similar*
Mortality from all causes aged under 75	2022-2024	362.2 per 100,000	DSR	394.2 per 100,000	Similar*
Mortality from causes considered preventable, aged under 75	2022-2024	159.4 per 100,000	DSR	191.8 per 100,000	Similar*
Mortality from cancer, all ages	2022-2024	252.2 per 100,000	DSR	273.7 per 100,000	Similar*
Mortality from cancer aged under 75	2022-2024	133.0 per 100,000	DSR	142.5 per 100,000	Similar*
Mortality from CVD, all ages	2022-2024	275.8 per 100,000	DSR	264.4 per 100,000	Similar*
Mortality from CVD aged under 75	2022-2024	83.9 per 100,000	DSR	88.5 per 100,000	Similar*
Mortality from CHD, all ages	2022-2024	94.5 per 100,000	DSR	96.7 per 100,000	Similar*
Mortality from Stroke, all ages	2022-2024	73.5 per 100,000	DSR	53.4 per 100,000	Similar*
Mortality from respiratory diseases, all ages	2022-2024	108.5 per 100,000	DSR	126.6 per 100,000	Similar*
Mortality from COPD, all ages	2022-2024	37.0 per 100,000	DSR	66.4 per 100,000	Better*
Alcohol-related mortality	2022-2024	56.4 per 100,000	DSR	53.1 per 100,000	Similar*

South Coast Neighbourhood Health Area (NHA) is one of the most densely populated parts of Portsmouth and has greater ethnic diversity than the city overall. The area includes a substantial student population, many of whom live in shared accommodation. It has lower proportions of children than Portsmouth overall, a similar proportion of residents aged 65 years and over and a higher proportion aged 85 years and over. Population forecasts indicate decreases in the number of children and growth in older age groups.

The NHA has a comparatively positive overall deprivation profile. None of its population is recorded as living in the most deprived national decile, and average scores for overall deprivation, income, employment and deprivation affecting older people are better than Portsmouth's. Children are significantly less likely to live in absolute or relative low-income families, and the Children and Young People deprivation sub-domain score is also better. However, crime, fuel poverty and overcrowding compare less favourably than the city average.

Most indicators for children and young people are similar to the Portsmouth average, including low birth weight babies, childhood obesity and hospital admissions for injuries and self-harm. Adult recorded prevalence of current smoking and obesity is significantly lower than the Portsmouth average. In contrast, adult recorded prevalence of unhealthy alcohol use is significantly higher.

Recorded prevalence indicators for asthma, COPD, hypertension, diabetes and five or more long-term conditions are lower than the Portsmouth average. Adult recorded prevalence of severe mental illness is higher, while coronary heart disease and dementia are similar. The proportion reporting bad or very bad health is lower than the city average.

All-cause emergency hospital admissions, COPD emergency admissions and emergency admissions following self-harm are significantly lower than the Portsmouth average. Most other emergency admission measures are similar. Life expectancy and most mortality measures are also similar to Portsmouth, although COPD mortality is lower.

Overall, South Coast NHA has several comparatively good health indicators. Adult recorded prevalence of unhealthy alcohol use represents a potential focus for prevention, while the higher recorded prevalence of severe mental illness should be considered separately within support for long-term health needs. Fuel poverty, overcrowding and crime are further areas where the NHA compares less favourably.

Appendix 7 South East neighbourhood health area profile as at 26th August 2026

Legend	Meaning
*	Comparison uses confidence intervals
†	Comparison uses values only and is not statistically tested
Better*	Statistically better than Portsmouth
Worse*	Statistically worse than Portsmouth
Higher*	Statistically higher than Portsmouth
Lower*	Statistically lower than Portsmouth
Similar*	Not statistically different from Portsmouth
Better†	Better than Portsmouth based on a value-only comparison; not statistically tested
Worse†	Worse than Portsmouth based on a value-only comparison; not statistically tested
Higher†	Higher than Portsmouth based on a value-only comparison; not statistically tested
Lower†	Lower than Portsmouth based on a value-only comparison; not statistically tested
Not compared	A comparison was not available

Indicator	Reporting period	Value	Statistic type (see Value)	Value Portsmouth	NH compared to Portsmouth
% population aged 0-4 years (latest year)	2024	5.4%	%	5.3%	Higher†
% population aged 0-15 years (latest year)	2024	17.8%	%	17.9%	Lower†
% population aged 65+ years (latest year)	2024	18.2%	%	14.9%	Higher†
% population aged 85+ years (latest year)	2024	2.6%	%	2.0%	Higher†
Population density (people per square km)	2024	5399.37	People per square km	5306.22	Higher†
HCC SAPF: Population change aged 0-4 years forecast in 2031	2024 to 2031	-4.2%	%	-1.8%	Lower†
HCC SAPF: Population change aged 0-15 years forecast in 2031	2024 to 2031	-5.9%	%	-6.2%	Higher†
HCC SAPF: Population change aged 65+ years forecast in 2031	2024 to 2031	14.8%	%	17.1%	Lower†
HCC SAPF: Population change aged 85+ years forecast in 2031	2024 to 2031	23.0%	%	18.7%	Higher†
% of population of ethnic minorities	2021 Census	16.4%	%	22.3%	Lower†
% of households with no cars or vans	2021 Census	22.5%	%	30.3%	Lower†
% population in most deprived decile (latest year)	2024	0.0%	%	12.2%	Lower†
IMD 2025 average score	IoD 2025	18.23	Score	26.38	Better†
Income domain average score	IoD 2025	19.4%	%	25.9%	Better†
Children aged under 16 years in absolute low-income families (Before Housing Costs)	2024/25	14.2%	%	20.7%	Better*
Children aged under 16 years in relative low-income families (Before Housing Costs)	2024/25	14.2%	%	20.7%	Better*
IDAOPi average score	IoD 2025	14.7%	%	21.4%	Better†
Employment domain average score	IoD 2025	11.1%	%	14.0%	Better†
Unemployment: people claiming out of work benefit (aged 16 to 64 years)	Mar 2026	35.4 per 1,000	Rate per 1,000	45.4 per 1,000	Better*
Crime domain average score	IoD 2025	0.26	Score	0.55	Better†
% of households fuel poor	2026 (2024 data)	9.6%	%	10.9%	Better†
% of households overcrowded (occupancy rating of rooms is -1 or less)	2021 Census	3.7%	%	7.1%	Better†
Air quality indicator average value	IoD 2025	2.53	Score	2.82	Better†
Live birth rate	2024	8.7 per 1,000	Rate per 1,000	9.5 per 1,000	Similar*
General fertility rate	2024	43.4 per 1,000	Rate per 1,000	42.7 per 1,000	Similar*
% of low birth weight babies (out of live births)	2018 - 22	7.7%	%	7.7%	Similar*
Children and Young People Sub-domain average score	IoD 2025	0.31	Score	0.62	Better†
Reception prevalence of obesity (including severe obesity)	2022/23 to 2024/25	9.7%	%	11.1%	Similar*
Year 6 prevalence of obesity (including severe obesity)	2022/23 to 2024/25	22.8%	%	24.8%	Similar*
Emergency hospital admissions: all causes (aged under 5)	2021/22 to 2024/25	120.4 per 1,000	Rate per 1,000	129.1 per 1,000	Similar*
Unintentional and deliberate injuries: hospital admissions in children aged under 5 years	2021/22 to 2024/25	58.3 per 10,000	Rate per 10,000	69.3 per 10,000	Similar*
Unintentional and deliberate injuries: hospital admissions in children aged under 15 years	2021/22 to 2024/25	62.3 per 10,000	Rate per 10,000	62.8 per 10,000	Similar*
Hospital admissions as a result of self-harm (aged 10-24 years)	2021/22 to 2024/25	355.6 per 100,000	DSR	343.7 per 100,000	Similar*
% of people aged 5 and over providing 50+ hours unpaid care (age-standardised)	2021 Census	2.3%	%	2.7%	Lower†
Recorded prevalence of current smokers (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	13.3%	%	15.8%	Better*
Recorded prevalence of obese (including severely obese) adults (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	25.2%	%	26.6%	Better*
Recorded prevalence of unhealthy alcohol use (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	13.5%	%	11.5%	Worse*
Recorded prevalence of Asthma (age-standardised, all ages)	29 Oct 2025 snapshot	11.4%	%	10.4%	Worse*
Recorded prevalence of COPD (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	4.5%	%	5.1%	Similar*
Recorded prevalence of CHD (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	6.1%	%	6.4%	Similar*
Recorded prevalence of hypertension (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	30.2%	%	30.2%	Similar*
Recorded prevalence of diabetes (age-standardised, all ages)	29 Oct 2025 snapshot	9.2%	%	10.0%	Similar*
Recorded prevalence of Severe Mental Illness (age-standardised, aged 20+ years)	29 Oct 2025 snapshot	1.3%	%	1.4%	Similar*
Recorded prevalence of dementia excluding care homes (age-standardised, aged 65+ years)	29 Oct 2025 snapshot	7.0%	%	6.5%	Similar*
Recorded prevalence of 5+ long-term conditions (age-standardised, aged under 75 years)	29 Oct 2025 snapshot	2.2%	%	2.5%	Better*
% of people with bad or very bad self-reported health (age-standardised)	2021 Census	5.0%	%	6.0%	Better†
Emergency hospital admissions: all causes	2021/22 to 2024/25	10910.2 per 100,000	DSR	12025.5 per 100,000	Better*
COPD: emergency hospital admissions (aged 35 and over)	2021/22 to 2024/25	336.2 per 100,000	DSR	478.9 per 100,000	Better*
Coronary heart disease: emergency hospital admissions	2021/22 to 2024/25	186.7 per 100,000	DSR	194.8 per 100,000	Similar*
MI (Heart attack): emergency hospital admissions	2021/22 to 2024/25	125.3 per 100,000	DSR	135.9 per 100,000	Similar*
Stroke: emergency hospital admissions	2021/22 to 2024/25	166.0 per 100,000	DSR	173.3 per 100,000	Similar*
Emergency hospital admissions as a result of self-harm (all ages)	2021/22 to 2024/25	150.9 per 100,000	DSR	179.3 per 100,000	Similar*
Emergency hospital admissions due to falls in people aged 65 and over	2021/22 to 2024/25	1479.8 per 100,000	DSR	1630.2 per 100,000	Similar*
Hip fractures in people aged 65 and over	2021/22 to 2024/25	538.4 per 100,000	DSR	545.2 per 100,000	Similar*
Life expectancy at birth (males)	2022-2024	78.85 years	Years	78.06 years	Similar*
Life expectancy at birth (females)	2022-2024	84.32 years	Years	82.55 years	Better*
Life expectancy at age 65 (males)	2022-2024	18.46 years	Years	17.71 years	Similar*
Life expectancy at age 65 (females)	2022-2024	21.81 years	Years	20.63 years	Better*
Mortality from all causes, all ages	2022-2024	951.2 per 100,000	DSR	1059.7 per 100,000	Better*
Mortality from all causes aged under 75	2022-2024	329.7 per 100,000	DSR	394.2 per 100,000	Better*
Mortality from causes considered preventable, aged under 75	2022-2024	166.5 per 100,000	DSR	191.8 per 100,000	Similar*
Mortality from cancer, all ages	2022-2024	253.2 per 100,000	DSR	273.7 per 100,000	Similar*
Mortality from cancer aged under 75	2022-2024	126.1 per 100,000	DSR	142.5 per 100,000	Similar*
Mortality from CVD, all ages	2022-2024	230.9 per 100,000	DSR	264.4 per 100,000	Similar*
Mortality from CVD aged under 75	2022-2024	61.4 per 100,000	DSR	88.5 per 100,000	Similar*
Mortality from CHD, all ages	2022-2024	78.9 per 100,000	DSR	96.7 per 100,000	Similar*
Mortality from Stroke, all ages	2022-2024	35.3 per 100,000	DSR	53.4 per 100,000	Similar*
Mortality from respiratory diseases, all ages	2022-2024	97.0 per 100,000	DSR	126.6 per 100,000	Similar*
Mortality from COPD, all ages	2022-2024	51.9 per 100,000	DSR	66.4 per 100,000	Similar*
Alcohol-related mortality	2022-2024	55.6 per 100,000	DSR	53.1 per 100,000	Similar*

South East Neighbourhood Health Area (NHA) has a mixed-age population, with a proportion of children broadly comparable with the Portsmouth average and a higher proportion of older residents. Around 18% of residents are aged 65 years and over, while 2.6% are aged 85 years and over. The population is less ethnically diverse than Portsmouth overall and its density is slightly higher. Population forecasts indicate growth in the older population, including a 23% increase among residents aged 85 years and over between 2024 and 2031. The NHA is also home to St Mary's Community Health Campus.

The area's socioeconomic profile is generally more positive than the Portsmouth average. None of the population is recorded as living in the most deprived national decile, and the NHA has better overall deprivation, income, employment, crime and Income Deprivation Affecting Older People scores. Children are significantly less likely to live in absolute or relative low-income families, while the Children and Young People deprivation sub-domain score is also better. Fuel poverty and overcrowding are less common and the air quality indicator is better than the Portsmouth average.

Most indicators for children and young people are similar to Portsmouth, including low birth weight babies, childhood obesity and hospital admissions for injuries and self-harm. Adult recorded prevalence of current smoking and obesity is significantly lower than the Portsmouth average. In contrast, adult recorded prevalence of unhealthy alcohol use is significantly higher.

Recorded prevalence of asthma is significantly higher than Portsmouth, but most other long-term condition indicators are similar. Recorded prevalence of five or more long-term conditions among people aged under 75 years and the proportion reporting bad or very bad health are both lower than the city average.

All-cause emergency hospital admissions and COPD emergency admissions are significantly lower than the Portsmouth average. Other emergency admission measures, including cardiovascular conditions, self-harm, falls and hip fractures, are similar to Portsmouth. Female life expectancy at birth and at age 65 is better than the city average, while male life expectancy is similar. All-cause and premature mortality are significantly lower, and most cause-specific mortality indicators are similar to Portsmouth.

Overall, South East NHA has a relatively positive health profile. Many measures of deprivation, health status, emergency hospital admissions and mortality compare favourably with the Portsmouth average. Population forecasts indicate continued growth in the older population, particularly among residents aged 85 years and over. Adult recorded prevalence of unhealthy alcohol use is higher than the Portsmouth average and may represent an important focus for prevention and health improvement activity. Recorded prevalence of asthma is also higher than the city average. The profile highlights the importance of supporting healthy ageing, maintaining positive health outcomes and targeting prevention activity where specific risks remain.

Appendix 8 Combined Community Engagement Feedback

Combined Findings from Drayton, Cosham and Paulsgrove

Neighbourhood Health Consultation

Combined Findings from Drayton, Cosham and Paulsgrove



By Seekers Create
04/09/2026



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Drayton / PASCO Neighbourhood Health Consultation Report

Drayton / PASCO Neighbourhood Health Consultation Report



By Seekers Create
17/08/2026



1

Cosham / Community Kettle

Neighbourhood Health Consultation Report

Cosham / Community Kettle



By Seekers Create
25/08/2026



1

Paulsgrove / St Michael's Church

Neighbourhood Health Consultation Report

Paulsgrove / St Michael's Church



By Seekers Create
31/08/2026



1

Neighbourhood Health Consultation

Combined Findings from Drayton, Cosham and Paulsgrove



By Seekers Create
04/09/2026

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1. Context and Approach

The three **Neighbourhood Health** sessions in Drayton, Cosham and Paulsgrove used facilitated focus-group discussion, participatory mapping and light-touch structured data collection to explore how people experience neighbourhood, community, health and access in everyday life.

The approach produced a detailed body of qualitative evidence. Participants were able to describe their neighbourhood in their own terms, map the places they regularly use, talk through real travel decisions and explain how health, mobility, relationships, transport and personal circumstances affect their ability to find and use support. Rather than reducing neighbourhood health to a set of fixed questions, the sessions allowed themes to develop through conversation and gave participants space to explain why particular places, services and relationships mattered to them.

The game cards provided an additional comparative layer. Across the three sessions, 37 completed cards captured information about age, travel expectations, current and preferred sources of health and wellbeing advice, and what participants felt would make their neighbourhood happier and healthier. The structured responses support the themes emerging through the conversations rather than operating as a separate population survey.

The three settings also brought different perspectives. Drayton/PASCO involved a predominantly older group, Cosham/Community Kettle was weighted towards middle-aged and older participants, while Paulsgrove/St Michael's included a greater proportion of working-age adults. Similar themes emerging across these different groups strengthen the overall picture, while differences between the locations help show how local circumstances affect people's experience of Neighbourhood Health.

2. Neighbourhood is Defined Through Everyday Life

One of the clearest findings across all three sessions was that participants understood neighbourhood as something lived rather than something defined entirely by administrative boundaries.

Place still mattered. People used names such as Drayton, Farlington, Cosham, Hilsea, Paulsgrove and "The Grove", and some participants could describe recognisable roads or boundaries around their area. However, the area that functioned as their neighbourhood was often wider or different. Family relationships, shopping, community activity, parks, walking routes, personal history and familiar venues all affected where people felt connected.

Drayton provided a particularly clear example of formal boundaries becoming less important in everyday life. Participants living close to the Portsmouth and Havant boundary described

neighbours and relationships continuing across it. The report identified geographical proximity, social connection and emotional connection as overlapping elements of neighbourhood.

“Neighbourhood is about feeling safe and belonging.”

Cosham showed the same principle through Community Kettle. Participants came from Cosham, Hilsea, North End and Wymering, yet the relationships created through the venue meant that it formed part of their community. Some participants described considerably weaker connections with people living immediately around their homes. Community was associated with knowing people, being recognised and having somewhere where help could be asked for informally.

Paulsgrove combined a strong local identity with a much wider lived community. Participants used “Paulsgrove” and “The Grove” naturally, but everyday routines extended towards Cosham, Portchester, North Harbour and Port Solent. St Michael’s extended this further because people travelled there through family links, activities and relationships, including people who did not live in the immediate area.

“I saw that sense of community. You come in and everyone makes you feel really welcome. It’s more because of that social side.”

Across the three sessions, the repeated relationship is between familiarity, trust and localness. A venue does not necessarily feel local because it is the nearest building. A place slightly further away may feel much more accessible because people already use it, know who will be there and feel comfortable entering it.

This has direct implications for Neighbourhood Health. Planning around postcode or ward boundaries alone risks missing the places that already function as part of people’s community.

3. Access is About the Experience of the Trip, Not Simply Distance

The three sessions also produced a consistent finding around travel. There was no single distance or travel time that could describe reasonable access to health support.

Participants made decisions according to what they needed, how they were feeling, the transport available and what they expected to receive at the destination. Walking ability, public transport, access to a car, traffic, parking, cost, pain, mobility, sensory needs, safety and time of day could all change somebody’s effective travel area.

Drayton showed the strongest concentration around shorter journeys. Ten of the 24 respondents selected up to 15 minutes and another ten selected up to 30 minutes. The older profile of the group is relevant here. Participants described walking limitations, reliance on buses and cars,

parking problems and the way illness could reduce the distance somebody could manage on a particular day.

Cosham produced a wider spread of travel times. The conversation made the reason particularly clear. For a lower-level concern or something creating uncertainty, people wanted somewhere nearby where they could ask a question and understand what to do. For something serious, participants became much more prepared to travel.

“If it was something you desperately needed answers to, you wouldn’t have much choice. You’d find a way to go.”

Paulsgrove showed greater willingness to travel for the right healthcare. Participants discussed journeys of 45 minutes and considerably further for specialist or earlier appointments. However, that flexibility often depended upon access to a car. Public transport, mobility difficulties, sensory needs and cost could make the same trip much harder for somebody else.

One particularly useful insight from Paulsgrove concerned sensory accessibility. A family described choosing to drive relatively short distances because dogs, birds, noise and other environmental triggers could make walking difficult.

“Sometimes it’s easier to just drive there because it eliminates all of those triggers.”

The three reports therefore show a strong relationship between the level of health need and the distance people will consider travelling. People were generally prepared to make longer and more difficult trips for specialist treatment or an important appointment. They were much less positive about making those journeys simply to ask an initial question, obtain reassurance, receive basic advice or work out which service they needed.

This suggests that Neighbourhood Health does not need to place every health service within every neighbourhood. The stronger case is for early advice, information, prevention and initial support to be available very locally, with routine and specialist healthcare operating across progressively wider areas.

Accessibility also begins before the physical trip. Cosham participants described online forms, appointment systems and unclear communication as barriers in themselves. One participant spent around 30 minutes completing an online GP form while unwell, only for the form to time out. Another described an older neighbour who was unable to use online access and was told to visit the surgery for help despite being too unwell to get there.

A service can therefore be geographically close but practically difficult to reach.

4. Trusted Community Places Already Form Part of the Health System

A major theme across all three sessions was the amount of health and wellbeing support that already happens outside formal healthcare.

Friends, family, community groups and familiar organisations helped people understand information, decide what to do, find services and sometimes physically reach appointments.

The structured responses reinforce this. Across the 37 completed game cards, community centres, halls and family hubs increased from 9 current selections to 15 preferred future selections. GP selections increased from 26 to 28, while online sources reduced from 22 current selections to 15 future selections. These figures should be read as a supporting comparison across the three groups, but they sit closely alongside the qualitative findings.

Importantly, the conversations did not suggest that participants wanted community groups to take over the role of GPs or clinical services.

In Drayton, the GP remained by far the dominant formal source of advice, selected by 21 of 24 respondents both currently and for the future. At the same time, future interest grew in pharmacies, community settings and council support.

“More support from the GP practice; more activity from community groups. GP practices need to be linked with different community groups.”

Another participant expressed the same principle differently:

“Bring info/research into the community; not all health and social care needs to be provided in clinical settings.”

Cosham showed how this could work in practice. Community Kettle already provided informal health support through everyday relationships. People discussed health concerns while taking part in activities, shared their own experience and helped one another work out what to do.

“We do have these conversations while we’re knitting. That’s how we find things out about people.”

Some participants also accompanied people to appointments because they did not want to attend alone. This is not clinical provision, but it can make clinical care easier to access. Participants were equally clear that community venues needed strong connections with professional services. A community health role would offer limited benefit if it simply created another place from which people were redirected elsewhere.

Paulsgrove developed this further through the idea of a neighbourhood hub.

“A hub which all can use, even if for information or as simple as a chat. A united front for all to use.”

The common proposition across the three areas is therefore not a new community health service operating separately from existing provision. It is a connected local front door, using places and relationships that already exist and linking them directly to appropriate professional knowledge and services.

5. Important Differences Between the Three Locations

Although the overall themes were closely aligned, each location added something different to the combined picture.

Drayton placed greater emphasis on shorter travel times, GP provision, pharmacies and the effect of age and mobility on access. It also highlighted the relationship between neighbourhood health and wider infrastructure. Participants talked about buses, shops, social activity, play areas, youth provision, cleaner streets and the importance of supporting services developing alongside new housing.

Cosham placed particularly strong emphasis on human contact and practical help. Friends and family were selected by all seven respondents as a current source of health and wellbeing advice. Community Kettle demonstrated how conversation, social connection and accompaniment already support health access. The session also raised some of the clearest concerns about difficult digital processes and people being passed between services without a satisfactory answer.

Paulsgrove demonstrated stronger current digital use. All six game-card respondents selected online information as something they currently used, although only four selected it for the future. Participants still wanted printed information and direct conversation alongside digital access. Paulsgrove also raised specific issues around dentistry, sensory access, the needs of carers and companions, and the importance of services being consistent over time.

The Paulsgrove discussion around consistency adds an important principle to the combined findings.

“There’s only one word I can give you, and that’s consistency. Don’t be here for three months and then disappear.”

Trust takes time to develop. If people are expected to use community-based health provision, it needs enough continuity for them to learn what it offers and build it into their normal lives.

6. Recommendations for Neighbourhood Health

The combined findings suggest the following direction for future Neighbourhood Health provision:

1. **Plan around lived neighbourhoods.** Use local knowledge, community activity, travel patterns and trusted venues alongside geographical data. People routinely cross formal boundaries and may have stronger community relationships outside the area immediately around their home.
2. **Develop a connected network of existing community access points.** Community centres, churches, family hubs and other established settings can provide familiar places through which people can begin a conversation about health. Different venues may serve different groups, making a network more useful than relying on one building.
3. **Create a clear local first point of contact.** People should be able to ask a health or wellbeing question without already knowing which organisation they need. The aim should be that somebody leaves with better information, reassurance or a clear next step rather than another telephone number.
4. **Connect community provision directly with professional services.** Local community organisations should support access rather than replace healthcare professionals. Strong working links with GPs, pharmacies, council services and other health providers would allow trusted local relationships to connect people with appropriate expertise.
5. **Keep early help and prevention close to everyday community life.** General health information, lower-level advice, prevention, wellbeing activity and help understanding where to go next have a strong case for very local delivery. Specialist services can operate across a wider geography where this is clinically appropriate.
6. **Design access around practical travel rather than mileage.** Consider walking ability, public transport routes, frequency, parking, traffic, cost, mobility aids, sensory requirements, safety and the return trip. The same service will have a very different level of accessibility for different residents.
7. **Offer digital, telephone, printed and face-to-face routes.** Digital access is useful and already well established for some participants, particularly in Paulsgrove. It should sit alongside other routes rather than becoming the only route into support. Printed local information also has value because it can be kept and referred to later.
8. **Build continuity into local provision.** Where communities are expected to trust and use a neighbourhood service, the presence needs to be reliable. Linking professional input to community organisations that remain active between sessions can help maintain relationships and provide continuity.
9. **Recognise social connection as part of health.** Participants consistently connected wellbeing with friendship, community activity, exercise, parks, local shops, opportunities for children and young people, safe streets and places where people can talk. Neighbourhood Health should connect clinical support with this wider local infrastructure rather than treating them as separate subjects.
10. **Use continuing community engagement to shape local delivery.** The three sessions show that a common model can sit alongside different local priorities. Continuing

focus-group style engagement can help identify which venues people trust, which access barriers matter most locally and where particular gaps such as dentistry, transport or activities need greater attention.

7. Overall Conclusion

Taken together, the Drayton, Cosham and Paulsgrove sessions provide a coherent picture of what **Neighbourhood Health** means from the perspective of people using communities and health services in everyday life.

Neighbourhood is partly geographical, but it is also built through relationships, routines, familiarity and belonging. The same principle applies to health access. Being physically close to a service helps, but proximity has limited value if somebody cannot travel there comfortably, cannot use the booking system, does not understand where to go or does not feel confident asking for help.

The three sessions also show that community infrastructure already plays a significant role in health and wellbeing. Groups and trusted venues provide information, reassurance, companionship and informal routes towards formal support. Their strength comes from relationships that already exist.

The opportunity for Neighbourhood Health is therefore to connect these community relationships much more closely with professional healthcare rather than constructing an entirely separate local system.

The emerging model is one in which people have **a reliable and recognisable local place to start**, supported by several ways of making contact and clear connections into professional services. Early advice, prevention and wellbeing support can happen close to everyday community life. Routine and specialist care can operate across wider areas according to need.

Across all three locations, the strongest message is that local health support works best when people can **reach it, understand it, trust the people involved and leave knowing what happens next**.

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Drayton / PASCO Neighbourhood Health Consultation Report



By Seekers Create

17/08/2026

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1. Context and Approach

This **neighbourhood health** consultation took place with the PASCO group at Drayton Community Centre. It explored how participants define neighbourhood and community, how these ideas relate to the places they use in everyday life, and how far they are willing or able to travel for health and wellbeing support. The wider programme is exploring how neighbourhood-based health services might be designed and located, alongside the practical and social factors that affect access.

The session used a large-scale map, facilitated conversation and individual game cards. Participants identified where they lived, discussed what they considered to be their neighbourhood, and used the map to consider how far they would walk, drive or travel by public transport for health and wellbeing support. The purpose of the mapping approach was to connect questions about access to real places, familiar routes and people's own experience of moving around their area.

Twenty-six people participated in the wider session and 24 completed game cards. The group was predominantly older. Eleven game-card respondents were aged 65 to 74, nine were 75 to 84 and two were aged 85 or over. In total, 22 of the 24 respondents, 91.7%, were aged 65 or over, and 23, 95.8%, were aged 50 or over. This age profile is relevant when considering walking distance, mobility, access to public transport and the effect of health on people's ability to travel.

The session took place in Drayton, but it should not be read as a representative survey of the population of Drayton. Participants came from a wider geographical area. Eight respondents recorded PO6 postcodes, five PO9, three PO4, three PO1 and individual respondents recorded PO2, PO7, PO11 and PO15 postcodes, with one postcode redacted. Participants described their own local areas using names including Drayton, Farlington, Cosham, Havant, West Bedhampton, Buckland, North End, Hilsea, Titchfield and Southsea/Milton. The findings therefore represent the experiences and views of people taking part in the **Drayton/PASCO consultation session**, rather than a population sample of one neighbourhood.

This wider spread became useful to the research. It allowed participants to compare different areas and exposed the difference between neighbourhood as something defined administratively and neighbourhood as something experienced through everyday life.

2. How Participants Understand Neighbourhood and Community

The consultation found no single definition of neighbourhood. Participants described it through several overlapping factors: where they live, where they spend time, the people they know, where family live, familiar places, personal history, safety and belonging. Home was often the starting point, but the discussion showed that it was rarely the only factor.

For many participants, neighbourhood initially meant the physical area around their home. This was particularly relevant to an older and largely retired group. Participants commented that they now spent considerably more time around home, meaning that the place where they lived and the place where they spent their time had become closely connected.

The written responses showed the same attachment to identifiable places. Twenty respondents answered the question about what they called their local area. Some simply wrote “Home” or “Home / Drayton”, while others identified places such as Farlington, Buckland, North End, Hilsea and West Bedhampton. Several responses covered more than one place, including “Farlington and Cosham; people and places; Havant and North Portsmouth”.

The conversation, however, showed that **where somebody lives and where they experience community can be different**. Family relationships could extend someone's community beyond their residential neighbourhood. Activities and social opportunities could do the same. Participants described travelling to other areas because there were people to meet or things happening there. This suggests that neighbourhood tends to start with place, while community can follow people's relationships and everyday activity.

One participant described the difference from another angle. They regarded their current neighbourhood mainly as a physical place because they did not know many of the people around them. This provides an important distinction. Someone can live within a neighbourhood without necessarily feeling that they belong to its community.

The group placed considerable emphasis on people and relationships when discussing what turns an area into a community. Places such as community centres, shops and health facilities were valued, but the discussion suggested that buildings gain meaning through the people who use them. The group considered the example of placing a community centre or health centre in an area without involving or connecting with local people. The emerging view was that the building alone would not create community.

The existing PASCO group provided a practical example of this social role. One participant described how members helped each other make connections and solve problems:

“Because it's such a close group. You talk to someone and then we can solve the problem by getting together. Someone will say, ‘I can solve it for you. I'm going to see so-and-so.’”

This suggests that community groups can already act as informal support networks. People exchange knowledge, connect one another with help and make use of relationships that already exist.

Neighbourhood boundaries are real, but flexible

Formal boundaries were recognised by participants, but they did not always match people's lived experience. This became particularly clear for people living close to the Portsmouth and Havant boundary.

One participant explained:

“Our house is the last house in Havant and then it's Portsmouth. Our neighbours are in Havant as well as Portsmouth. Here, for instance, he lives just behind our house in Portsmouth and we live in Havant.”

The significance of the example was not that boundaries were irrelevant. Participants clearly knew where those boundaries were. Rather, the administrative line did not determine who they regarded as their neighbours.

The discussion therefore moved towards the idea that somebody can belong to more than one neighbourhood. Areas can overlap when the social relationships and geography continue across a formal boundary. For neighbourhood health, this suggests that rigid service boundaries may sometimes divide people whose everyday lives cross those lines routinely.

Personal history also shaped neighbourhood identity. When asked what can make somewhere feel like a person's neighbourhood, one participant answered:

“Where you grew up, you went to school there.”

This suggests that neighbourhood identity can remain connected to places from earlier periods of someone's life. Familiarity, established relationships and knowledge of an area may continue to affect where somebody feels comfortable accessing support, even after their address changes.

Safety and belonging added an emotional dimension. One contribution from the discussion was summarised as:

“Neighbourhood is about feeling safe and belonging.”

The game cards reinforced this. Participants used descriptions such as “neighbours”, “people and places”, “a mixture of people and locality”, “friendly”, “very quiet”, “nice location and lively” and “green environment”. They were describing the experience and character of a place as well as its location.

Taken together, the participant findings point to three overlapping aspects of neighbourhood: **geographical proximity, social connection and emotional connection**. Where someone lives matters. So do the people they know and the places where they participate. Familiarity, comfort, safety and belonging can also affect how local somewhere feels.

This means geographically local and socially local are not always the same thing. A facility can sit close to someone's home but have little connection with their daily life. Another place slightly

further away may feel easier to access because it is familiar, trusted or connected to people and activities they already know.



3. Travel, Distance and Accessibility

Participants did not describe one fixed distance that represented acceptable access to health and wellbeing support. Instead, they talked about **time, mode of travel, mobility, traffic, parking, public transport and their health at the point when they needed the service.**

The mapping activity explored walking, car and public transport separately. Participants used different coloured strings from their position on the map to represent the distances they felt able or prepared to travel. The exercise therefore explored personal travel areas rather than assuming that everyone living the same distance from a service has the same level of access.

The game-card statistics show that the main concentration of responses was within 30 minutes. Twenty-three of the 24 respondents marked at least one travel-time category. Two people selected more than one category, so the categories should not be treated as mutually exclusive.

Travel time marked	Respondents	% of all respondents
Up to 15 minutes	10	41.7%
Up to 30 minutes	10	41.7%
Up to 45 minutes	0	0%

More than 45 minutes	5	20.8%
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The statistical finding is therefore best understood as a **strong concentration around short journeys of 15 to 30 minutes, alongside a smaller group who were prepared to travel much further**. The game cards record overall travel expectations rather than separate times for each mode of transport, so the walking, driving and public transport findings below come mainly from the map activity and discussion.

Walking and personal mobility

The conversation suggests that around 15 minutes could represent an acceptable walking distance for some participants. One participant, when asked directly about travel, responded:

“Walking, 15 minutes.”

They then immediately added another consideration:

“The bus is not good, but it's free.”

Another participant estimated that reaching their health centre would require around a 25-minute walk. The discussion established that this was beyond the distance they would normally choose to walk.

These examples indicate that 15 minutes may provide a useful reference point when thinking about walkable local support for some people, but the evidence does not support treating it as a standard walking radius for the whole group.

For some participants, walking meaningful distances was not a realistic option at all. One participant was comfortable with around 30 minutes of travel by car or public transport but explained that they did not walk these days. Given the age profile of the group, this is an important finding. A service can be geographically close enough to appear walkable while remaining inaccessible on foot for some of the people living nearby.

Driving, traffic and parking

Driving expanded the area participants could reach, but it did not make distance irrelevant. Some participants preferred routine health and wellbeing support within a relatively short travel time, while others were comfortable with around 30 minutes.

Participants repeatedly translated distance into the practical experience of the trip. Traffic could turn what looked like a short distance on the map into a journey of half an hour. Parking could also determine if a location was workable. One participant compared nearby health facilities partly on the basis that one had parking while another did not.

This suggests that straight-line distance provides only part of the picture. For people travelling by car, accessibility includes travel time, congestion, ease of route and the ability to park at the destination.

Public transport

Public transport created different opportunities and barriers. Free bus travel could make longer journeys financially manageable for older residents, even where participants were not particularly positive about the service itself.

At the same time, public transport was not available as a practical option for everyone. One participant explained that they could walk or drive to their surgery but could not reach it by bus.

The game-card comments support this concern. One participant specifically identified the “availability of frequent bus service” as something needed to make their local area happier and healthier.

The finding is therefore not simply that public transport needs to be nearby. **A route has to work for the person and the destination.** Frequency, connections, cost, mobility and the location of stops all affect how useful public transport is for accessing health support.

Health can change someone's travel radius

One of the clearest points in the discussion was that participants struggled to describe an acceptable travel distance without considering their health at the time.

When a conversation tried to separate the distance somebody would travel from the circumstances of their health need, one participant responded:

“How sick you are.”



They then explained that even for an appointment they already had planned, their decision about how to get there would depend on how well they felt that day.

This distinction matters. **How far someone is willing to travel is not necessarily the same as how far they are able to travel when they need healthcare.**

Someone may normally walk but need a car when they feel unwell. A person may own a car but not feel able to drive when ill. Somebody may normally tolerate a 30-minute trip but find that unreasonable while experiencing symptoms or recovering from treatment.

Participants also distinguished everyday health and wellbeing support from more serious or urgent health needs. The findings therefore suggest that health services should not all be assessed against one travel threshold. The acceptable distance for information, prevention or routine wellbeing support may differ from GP appointments, ongoing clinical care and specialist services.

4. Where Participants Get Support Now and What They Want in Future

The game cards asked participants where they currently receive health and wellbeing advice and where they would like to receive it in future. Respondents could select several options, so the percentages show how many people chose each source rather than a single preferred service.

Source of health and wellbeing support	Current	Future	Change
GP	21 people, 87.5%	21 people, 87.5%	No change
Friends & Family	15, 62.5%	15, 62.5%	No change
Online	12, 50.0%	9, 37.5%	-3
Dentist	10, 41.7%	8, 33.3%	-2
Chemist	9, 37.5%	13, 54.2%	+4
Community Centre / Hall / Family Hub	2, 8.3%	7, 29.2%	+5
Support Groups	8, 33.3%	8, 33.3%	No change

Portsmouth City Council	6, 25.0%	10, 41.7%	+4
Food Banks / Pantries	0	0	No change
Other	1, 4.2%	2, 8.3%	+1

The GP remains the dominant formal source of support. Twenty-one of the 24 respondents currently use their GP for health and wellbeing advice, and the same number selected the GP for the future. The participant findings therefore show continued demand for general practice rather than a desire to replace it with a different neighbourhood service.

Friends and family were equally stable, selected by 15 respondents both currently and for the future. This reinforces the earlier discussion about community and relationships. Informal support already forms part of the way people understand health, seek advice and make decisions.

The largest increase in the game cards was for community centres, halls and family hubs, moving from 2 people currently to 7 people for the future. Chemists increased from 9 to 13, and Portsmouth City Council from 6 to 10. Online support moved from 12 current selections to 9 future selections.

These numbers should be read as preferences within this group rather than forecasts of demand across the wider population. Within the session, however, they show interest in having a broader range of places through which people can obtain health and wellbeing advice.

The written responses help explain what that might mean in practice. One participant wrote:

“More support from the GP practice; more activity from community groups. GP practices need to be linked with different community groups.”

Another wrote:

“Bring info/research into the community; not all health and social care needs to be provided in clinical settings.”

Rather than suggesting that participants want all services moved into one community venue, these responses point towards stronger links between existing health provision and the places people already use.

The game cards also asked what people felt was needed to make their local area happy and healthy. Eighteen participants provided written comments. Health provision appeared within these responses, including GP support, wellbeing support, doctors, pharmacies and quick access to services, but people's answers extended well beyond healthcare.

Participants also identified good friends and neighbours, exercise, socialising, local shops, cleaner streets, fewer cars, less late-night noise, frequent buses, places for children to play football, children's play areas and youth clubs.

The responses show that people in this session understood neighbourhood health in broad terms. Access to healthcare mattered, but so did transport, relationships, physical activity, the local environment and opportunities for people to spend time together.

The recorded conversation about newer housing developments raised a similar concern. Participants described areas where large numbers of homes had been built but where they felt that shops, schools, doctors and other supporting services had not developed alongside them. This suggests that participants saw health access as part of the wider infrastructure that allows a neighbourhood to function.

5. Interpretation and Implications for Neighbourhood Health

What the findings suggest

The evidence from the Drayton/PASCO session suggests that neighbourhood should be understood as a **lived area rather than a fixed service boundary**. Participants used geographical names and recognised formal boundaries, but their actual communities extended through relationships, family, familiar places, activities and personal history. Safety and belonging also affected how people described where they felt connected.

The travel evidence adds another dimension. Accessibility is not adequately described by miles from a service. The same location can be accessible to one resident and difficult for another because of mobility, health, parking, traffic or public transport. A person's effective travel area can also change when they become unwell.

The statistics show that short travel times of 15 to 30 minutes were common preferences within the group, but they do not support one universal catchment. Some participants wanted services close by, others were prepared to travel further, and some could not use particular transport options regardless of distance.

The service-preference data also suggests that participants are interested in a **network of health and wellbeing support rather than one single location**. GPs remain central, while the increased future selections for chemists, community settings and council support suggest scope for other local routes into advice, information and support.

Implications for future provision

Taken together, these findings suggest that neighbourhood health provision could be planned around **lived catchments**, taking account of where people actually go and the places with which they already have relationships.

Very local community settings may be particularly suited to information, prevention, wellbeing support, early help and signposting. These are forms of support that may benefit from being close to home and connected with familiar organisations. Routine clinical services may operate across a wider area, with specialist provision covering a wider geography again.

This should not be interpreted as a rigid tier based on distance. The central finding is that different forms of support create different travel expectations, and people's circumstances affect what is realistically accessible.

Existing community settings may also provide an important connection between residents and formal services. The participant discussion showed that trusted groups already help people share information and connect one another with support. The game-card responses similarly expressed interest in stronger links between GP practices and community groups.

Service planning should therefore consider **social access as well as physical access**. A location may technically be nearby, but that alone does not make it part of someone's neighbourhood. Familiarity, confidence, relationships and the practical experience of reaching the service all contribute to accessibility.

Overall conclusion

The Drayton/PASCO consultation does not identify one neighbourhood boundary or one ideal travel radius. Instead, it shows why neighbourhood health needs a more flexible understanding of locality.

For participants in this session, neighbourhood was shaped by place, people and belonging. Access to health support was shaped by time, mobility, transport and how well somebody felt when they needed help. Their preferences for future support retained the GP at the centre while showing interest in a wider network involving pharmacies, community settings and other local sources of support.

The main finding is therefore not that every health service needs to be placed within a particular number of minutes from home. It is that **services need to reflect the way people actually experience their local area and the practical conditions under which they seek help**.

Neighbourhood Health Consultation Report

Cosham / Community Kettle



By Seekers Create

25/08/2026

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1. Context and Approach

This Neighbourhood Health consultation took place at Community Kettle in Cosham. It explored how participants understand neighbourhood and community, what makes an area feel local to them, how travel and accessibility affect their ability to use health and wellbeing services, where they currently seek advice and support, and what they would prefer in future.

The session used open group discussion alongside a participatory mapping activity and a short game card. Participants were invited to talk about where they live, the places they regularly use and the people and activities they associate with their community. The mapping activity explored the areas people could or would travel to on foot, by car and by public transport, while the game cards gathered comparable information about local area, health and wellbeing support, travel time, age and what participants felt would help create a happier and healthier neighbourhood.

Seven completed game cards were collected. The wider conversation involved a small group of people connected to Community Kettle, including regular attenders and volunteers. The age profile of completed cards was weighted towards middle-aged and older adults.

Profile measure	Count / share
Completed game cards	7
20–24	1 (14.3%)
50–64	4 (57.1%)
65–74	1 (14.3%)
75–84	1 (14.3%)

Four of the seven respondents were aged 50–64, two were aged 65 or over and one was aged 20–24. There were no completed cards from people aged 25–49 or from under-20s. This age profile is relevant to some of the issues raised during the consultation, particularly mobility, access to digital services, health-service use and participants' comparisons between present-day community life and earlier experiences.

The geographical reach of the session extended beyond a single formal Cosham boundary. Participants described their local area using places including Cosham, North End, Hilsea and Wymering. Five respondents recorded PO6 postcodes and two recorded PO2 postcodes. Community Kettle therefore appeared to serve people from a wider lived catchment rather than only those living immediately around the venue.

This matters because the consultation repeatedly showed that people do not necessarily define their neighbourhood through administrative boundaries. Relationships, activities, routines and places of trust often had greater influence on where participants felt they belonged.

The findings represent the experiences of participants in this session and should not be assumed to represent every resident across Cosham or the wider surrounding area. Their value lies in the detail they provide about how neighbourhood, community, travel and access are experienced in everyday life.

2. How Participants Understand Neighbourhood and Community

One of the clearest findings was that participants did not use the words neighbourhood and community to mean exactly the same thing. Neighbourhood was often described in geographical terms: the street where someone lived, surrounding roads, nearby shops, parks and the places they could easily reach. Community was more strongly associated with relationships, familiarity, mutual help and a sense of belonging.

Participants described the difference in emotional terms. A neighbourhood could exist around someone without necessarily creating a feeling of community. During the discussion, the idea emerged that a neighbourhood could almost exist “without a soul”, while community was associated with an extended or chosen family.

“We all help each other. We’re all here for each other. If anybody walks in here with a problem, we’ll do our level best to help.”

Community Kettle itself was a strong example of this distinction. Participants described it as a place where they knew people, spent time, helped others and felt supported. Several talked about it in family terms. For some, its importance came less from its physical location than from the relationships that existed there.

One participant described choosing to spend her time at the Kettle rather than returning to a former craft business because the venue gave her connection, purpose and people to talk to.

“I’d far rather be here than sat at home on my own. I’ve got my assistance dog, but then I’ve got nobody to talk to. I’d far rather be in here.”

This points to an important distinction between being geographically local and socially local. Someone can live very close to other people without feeling connected to them. One participant described living in Hilsea within an area containing a strong extended family network but still feeling outside it.

“There are people around me, but they don’t talk. When we first moved in we were welcome, but we’ve always been the outsiders.”

Another participant described an even stronger experience of disconnection, saying she did not consider the area around her home a community and instead associated it with loneliness. This was not the dominant view in the session, but it illustrates why proximity alone does not create belonging.

The reverse was also evident. Participants could feel strongly connected to places further from home because that was where important relationships or activities were located. Community Kettle functioned in this way for some people. Although they lived elsewhere, the venue remained part of what they understood as their community.

Personal history was also important. Participants talked at length about places they had lived previously and about how community had changed over time. Memories of Portsea, Charlotte Street Market and small groups of local shops were associated with daily recognition and repeated contact. People remembered traders who knew what customers would buy, neighbours who knew each other and shops that doubled as social spaces.

One participant recalled her mother running a haberdashery shop where customers would stay for tea rather than simply buying something and leaving.

“My mum had a shop and there were six shops on our little block. People would come in for wool and stay for a cup of tea. Even the local policeman would come in.”

These memories suggest that local shops and shared spaces once played a significant role in sustaining social contact. The importance was not simply having facilities nearby. It was the repeated interaction those places created.

Several participants felt their lived neighbourhood had become smaller over time. Childhood memories described wider areas in which people knew each other and children travelled further together. Some participants felt that their present-day neighbourhood might extend only a few streets around home.

Part of this appeared to reflect wider social changes, but life stage also mattered. Having children in a local school could expand a parent's network through friendships with other families. Dog ownership could create regular contact with people along walking routes. As children grew older or daily routines changed, those connections could reduce again.

A participant who had moved to the area while raising children explained how school and dog walking helped build her local relationships. Her neighbourhood became larger because her everyday routine created repeated contact with other people.

Dog walking was one of the clearest examples of an activity creating its own community. Participants described parks and walking routes as places where they regularly met others and formed relationships.

“If you've got a dog and you walk it, you have a community.”

King George, Great Salterns, Drayton Park, Alexandra Park, Foxes Forest and routes towards the Eastern Road appeared in these conversations. Some participants travelled considerable distances on foot, while others stayed within a much smaller area. The important point was that these everyday routes helped define where their lived neighbourhood began and ended.

Green spaces also operated as social anchors. People did not necessarily think about the official boundary of an area when describing their neighbourhood. They thought about the places they regularly reached and used.

The boundaries were also affected by time of day and feelings of safety. One participant said she no longer felt comfortable walking in her neighbourhood at night after changes to street lighting made it harder for her to see clearly. Another avoided Commercial Road because she found it crowded and intimidating.

For another participant, concerns about foxes had changed when she walked her dog. She described how evening walks had once involved spending several hours in the park talking with other dog owners while the dogs played together. Losing that routine also reduced an opportunity for social contact.

These experiences show that neighbourhood boundaries are not fixed. They expand and contract according to relationships, mobility, confidence, safety, daily activity and stage of life.

Within this group, neighbourhood therefore had several overlapping layers. There was the immediate area around home, the wider area created through routine activities and travel, and the social community formed around relationships and trusted places.

These layers did not always match. Someone could feel little connection to their immediate street while feeling strongly connected to a community venue elsewhere. For neighbourhood health provision, this suggests that the places people already trust and use may be as important as formal geographical boundaries.

3. Travel, Distance and Accessibility

Travel responses from the seven completed game cards were spread across several time periods rather than showing one clear preferred distance.

Travel time marked	Count	% of 7 cards
Up to 15 minutes	1	14.3%
Up to 30 minutes	2	28.6%
Up to 45 minutes	2	28.6%

More than 45 minutes	2	28.6%
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One respondent marked both the 45-minute and more-than-45-minute categories, while one did not mark a travel-time category. The responses therefore indicate a broad spread of travel tolerance rather than a single threshold that can be applied to everyone.

The conversations help explain this variation. Participants did not describe their willingness to travel as fixed. It changed according to the seriousness of the health issue, how they felt at the time, the transport available and how confident they were that the destination would provide useful help.

For minor or uncertain health concerns, participants generally preferred support to be close to home. They wanted somewhere accessible where they could ask a question, receive reassurance and understand what they should do next.

For more serious health needs, the calculation changed. Participants said they would travel further if an appointment was important or if they needed an answer to a significant health problem.

“If it was something you desperately needed answers to, you wouldn’t have much choice. You’d find a way to go.”

This highlights a key difference between how far someone is willing to travel and how far they are physically able to travel when they are unwell.

A person might normally be prepared to travel 30 or 45 minutes but find that same trip very difficult when experiencing pain, illness, fatigue or reduced mobility. Participants discussed St Mary’s Walk-in Centre in these terms. It was possible to travel there, but for an older person who was already unwell, getting to the bus, travelling across the city and reaching the service could be demanding.

The destination had not changed, but the practical accessibility of it had.

Walking distances varied considerably. One participant described walking from North End towards Great Salterns and the Eastern Road. Others described much shorter routes around King George or Gurnard Park. Another participant explained that problems with her knees meant she did not walk far.

These examples show why walking catchments cannot be assumed from distance alone. Age, pain, health, confidence and purpose all influence how far somebody can realistically travel.

Green space could increase willingness to walk because it created a destination and an opportunity for social contact. At the same time, concerns about lighting, safety or particular routes could reduce the area people felt able to use.

“I used to walk around my neighbourhood at night, but since they changed the street lighting I can’t see as much as I used to. I don’t go out there at night now.”

Driving significantly enlarged the area some participants could reach. One younger participant described around 20 minutes by car as a meaningful boundary. Others pointed out that Portsmouth is compact enough for a short drive to cross several perceived neighbourhoods.

Traffic could change the meaning of those travel times. A 20-minute journey could cover very different distances at different times of day.

Driving also depended on personal circumstances. One participant relied on her husband because she did not drive. Another had temporarily stopped driving following problems with her eyesight. In that situation, a health issue itself reduced her ability to access other health services.

Parking and access to a vehicle also influenced travel. Participants talked about relying on others for transport, cars being unavailable or blocked in, and the practical complications involved in getting somewhere. These examples show why describing a service as accessible by car does not necessarily mean a person can use it.

Public transport worked particularly well when the route matched the destination. One participant explained that a bus stopped almost directly outside Community Kettle, making the venue easy to use.

Where bus routes were indirect or did not run conveniently, the effective travel area reduced. Participants also described bus travel to hospital and walk-in services as adding extra effort for someone already feeling unwell.

Mobility aids created another important perspective. One participant using an electric wheelchair explained that the chair allowed her to travel much further than she could walk.

“I’ve got an electric chair so I don’t walk, and I would say I practically cover all of that. It gives you your independence back.”

Her account showed that mobility aids can expand rather than restrict a person’s accessible area. She also talked about the initial reluctance she had felt about using a chair and the stigma she associated with it. Other participants expressed similar hesitation about using mobility aids such as walking sticks.

Mobility therefore needs to be understood in terms of what enables someone to take part in daily life rather than simply how far they can walk.

The consultation also identified barriers that existed before a journey even began. Participants described digital booking systems, difficulties getting appointments and unclear communication between services.

One participant described trying to complete an online GP form while already feeling unwell.

“I spent 30 minutes trying to fill out the online form and got in such a state because I wasn’t feeling well. By the time I filled it out, it timed out.”

Another described an older neighbour who did not use the internet and struggled to access an online booking system.

“She hasn’t got the internet. They tell her to come into the surgery and they’ll do it with her, but she’s not well and she can’t get to the surgery.”

This demonstrates that a health service can be geographically close while remaining difficult to access in practice.

A neighbourhood health model based only on distance would therefore miss much of what participants described. The effective travel area changes according to the type of health need, a person’s condition that day, transport options, mobility, traffic, parking, bus routes, safety, time of day and the processes required to access the service.

4. Where Participants Get Support Now and What They Want in Future

Participants could select more than one answer when identifying where they currently get health and wellbeing advice and where they would prefer to get it in future. Percentages therefore do not total 100%.

Because the sample contains seven completed game cards, counts are particularly important alongside percentages.

Advice / support source	Current count	Current %	Future count	Future %	Change
Online	4	57.1%	2	28.6%	-2
GP	2	28.6%	4	57.1%	+2
Dentist	2	28.6%	2	28.6%	0
Chemist	5	71.4%	3	42.9%	-2
Friends & Family	7	100.0%	5	71.4%	-2
Community centre / hall / family hub	4	57.1%	5	71.4%	+1

Support Groups	0	0.0%	1	14.3%	+1
Portsmouth City Council	0	0.0%	1	14.3%	+1
Food banks / pantries	0	0.0%	0	0.0%	0
Other	1	14.3%	2	28.6%	+1

The current pattern shows a strong dependence on informal and easily available sources. All seven respondents selected friends and family, while five selected a chemist. Four selected online information and four selected a community centre, hall or family hub.

Only two selected their GP as a current source of advice, the same number as a dentist.

In future, the pattern moves towards a combination of trusted community settings and professional health support. Five respondents selected community centres, halls or family hubs, compared with four currently using them. GP preference increased from two people to four.

At the same time, online sources reduced from four to two and chemists reduced from five to three. Friends and family remained important, with five respondents still selecting them for future support.

These changes involve small numbers and should not be treated as population-level trends. Within the consultation group, however, the pattern is consistent with the discussion. Participants valued the convenience of online information and pharmacies but did not always feel those options provided the level of reassurance or resolution they needed.

For lower-level health concerns, participants wanted somewhere they could speak to a person who could help them understand the issue and what to do next. Chemists and opticians were discussed as potentially useful local sources, but several participants felt that staff did not always have enough time or that different services did not communicate well enough with one another.

“You ring one place and they tell you to speak to the doctor. You speak to the doctor and they tell you to speak to them. There’s no communication.”

GP access generated some of the strongest frustration. Participants talked about difficulties getting appointments and systems that felt difficult to use when somebody was already unwell.

The discussion also made an interesting distinction around waiting. Participants did not necessarily object to waiting if they knew they would eventually be seen. Some remembered previous systems where people could arrive at a surgery, wait their turn and receive help.

The greater frustration came from not knowing when help would be available or being unable to secure an appointment at all.

One participant described trying to help a neighbour who was ill and being offered an appointment the following week.

The issue was not simply convenience. Participants felt that a person asking for help because they were unwell needed a route that responded to the situation they were experiencing at that moment.

Community venues offered a different type of support. Community Kettle already operated as a place where people talked about health while taking part in everyday activities.

Participants described sharing personal experience, asking other members or staff for advice and helping people work out where to go next.

“We do have these conversations while we’re knitting. That’s how we find things out about people.”

There were also examples of participants accompanying other people to medical appointments.

“We get older people in here who don’t have anybody to go to the doctors or hospital with. I’ve gone to appointments with people because they don’t want to go on their own.”

This role should not be confused with clinical healthcare. It is instead a form of social support, reassurance and practical help that can make formal healthcare easier to access.

The increased future preference for community centres, halls and family hubs is therefore consistent with the experience participants already had at Community Kettle. Five of seven respondents selected this form of support for the future.

The findings suggest that people value places where they already feel comfortable and where asking for help does not require entering an unfamiliar or highly formal setting.

However, participants also wanted reliable professional advice. A community venue would have limited value if it simply became another place where someone was told to contact a different service. Any neighbourhood health role based in community settings would therefore need strong links to clinical services and clear referral routes.

Written answers about what was needed to create a happy and healthy neighbourhood reinforced the same themes.

Comments included:

“Friendly neighbours/community. To feel safe.”

“Friendly people – good community of people/neighbours.”

“Community Centre.”

One respondent gave a particularly service-focused answer:

“G.P. that are actually accessible; a walk-in centre that is closer to us and accessible.”

These responses show that participants did not separate health completely from wider neighbourhood life. Feeling safe, knowing other people, having places to meet and being able to reach healthcare were all part of what they considered a healthy local area.

Green spaces and everyday activities also contributed. Parks and dog walking were described as places where relationships formed and people had reasons to leave home.

One participant felt there were too few green spaces, while other conversations showed that lighting, feelings of safety and other environmental conditions affected how those spaces were used.

Transport formed another part of this picture. A community service located close to a useful bus route may be accessible to someone who does not drive. A service only a short geographical distance away may be much harder to reach if public transport is indirect.

The consultation therefore connects neighbourhood health with the wider local infrastructure that supports everyday life.

There was also some concern about opportunities for younger people to develop social connections. One participant compared childhood experiences of playing and socialising in larger groups with what she saw among younger people today.

This was an individual perspective rather than a finding shared across all participants, but it adds to the wider discussion about how opportunities to meet and build relationships influence feelings of community.

5. Interpretation and Implications for Neighbourhood Health

What the findings suggest

The findings suggest that neighbourhood health cannot be understood through geography alone.

Participants' lived neighbourhoods were shaped by relationships, activities, familiar places and routes that they could realistically use. Community Kettle provides a clear example. Its social reach extended beyond the streets immediately surrounding it because people travelled there to see friends, volunteer, take part in activities and seek support.

For some participants, a community venue could feel socially closer than their immediate residential neighbourhood.

The findings also suggest that the value of local health support changes according to the type of need.

For a minor concern or something creating uncertainty, participants generally wanted help nearby. They wanted to be able to ask somebody knowledgeable, receive reassurance and understand the next step without making a long journey.

When an issue became more serious, distance mattered less. Participants said they would travel further if that was necessary to get the right treatment or an important answer.

This means there is no single useful answer to the question of how far someone will travel for healthcare. A more useful question is how far someone can reasonably travel for that particular health need, on that particular day, using the transport and support available to them.

The spread of travel-time responses supports this. No single time band dominated the game-card responses. The conversations explain why. Travel changes according to age, mobility, illness, traffic, bus routes, confidence, time of day and severity of need.

Another strong finding is that physical proximity does not automatically mean accessibility.

Participants described barriers created by digital booking systems, difficulties getting GP appointments, unclear responsibility between services and a lack of confidence that the service they approached would actually resolve the problem.

A nearby service can therefore feel functionally distant if getting through its front door, telephone system or online process is difficult.

The future support preferences point towards services that combine human contact with professional knowledge. Community venues and GPs both increased as preferred future sources, while reliance on online support and chemists reduced.

The consultation also highlights the amount of health support already carried by personal and community networks.

All seven respondents currently relied on friends and family for health and wellbeing advice. Participants at Community Kettle described sharing experience, helping people understand options and accompanying others to appointments.

This social support can help people access care, but it should not have to compensate for formal services that are difficult to reach or understand.

Mobility also needs to be viewed in terms of a person's practical capacity rather than simply how far they can walk.

For one participant, an electric wheelchair greatly expanded the area she could use. For another, knee problems reduced walking. Vision problems temporarily removed the ability to drive. Public transport worked well when a bus stopped close to the destination but less well when routes were indirect.

The effective neighbourhood for health can therefore grow or shrink as circumstances change.

Implications for future provision

Future neighbourhood health provision could make greater use of trusted community venues as accessible first points of contact.

This could be particularly useful for early advice, prevention, signposting and support with understanding what to do next. Community venues already have relationships with people who may not naturally approach a formal health setting for a lower-level concern.

Provision should follow the places people already use and trust rather than assuming that formal neighbourhood boundaries define where people feel connected.

A venue in Cosham may naturally attract people from Hilsea, North End, Wymering and other surrounding areas because people organise their lives around relationships and routines rather than administrative lines.

Local health provision should also provide several ways to make first contact.

Participants' experiences suggest that digital systems should sit alongside telephone and face-to-face routes rather than replacing them. People who are older, unwell, digitally excluded or struggling with a complicated form may otherwise find themselves unable to access a service that is physically close to them.

There is a strong case for qualified support for lower-level health concerns within or close to community settings.

Participants described situations where they wanted reassurance about medication, symptoms or a health concern that did not necessarily justify travelling to hospital but still needed a confident answer.

Closer connections between community venues, primary care and pharmacies could help provide this, as long as each service has a clear role and people are not repeatedly redirected without resolution.

Transport planning should use real travel experiences rather than distance alone.

Planning should consider walking conditions, bus routes and frequency, traffic, parking, mobility-aid access and how difficult the journey becomes when somebody is unwell.

The time of day also matters. Lighting, personal safety and confidence affected some participants' willingness to walk locally in the evening.

A service catchment that appears small and accessible on a map may therefore feel much larger to the person trying to use it.

There may also be value in community-based accompaniment or connector roles.

Participants already described going with people to hospital or GP appointments because they were anxious about attending alone. Formalising some of this support through community connectors, volunteers or peer networks could help people follow through with referrals and appointments.

This should support rather than replace professional healthcare.

Community activity itself also has a role in neighbourhood health.

Craft groups, volunteering, dog walking, parks and regular social contact gave participants reasons to leave home and created relationships through which information and support could move.

The strongest comments about loneliness came from situations where those networks were missing.

Neighbourhood health provision could therefore connect health advice and prevention activity with existing community groups rather than treating clinical health and social connection as separate issues.

Clearer information about what different services actually provide would also help.

Participants described frustration at approaching one service only to be told to contact another. People need to understand which services can help with different levels of health concern and what will happen when they contact them.

Better coordination could reduce repeated calls, unnecessary travel and the feeling of being passed between services.

Further consultation would help test these findings with groups less visible in this session. The completed game cards were weighted towards people aged 50 and over, with only one participant aged 20–24 and none aged 25–49.

Future sessions could explore the same issues with younger people, working-age adults, parents of younger children, people who do not currently use community venues and people with a wider range of mobility and access needs.

Overall conclusion

The Cosham / Community Kettle consultation found that neighbourhood health is shaped by relationships and practical access as well as geography. Participants described community through people who know, support and spend time with each other, while the immediate area around home could sometimes feel socially disconnected.

Community Kettle showed how a trusted community hub can draw people from across several local areas and become part of their lived neighbourhood.

The consultation also found that there is no single appropriate travel distance for health support. Participants generally preferred lower-level advice to be close and easy to access, while accepting longer journeys for serious or important care. Their actual ability to travel changed according to health, mobility, transport, traffic, safety and the way services could be contacted.

The findings point towards neighbourhood health provision that is local where it needs to be, connected to trusted community spaces and backed by clear professional advice and onward routes. For participants in this session, proximity mattered most when people could genuinely use the service, trust it and get the help they needed.

Neighbourhood Health Consultation Report

Paulsgrove / St Michael's Church



By Seekers Create
31/08/2026

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1. Context and Approach

This Neighbourhood Health consultation took place at St Michael's Church in Paulsgrove as part of a wider community event. It explored how people understand their neighbourhood and community, the places they use in everyday life, how far they are willing and able to travel for health and wellbeing support, where they currently find information and advice, and what they would like to see provided locally in future.

The session combined informal conversation, participatory mapping and a short game card. Participants located themselves on maps of Paulsgrove and the wider Portsmouth area, then used routes and distances to explore walking, public transport and car travel. This created discussion about the difference between a formal neighbourhood boundary and the area somebody actually uses as part of their daily life.

The consultation also explored the social side of neighbourhood health. St Michael's was particularly useful in this respect because people did not describe the church only as a building or a place of worship. It was also used for community events, children's activities, social contact, information and informal support. Some people taking part had strong family connections to Paulsgrove without living immediately nearby, showing how local community networks can extend beyond residential boundaries.

Six completed game cards were collected, all with postcodes. Half of respondents were aged 35–49, two were aged 50–64 and one was aged 75–84.

Profile measure	Count / share
Completed game cards	6
Postcodes recorded	6
35–49	3 (50.0%)
50–64	2 (33.3%)
75–84	1 (16.7%)

There were no completed cards from people under 35, aged 65–74 or aged 85 and over. The quantitative findings therefore represent a small group weighted towards working-age adults, although the wider event included conversations with older residents and people using mobility aids.

The responses also show that local identity was not expressed in one consistent way. Participants described their area as “Paulsgrove”, “The Grove”, “Borderline Cosham and Portchester” and “Community orientated; supportive”. One respondent simply described Paulsgrove as “It's OK”. These different descriptions are important because they show that

neighbourhood can be understood as a named place, a boundary, a set of relationships or an assessment of what living there feels like.

The findings should therefore be understood as detailed insight from people who took part at St Michael's rather than as a representative survey of every resident in Paulsgrove. The value comes from the way the game-card responses and conversations reveal how geography, relationships, trust, transport, information and local services interact in everyday life.

2. How Participants Understand Neighbourhood and Community

Paulsgrove produced a strong sense of place, but participants did not always describe its boundary in the same way. Some thought about recognisable roads and physical edges. Others defined the area through the places they used, such as local shops, North Harbour, Port Solent, Cosham and St Michael's.

"The Grove" was used on two of the six completed game cards, suggesting that the shortened local name carries its own identity. Other respondents used Paulsgrove directly, while one described living on the borderline between Cosham and Portchester.

One discussion explored the boundary between Paulsgrove, Wymering and Portchester in detail. The participant could identify roads that felt like formal edges of Paulsgrove, but their lived area extended beyond them because everyday shopping and other activities took place further away.

Local shopping patterns were a good example. One participant described using North Harbour because it offered better choice and value than some of the smaller shops immediately nearby.

"The little shops near us are so expensive. I only go there in an emergency."

This meant that places outside the tightest residential boundary could still form part of the participant's normal neighbourhood. Port Solent and North Harbour were included because they were regularly used and, for that participant, could be reached on foot.

Interestingly, the participant did not feel that their neighbourhood itself would necessarily become smaller if their walking ability reduced. They still thought of the same places as part of their neighbourhood, but the way they reached them would change. A bus journey could replace a walk even if it took longer.

This suggests a distinction between someone's mental picture of their neighbourhood and their practical ability to move around it. The place can remain familiar and socially relevant even when mobility changes.

For other participants, neighbourhood was much more closely tied to the distance they normally walked. One family described an area of roughly a 15 to 20 minute walk around home as a reasonable representation of their local neighbourhood.

However, their sense of community was larger than this physical area. St Michael's was described as one of the places that extended it.

One participant explained that their family regularly came to the church even though they were not churchgoers.

"Even though we don't go to church or anything, we come here quite a lot. It's good for community events like today, and they put on a lot for Easter and stuff like that."

The nearby adventure playground was also part of this local network. Church activities, children's facilities and family connections created a practical group of destinations around which community life happened.

This was reinforced by people comparing Paulsgrove with places where they had lived previously. One participant who had lived in North End felt their family had become much more involved in community life after moving to Paulsgrove.

"We used to live in North End and we didn't access the community anywhere near as much as we do now. I think there's an awful lot here."

Family relationships played a role. The participant's partner had grown up in Paulsgrove, his parents lived nearby and other relatives remained in the area. Moving to Paulsgrove therefore meant moving into an existing support network rather than simply changing address.

St Michael's then added another layer to that network.

The importance of the church was particularly clear in another conversation with a family who did not live immediately in Paulsgrove but travelled to St Michael's each week. Their immediate residential neighbourhood was elsewhere, but their stronger community relationships were connected to the church.

The reason was less about religious practice and more about the experience of being welcomed and included.

"I saw that sense of community. You come in and everyone makes you feel really welcome. It's more because of that social side."

The contrast with their residential neighbourhood was notable. They described cordial relationships with some immediate neighbours, but little wider connection.

"I couldn't tell you any of their names."

They felt far more connected to people at St Michael's and said they would be more likely to find information, support and useful relationships through the church community than through people living near their own home.

This provides one of the clearest findings from the Paulsgrove session. A person's community can exist somewhere other than their immediate residential neighbourhood. It can be created through regular attendance, relationships and trust.

St Michael's also appeared to have a wider social catchment than Paulsgrove itself. A separate conversation involved women who had travelled from other parts of Portsmouth, including areas around Southsea and Fratton. Their husbands had grown up in Paulsgrove or Wymering, which meant they still felt a connection to the area and were comfortable returning.

They particularly valued the fact that St Michael's welcomed people regardless of where they lived. This suggests that a trusted neighbourhood venue can serve people connected to an area through family history and relationships as well as current address.

Participants also described the culture of the venue as important. The building mattered in terms of physical accessibility, but people felt that the welcome they received from those inside was at least as significant.

One discussion described how simply having someone at the door who welcomes a new person can affect how comfortable the first visit feels. Participants also talked about young people coming into the church to ask to borrow a football and being trusted to take it out, play and return it.

This type of everyday interaction gave the venue an informal role beyond formal programmes.

The findings suggest that community infrastructure cannot be assessed only by counting buildings. A building becomes socially useful when people know they can enter, feel welcome and expect somebody inside to respond positively.

Historical change was also raised. One contributor remembered a time when Paulsgrove had a wider mix of small local shops and services, including a butcher, greengrocer, pharmacy, sweet shop, fish and chip shop and barber. Their concern was not simply about retail choice. The decline of these local facilities was linked to a broader feeling that some of the places around which everyday community activity happened had been lost.

The same discussion connected this with a perceived lack of things for young people to do. Young people gathering around the church were described less as a problem in themselves and more as a sign that there were limited places for them to go.

There was also discussion about adults who may need somewhere informal to seek support or simply talk, including autistic adults and families supporting people with additional needs.

One contributor summarised the principle simply:

“There needs to be somewhere where everyone can go, even if it’s just for a simple chat.”

This links closely to one of the strongest written game-card responses:

“A hub which all can use, even if for information or as simple as a chat. A united front for all to use.”

The Paulsgrove findings therefore describe neighbourhood as a mixture of physical place and social connection. The formal boundary remains meaningful, particularly through strong local identity such as “The Grove”, but participants’ real communities were organised around family, regular activities, trusted venues and places where they felt welcomed.

3. Travel, Distance and Accessibility

The game-card travel responses show that participants were prepared to consider several different travel times. These were multi-select answers, with some people marking different times for different forms of travel.

Travel time marked	Count	% of 6 cards
Up to 15 minutes	3	50.0%
Up to 30 minutes	3	50.0%
Up to 45 minutes	4	66.7%
More than 45 minutes	2	33.3%

Because participants could mark more than one answer, these figures should not be read as six competing preferences. Instead they show that the acceptable travel area changes according to how somebody travels and what they are travelling for.

The largest number of respondents marked up to 45 minutes. Half also marked 15 minutes and half marked 30 minutes, while two marked more than 45 minutes.

The conversations show why the pattern is broad.

For some participants, walking formed a major part of daily life. One participant described being able to walk between home, local shops and Cosham and said they were comfortable walking for around 25 to 30 minutes.

When asked if they would walk further for something they needed, they were willing to extend that to around 45 minutes.

Another participant described walking to North Harbour and including Port Solent within their neighbourhood because it was physically reachable. However, they also explained that although they might manage the outward walk to a destination, managing the return could be more difficult.

This is an important distinction. A service that sits within somebody's maximum walking distance is not automatically accessible if the full return journey is too demanding.

Public transport could extend the area, but it could also add significant time. One participant described using a bus rather than walking for a longer shopping trip and estimated that this could add around half an hour to the journey.

They were still prepared to make the trip because the destination offered something they valued.

This suggests that participants were not evaluating travel time in isolation. They were comparing the effort of the journey with what they expected to get at the other end.

The same principle applied more strongly to healthcare.

One family explained that they had travelled as far as Basingstoke for appointments when that was where an earlier appointment was available.

"As long as it's a sooner appointment, I'm quite happy to travel."

For serious or specialist healthcare, getting the right appointment could therefore matter much more than keeping the service within the immediate neighbourhood.

The same participant was clear that this flexibility depended heavily on having access to a car.

"If I was relying on public transport, it would be harder."

This difference between willingness and ability is important. Someone may say they would travel almost any distance for a specialist appointment, but that does not mean everybody has the same ability to make that journey.

One participant in Paulsgrove did not drive at all. They normally walked to their GP and used public transport when needed. They described travelling towards Cosham by bus for some services and said that a future local hub around the shops or community centre would be useful.

"Anything down below the shops would be nice. Community centre around that area."

This shows how local provision has different value for people with different transport options. A short journey may be convenient for a driver but significantly more important for somebody dependent on walking or buses.

The consultation also identified a less obvious reason why somebody might choose to drive even when a destination could be reached on foot.

One family described driving most places because parts of the walking environment could cause sensory distress. Dogs, birds, loud noises and other triggers made some journeys difficult.

“Sometimes it’s easier to just drive there because it eliminates all of those triggers.”

This adds an important dimension to accessibility. Travel mode cannot be understood only through distance, physical disability or personal preference. Sensory needs, anxiety and environmental conditions may affect which routes are realistically usable.

For this family, the geographical neighbourhood might be small enough to walk across, but driving made participation considerably easier. The car effectively removed barriers that were not visible on a map.

Mobility difficulties were raised elsewhere in the event. A conversation with three women using mobility scooters or walking frames highlighted another form of travel burden. One described travelling with her husband when he attended treatment despite having mobility difficulties herself.

Her experience also raised the issue of what happens to carers or companions while another person receives treatment. Travel to healthcare is often made by households rather than isolated patients. Someone may be accompanying a partner, managing their own mobility needs and then spending a long period waiting without any useful activity or support.

Cost was also raised in the broader discussion. Travel becomes harder when households are already managing rent, food, bills and fuel. For some people, the decision about where to access support cannot be separated from what the journey costs.

This matters particularly if people are expected to travel regularly rather than for a one-off specialist appointment.

Paulsgrove therefore shows at least three different travel needs. There is a very local area people want to reach easily on foot, a wider area they can reach through bus or car travel for routine needs, and a much larger area they may accept for specialist or urgent healthcare.

These areas are not fixed. They change according to mobility, sensory needs, cost, transport access, the value of the destination and the seriousness of the health issue.

The findings do not support one travel-time threshold for neighbourhood health provision. Instead, they suggest that early advice and routine support benefit from being highly local, while specialist treatment can operate across a much wider area if people are given realistic ways to reach it.

4. Where Participants Get Support Now and What They Want in Future

The six game cards asked where people currently get health and wellbeing advice or support and where they would like to get it in future. Participants could select several sources, so percentages do not total 100%.

Advice / support source	Current count	Current %	Future count	Future %	Change
Online	6	100.0%	4	66.7%	-2
GP	3	50.0%	3	50.0%	0
Dentist	1	16.7%	1	16.7%	0
Chemist	2	33.3%	2	33.3%	0
Friends & Family	3	50.0%	1	16.7%	-2
Community centre / hall / family hub	3	50.0%	3	50.0%	0
Support Groups	2	33.3%	1	16.7%	-1
Portsmouth City Council	3	50.0%	2	33.3%	-1
Food banks / pantries	2	33.3%	0	0.0%	-2
Other	2	33.3%	1	16.7%	-1

The clearest statistical finding is the role of online information. All six respondents selected online sources as something they currently use. Four of six also selected online support for the future, making it the most frequently selected future option.

Paulsgrove therefore differs from a model in which digital access is mainly understood as a barrier. Within this group, online information was already a normal part of how people looked for advice.

However, the fall from six current users to four future selections suggests that participants did not necessarily want online information to carry as much of the role in future.

GPs and community centres, halls or family hubs each remained selected by three of six respondents both now and in future. This places formal primary care and community settings on an equal footing within this small sample.

The future responses were generally more selective than the current responses. No source increased numerically. This may suggest that participants were identifying a smaller group of routes they particularly wanted to rely on rather than repeating every source they currently use.

The qualitative conversations add considerable detail to this pattern.

Printed information remained important despite universal current use of online sources. One participant spoke at length about a quarterly information publication delivered through the door. They valued it because it could be kept, read at a convenient time and returned to when needed.

“It comes through the door. It’s really good. It really is a good book. It’s so informative.”

The participant described using it for information about local activity, housing, council spending, council tax and other practical issues. Because they worked full time, they could not always attend community meetings. The publication gave them a way of staying informed without having to be available at a particular time.

“I find I get a lot from it.”

They kept the publication until the next edition arrived so they could refer back to it. This shows that accessible information does not have to mean online information. A physical publication can work particularly well when it arrives automatically, uses familiar language and allows people to read it at their own pace.

Digital and printed communication should therefore be viewed as complementary rather than competing options.

Dentistry emerged as a specific gap. Only one respondent selected a dentist as a current or future advice source, but two written responses independently highlighted the need for greater dental provision.

One simply wrote:

“Dentist.”

Another wrote:

“More dentists.”

The same need emerged directly in conversation.

“A dentist would be nice.”

This suggests that the low number selecting dentists may reflect limited practical access rather than low demand. The finding deserves attention because a service can appear unimportant in a current-use table precisely because people struggle to access it.

The strongest future theme, however, was the idea of a community hub.

One respondent wrote:

“A hub which all can use, even if for information or as simple as a chat. A united front for all to use.”

This description is broader than a clinic. It describes somewhere people can approach without needing to know exactly what service they need before they arrive.

The conversations supported this. Participants discussed locations around the local shops and community centre as possible access points, while St Michael’s itself demonstrated many of the characteristics that people valued in a community hub.

It was familiar, open, used for different activities and associated with people who would talk to someone rather than immediately directing them elsewhere.

A local hub was also seen as potentially useful for general health information, healthy eating advice and other lower-level wellbeing needs.

The distinction between this and specialist healthcare was fairly clear. Participants were prepared to travel significant distances for a hospital or specialist appointment. What they wanted much closer to home was advice, information, an initial conversation and support in working out what to do next.

Consistency was one of the strongest messages about how such provision should operate.

One contributor described previous services appearing for a short period before disappearing.

“There’s only one word I can give you, and that’s consistency. Don’t be here for three months and then disappear.”

The concern was that people adapt their routines around a service. They learn when it is available, start using it and begin to trust that it will be there. If it then disappears after a short funding period, people are left unsure where to go next.

“People get used to a routine. You start putting it into your daily routine, then take that away. What happens? You don’t know what to do or where you can go.”

This has direct relevance to neighbourhood health provision. Trust is not only created by the quality of a single interaction. It is also created by reliability over time.

A temporary drop-in held in a community venue may be geographically accessible but still fail to become part of community life if residents expect it to disappear.

Participants' experiences at St Michael's suggest that existing community organisations have an advantage because their presence does not begin and end with a health programme. The relationships, activities and routines already exist.

This does not mean community groups should replace healthcare professionals. It suggests that they can provide a stable local front door connected to professional support.

There was also evidence that people already use community relationships for informal health navigation. One church user described St Michael's as somewhere they were more likely to find information and support than through neighbours near their home. Different groups operating through the venue created informal connections to a wider range of support.

Trust was central to this.

Participants described trust as coming from people who are relatable, welcoming and willing to speak in a human way. They felt a formal or professional role on its own did not automatically create that relationship.

The church was valued because people felt recognised when they arrived and knew that others would respond.

This point was illustrated by people attending from outside Paulsgrove. Their residential address did not stop them regarding St Michael's as somewhere they could comfortably return to for activity and connection.

The written responses about what makes an area happy and healthy broadened the findings beyond healthcare services.

One participant wrote:

“Open spaces accessible to all. Access to health care. Community activities. Activities for children.”

Another wrote:

“Better education.”

Another raised local environmental conditions and the responsiveness of local government:

“More dentists. More help from councillors. Asked councillor to remove rubbish and they didn't.”

The rubbish issue developed into a much longer conversation about unresolved waste near homes and uncertainty about which organisation was responsible for dealing with it.

For the participant, the issue affected how the area felt and their confidence that concerns would be acted upon. The problem was made worse by being told that something would happen and then seeing no change.

The discussion also included poor road surfacing and the general condition of local spaces. These concerns show that participants understood health and wellbeing as connected to the environment around them rather than only to medical services.

Accessible open space, clean surroundings, safe routes, activities for children, information, education and responsive local services were all part of the picture.

This broader understanding matters because neighbourhood health is likely to work best when local clinical support connects with the conditions that affect daily wellbeing rather than operating as a separate system.

5. Interpretation and Implications for Neighbourhood Health

What the findings suggest

The Paulsgrove consultation presents neighbourhood as a combination of place, access and relationships.

There is a strong local identity. “Paulsgrove” and “The Grove” were used naturally by participants, and people were able to discuss roads and boundaries that represented the area. At the same time, the places used in everyday life extended towards Cosham, Portchester, North Harbour and Port Solent.

The practical neighbourhood therefore stretches according to what people need and the transport available to them.

The social community can stretch even further.

St Michael's attracted people who lived nearby, people who attended weekly from elsewhere and people from other parts of Portsmouth who retained family links to Paulsgrove or Wymering.

This suggests that neighbourhood health provision should not assume that the nearest building to someone's home is automatically the place where they feel most comfortable seeking support.

Trust can create its own catchment.

St Michael's provides a strong example of what makes a community setting useful. Participants repeatedly focused on the people, welcome and social culture rather than the physical building alone.

Some people who did not identify strongly with formal church attendance still used the venue for events and community activity. Others travelled specifically because the social environment worked for them.

This suggests that placing a health function in a community venue is not enough by itself. The service needs to work with the culture and relationships that make that venue trusted in the first place.

The consultation also shows that local and specialist healthcare serve different geographical needs.

For specialist treatment, participants could be highly flexible. People described travelling considerable distances when that meant getting an earlier or appropriate appointment.

For general information, lower-level health concerns and initial support, the preference was much more local.

This points towards a layered model rather than trying to provide every health service within one neighbourhood hub.

A local access point could help people understand a concern, find information, receive basic advice and connect to the right service. Specialist treatment could remain further away where necessary.

Transport planning must also recognise that people with the same postcode can have very different effective travel areas.

One person may walk for 45 minutes comfortably. Another may use a bus. Someone else may drive a short distance because walking creates sensory distress. A person using a mobility scooter may travel further but still experience difficulty when accompanying somebody else to treatment.

Travel should therefore be understood through practical effort rather than distance alone.

The game-card statistics support this. Participants selected multiple travel times and linked them to different transport methods. There was no single point after which travel became unacceptable.

Another clear finding is that digital access is already highly established. Every completed game card selected online as a current source of support.

Future provision should therefore retain good digital access rather than assuming people want to move away from it entirely.

At the same time, the conversations show the continuing value of physical information and face-to-face contact. The participant who praised a publication delivered through the door demonstrates how useful information becomes when it fits naturally into someone's life.

The findings support a choice of routes: digital for people who want speed and immediate access, printed information for people who value something tangible and reusable, and human contact for questions that require conversation or reassurance.

The specific request for dental access should also be recognised. Dentistry was selected infrequently as a current source but was independently identified as something the area needed. This is a reminder that current use does not always measure need. Low usage can also indicate poor availability.

Finally, the consultation shows how strongly health is connected with the wider condition of neighbourhood life.

Participants talked about open space, rubbish, roads, opportunities for children, social activity, education, local shops and the availability of places to talk.

Neighbourhood health was therefore described through everyday life as well as healthcare.

Implications for future provision

A future neighbourhood health model in Paulsgrove could build from existing trusted community infrastructure rather than starting with an entirely new service identity.

St Michael's, community centres, family hubs and other established local spaces already have relationships and regular activity. They provide opportunities for health information and support to become part of everyday community life.

A local hub or connected network of hubs could provide an identifiable first point of contact for people who have a question but do not necessarily know which professional or service they need.

The participant description of "a hub which all can use" captures this well. The value lies in being able to enter for information, practical support or a conversation without having to arrive with a defined referral pathway.

Any local model should be able to connect people onward rather than becoming another signposting point with limited ability to help.

People should be able to ask a question and leave with a clearer next step.

Location will matter. The conversations suggest that areas around the local shops and community centre are seen as convenient because they sit within existing daily routes. St Michael's offers a different strength through trust and community relationships.

This points towards a network rather than assuming one building needs to perform every function. Advice could be available through several established places with shared referral arrangements and information.

Consistency should be treated as a major design principle.

Participants have experience of short-term services that appear and then disappear. This can weaken trust and discourage people from adapting their routines around future provision.

Neighbourhood health activity should therefore avoid creating expectations that cannot be maintained. Where a service is time-limited, this should be clear from the beginning and people should know what replaces it afterwards.

Where possible, professional input could be connected to organisations that remain present between sessions. This would allow the relationship with the community to continue even when a particular health professional is not physically there.

The findings also support a mixed communication model.

Online information should remain part of provision because all six respondents currently use it. However, online access should sit alongside printed information and face-to-face support.

A simple local information resource delivered through community venues or directly to homes could be particularly useful if it explains what services are available, where they are, who they are for and how people can make contact.

The positive response to a quarterly printed publication shows that information can remain useful for months when people are able to keep it and refer back to it.

Dental provision should be reviewed as a specific local issue. Multiple participants independently raised the need for dentists, despite low current use of dentists as a health-information source.

This suggests a need to distinguish between services people do not want and services people struggle to access.

Travel planning should also distinguish between routine neighbourhood health support and specialist care.

Routine information, early advice and preventative activity should be located within easy local reach. Specialist appointments can operate across a wider geography, but transport needs to be

considered for people without cars, people using mobility aids and people whose sensory or health needs make certain journeys difficult.

Transport support may also need to consider companions and carers. A person accompanying a partner to treatment may have their own health and wellbeing needs. Long waits can create an opportunity for additional information, social support or wellbeing activity rather than treating accompanying people as invisible to the service.

The physical and social environment around health provision also deserves attention.

Participants identified rubbish, local environmental maintenance, accessible open spaces and safe routes as part of what makes an area healthy.

Neighbourhood health partners could therefore work alongside community organisations and local services rather than restricting activity to medical issues.

Community activities for children and adults can also support prevention and social wellbeing. Participants connected a lack of activity with young people having nowhere to go and identified community activity as part of a happier and healthier area.

St Michael's provides an example of how one venue can connect generations through different activities. Similar provision could create opportunities for families, older adults, disabled residents, young people and people seeking informal support to use the same trusted community spaces in different ways.

Further engagement would help build on the six completed game cards, particularly with people under 35, people aged 65–74, people who rarely use community venues, people with limited digital access and residents whose mobility significantly restricts travel.

The wider event also showed that people connected to Paulsgrove may live elsewhere. Future planning should recognise these social connections rather than relying entirely on ward or postcode boundaries.

Overall conclusion

The Paulsgrove / St Michael's Church consultation found a strong local identity alongside a much more flexible lived community. People recognised Paulsgrove and "The Grove" as meaningful places, but their everyday lives extended towards Cosham, Portchester, North Harbour and other parts of Portsmouth. Their strongest community relationships could extend further still.

St Michael's demonstrated the importance of trusted social infrastructure. People valued the venue because they felt welcomed, could take part without needing a formal reason to be there and knew that community relationships already existed around it. For some participants, those

relationships were stronger than the connections they had with people living immediately around their homes.

Travel depended heavily on purpose. Participants were prepared to travel considerable distances for specialist or faster healthcare, but there was a clear case for general advice, information and early support to be available much closer to home. Walking ability, public transport, car access, mobility, sensory needs and cost all changed what was realistically accessible.

The support data adds a further distinction. Online information is already widely used in Paulsgrove, but participants also valued GPs, community settings, printed information and direct human contact. The findings therefore point towards a connected model rather than a single access route.

The strongest local proposition is a consistent, trusted neighbourhood health presence linked to existing community spaces. It should provide an easy place to ask questions, find information and connect to appropriate professional support, while allowing specialist services to operate across a wider area where needed.

For Paulsgrove, the quality of the relationship may be as important as the location. A neighbourhood health service is most likely to become part of community life when people know where it is, know who they will meet, trust that it will still be there and feel comfortable walking through the door.

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Form name	Test Integration Form
Reference	FS123456
Date	19/03/2024



Introduction

We have a bold Vision for the future of our City. By 2040 Portsmouth will be:

- A healthy and happy City - we enhance wellbeing through the education, care and support each person's needs for their physical and mental health and ensuring residents live in good homes where they feel safe and can thrive.
- A City rich in culture and creativity - we enjoy a vibrant cultural scene that makes the most of our location, heritage, and creative energy. We are known as a great, welcoming waterfront and city destination that brings people together.
- A City with a thriving economy - we supercharge local businesses and entrepreneurs, attract investment, builds strong partnerships to develop an excellent skills base and offer brilliant career opportunities for all.
- A City of lifelong learning - our young people are encouraged to develop high, positive aspirations and our adults have lifelong education opportunities that empower them and enrich their lives.
- A green City - we have excellent air quality, green spaces, sustainable transport, use renewable energy and live healthy and active lives. We protect and enhance our land and maritime environment for the future.
- A City with ease access to travel - we encourage and support more walking and cycling, have excellent public transport connections and we make it easy for people to travel for work and pleasure.

For this Vision to manifest into reality, we all have a part to play. We need to ensure that our policies, services, functions, projects and strategies have a positive direct or indirect impact on the above Aspirations. Integrated Impact Assessment is a screening and evaluation tool to review and measure impacts on the key areas crucial to delivery of our Aspirations.

Whilst completing the form, think of our shared values: COLLABORATION, COMMUNITY, EQUALITY, RESPECT and INNOVATION. These values must be at the heart of the way we behave, the way we work, and the way we shape our services and our plans.

Policy details

Directorate	HIOW Integrated Care Board
Service, function	Health and Care Portsmouth
Title of policy, service, function, project or strategy	Health and Care Portsmouth Neighbourhood Health Plan 2026–2029
Type of policy, service, function, project or strategy:	Strategic Plan
What is the aim of your policy, service, function, project or strategy?	The Health and Care Portsmouth Neighbourhood Health Plan sets out the shared approach for developing neighbourhood health across Portsmouth from 2026 to 2029. Its aim is to improve health and wellbeing outcomes and reduce inequalities by organising the collective contribution of communities, the VCSE sector, local government and the NHS more effectively around defined neighbourhood populations. It establishes the neighbourhood geographies, approach to identifying local priorities, delivery framework and accountability arrangements through which partners will increasingly align prevention, health, care, community support and action on the wider determinants of health. It does not replace the statutory or commissioning responsibilities of individual organisations or require every service to be delivered at neighbourhood level.
Has any consultation been undertaken for this proposal?	Yes. The Plan builds on established Portsmouth engagement and co-production and has also been informed by specific community engagement undertaken during 2026 to test the developing neighbourhood approach and proposed footprints.
What were the outcomes of the consultations?	Existing engagement consistently shows that residents understand health and wellbeing as being shaped by more than healthcare alone. Important themes include access to support, transport, housing and affordability, community safety, the quality of the local environment, social connection and trusted community relationships. Residents also value support that is easier to access, better coordinated and responsive to the circumstances of their local area. The 2026 neighbourhood engagement has specifically explored how residents define their neighbourhoods, where they see boundaries, how far they are willing or able to travel, what they expect to access locally and what they value within their communities.

Has anything changed because of the consultation?	Yes – the developing Plan and associated priorities have been shaped by the engagement.
Please provide details	The final 2026 engagement analysis has been used alongside the JSNA and population intelligence to confirm the proposed neighbourhood footprints and priorities. Resident and community insight has strengthened the Plan's emphasis on natural communities rather than purely administrative boundaries; the wider determinants of health; trusted and accessible community routes to support; community assets and VCSE participation; and the need for neighbourhood priorities and responses to vary according to local circumstances. It has also directly influenced the development and prioritisation of investment in Portsmouth's community connection infrastructure, building on community Help Desks, Community Connectors and Community Champions and developing more consistent information about the services and community assets available to residents. Earlier ABCD work in Portsea and Paulsgrove has already led to practical changes including community Help Desks and targeted wellbeing and prevention activity.
Did this inform your proposal?	Yes
Please provide details	Community engagement has informed both the design of the neighbourhood model and priorities for its development. In particular, it has contributed to the decision to develop a dedicated community connection layer, including: • neighbourhood Help Desks and accessible routes into support; • Community Connectors, Community Champions and related trusted community roles; • improved navigation between health, care, VCSE and wider support; • development of comprehensive service and community-asset information; and • stronger feedback of community intelligence into neighbourhood planning and improvement.

Equality Impact Assessment

This section is applicable to my policy	
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Please [watch this Equality Impact Assessment \(EIA\) webinar](#) (13 minutes) before completing the questions below, especially the EIA part of the form. EIAs are crucial and mandated by law - they are a proof we do our best to always fulfil our Public Sector Equality Duty and are a moral thing to do in ensuring barriers to accessing our services are removed or reduced, for both the staff and residents.

Confirm you've watched the webinar	
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Equality Impact Assessment - will it have any negative or positive impacts on the protected characteristics?

Please consider the following

- 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 karolina.szczepaniak@portsmouthcc.gov.uk or go to: [Equality and Diversity Strategy](#)

With the above in mind and following data analysis, who is the policy, service, function, project or strategy going to benefit or have a detrimental effect on and how?	The Neighbourhood Health Plan applies to the whole Portsmouth population, but is specifically designed to improve outcomes for people and communities experiencing poorer health, greater inequality, barriers to accessing support or greater risk of deterioration. Potential benefits include: • identifying differences in need, access and outcomes that may be hidden within citywide averages; • targeting additional support towards communities experiencing greater need or disadvantage; • improving prevention and earlier intervention across the life course; • improving coordination and navigation for people whose needs span different services; • strengthening trusted, accessible community
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	routes to support; and improving independence and reducing avoidable deterioration. Particular potential benefit exists for children and young people experiencing disadvantage; older people and people living with frailty; disabled and neurodivergent people; people with long-term physical or mental health conditions; people experiencing homelessness or multiple disadvantage; carers; people experiencing digital, communication or transport barriers; and communities experiencing socioeconomic disadvantage. The Plan also has the potential to promote greater equality for ethnic minority communities and people with limited English by using more local population intelligence, trusted community organisations and accessible community routes into support. There is no immediate change to entitlement, eligibility or access to existing services arising from approval of the Plan itself.
Will any of those groups be affected in a different way to others because of your policy, project, service, function, or strategy?	Yes. A central principle of the Plan is that different populations and neighbourhoods have different levels and types of need and should not automatically receive identical responses. For example: - children and young people require an all-age approach rather than a model dominated by frailty and urgent care; - older and disabled people may benefit particularly from more coordinated support but may also be more affected by transport, physical accessibility and digital barriers; - ethnic minority communities and people with limited English may require culturally appropriate information, interpretation and trusted routes into support; - people experiencing homelessness, multiple disadvantage or other inclusion-health needs may not fit neatly within geographical neighbourhood boundaries; - pregnancy and maternity may benefit from stronger connections between health, Public Health, Children's Services, Family Hubs and communities, although many maternity services appropriately operate at a wider geography; and - people living in more deprived communities may require greater or different support if neighbourhood health is to reduce rather than

	reproduce existing inequalities. For sexual orientation, gender reassignment and religion or belief, the evidence currently available is less complete. No direct adverse impact has been identified, but absence of evidence will not be treated as evidence of no differential impact. Marriage and civil partnership has no identified differential impact at this stage because the Plan does not make changes to employment arrangements.
If you are directly or indirectly discriminating, how are you going to mitigate the negative impact?	No direct or indirect discrimination has been identified from approval of the Plan. There are, however, potential equality risks in implementation. These include: • neighbourhood averages obscuring smaller communities experiencing inequality; • applying geographical boundaries too rigidly; • transport, digital, physical-accessibility, language or communication barriers; • a disproportionate focus on particular population groups at the expense of others; and • insufficient evidence about some protected characteristics. These risks will be mitigated by: • using neighbourhood profiles and more granular population intelligence rather than relying only on neighbourhood averages; • combining universal provision with targeted approaches according to need; • retaining citywide, specialist and needs-based approaches where neighbourhood geography is inappropriate; • maintaining face-to-face and other non-digital access alongside digital routes; • considering transport, physical accessibility, interpretation and communication requirements in subsequent service design; • reviewing engagement participation to identify under-represented communities and undertaking proportionate further engagement where required; and • completing further impact assessment where implementation results in material changes to services, locations, eligibility, workforce or commissioning arrangements.

Who have you consulted with or are planning to consult with and what was/will be your consultation methodology?	The Plan builds on engagement and co-production undertaken through Health and Care Portsmouth, involving Portsmouth City Council, NHS Hampshire and Isle of Wight, NHS providers, primary care, HIVE Portsmouth, VCSE organisations and communities. The specific 2026 neighbourhood engagement has been led by HIVE Portsmouth working with the Health Determinants Research Collaboration and Community Researchers. It has explored: • how residents define their neighbourhoods and boundaries; • how far people are willing or able to travel; • what people expect to access locally; and • what they value within their neighbourhood. Methods include co-produced questions, face-to-face neighbourhood surveys, area focus groups, asset mapping and interactive mapping, alongside digital participation and physical postcards/post boxes to widen access. The approach also builds on earlier Portsmouth engagement including Imagine Portsmouth, ABCD work in Portsea and Paulsgrove, Healthwatch/University of Portsmouth health inequalities research and ongoing community development. Final engagement analysis will be reviewed for geographic and demographic representation, and any significant gaps will inform further targeted engagement.
How are you going to review the policy, service, project or strategy, how often and who will be responsible?	The Plan covers 2026–2029 and will be reviewed through existing Health and Care Portsmouth governance. Progress will be monitored through neighbourhood population profiles, resident experience, access and outcome measures and delivery against agreed neighbourhood priorities. Reporting will flow through the Portsmouth Provider Partnership (P3) to Health and Care Portsmouth, with strategic progress reported to the Health and Wellbeing Board. The Plan will be reviewed at least annually, with priorities adapted where evidence shows changes in population need, inequalities or resident experience. Equality impact will be reviewed alongside this process, including analysis by protected characteristic and population group where data allows. Responsibility will sit jointly through Health and Care Portsmouth, supported by Portsmouth City Council and NHS HIOW Public Health/analytics and commissioning teams, with

	community insight provided through HIVE and wider VCSE partners. Any subsequent material change to service provision, eligibility, location, workforce, commissioning or organisational arrangements will require a further proportionate impact assessment rather than relying solely on this strategic IIA.
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Crime

This section is partly applicable to my policy	
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Crime - will it make our city safer?

Please consider the following

- 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: [Safer Portsmouth Partnership Plan 2018-2020](#)

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	Community safety has emerged through resident engagement as an important factor affecting health and wellbeing. Residents have identified antisocial behaviour, drug and alcohol activity, crime and fear of going out as issues that influence whether people feel able to walk locally, use green space, allow children outside, participate in community life and feel safe where they live. The Neighbourhood Health Plan does not replace existing policies and plans for community safety. Its relevance is through the way neighbourhood priorities are identified and acted upon. Where community safety is shown to be materially affecting the health and wellbeing of a priority population, the neighbourhood approach will: • make the health and wellbeing impact visible through local intelligence and resident insight; • connect the issue to the organisations and partnerships holding the relevant levers, including Community Safety, policing, housing, Public Health, Children's Services and VCSE partners; • ensure substance misuse, mental health, safeguarding and prevention services are connected where relevant; and • reflect community safety within neighbourhood priorities where evidence shows it is a significant local determinant of health. This is consistent with the emerging neighbourhood
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	model, which distinguishes between issues partners can deliver, those requiring better connection and coordination, and those where neighbourhood health should influence and escalate action through the appropriate responsible organisation or partnership.
How are you going to measure/check the impact of your proposal?	The Neighbourhood Health Plan will not create separate crime or community safety performance measures. Where community safety emerges as a neighbourhood health issue, this will be visible through resident insight and community connection activity, including the number and broad type of contacts recorded through neighbourhood Help Desks. Detailed monitoring of crime, antisocial behaviour, substance misuse and community safety outcomes will remain within the existing services, strategies and partnership arrangements responsible for those areas.

Housing

This section is not applicable to my policy	
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Housing - will there be a positive or negative impact on the provision of good quality homes?

Please consider the following

- 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?
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If you want more information contact [contact Shane Galvin](#)

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	
How are you going to measure/check the impact of your proposal?	

Health

This section is applicable to my policy	
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Health - will this help promote healthy, safe and independent living?

Please consider the following

- How will it improve physical and mental health?
- How will it improve quality of life?
- How will it encourage changes to healthy behaviours? How will
- it create healthy places? (Including workplaces)

If you want more information contact publichealth@portsmouthcc.gov.uk or go to:
Health and wellbeing strategy - Portsmouth City Council

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	The Neighbourhood Health Plan is intended to have a positive impact on physical and mental health, wellbeing and independence and to reduce inequalities in health outcomes across Portsmouth. Its overarching population outcome is to improve healthy life expectancy and reduce inequality in healthy life expectancy between communities. The Plan also seeks to support independence, reduce avoidable deterioration and improve access to coordinated health, care and community support. The neighbourhood approach supports these aims by: • using neighbourhood-level population intelligence, the JSNA, service-use information and resident insight to identify differences in health need, access and outcomes; • giving greater focus to populations experiencing poorer outcomes, greater inequality or unmet need; • strengthening prevention, earlier identification and proactive support; • supporting people with existing conditions to manage their health and maintain independence; • improving coordination between Public Health, social care, children's and wider Local Authority services, VCSE organisations, primary care and NHS providers; • making community and preventative support easier to find through Help Desks, Community Connectors, Community Champions and improved information about local services and assets; and • recognising that housing, income, employment,
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	community safety, social connection, education, physical activity and other wider determinants can materially affect health outcomes. Initial citywide priority populations include people living with frailty, people at risk of or living with cardiovascular disease, people with multiple long-term conditions and people with complex health and social needs, with the relative emphasis varying between neighbourhoods according to population need, inequalities and community insight. The Plan is also intended to contribute to healthy places, by ensuring that wider factors affecting health are visible within neighbourhood priority-setting and connected to the organisations and partnerships responsible for addressing them. No direct negative health impact has been identified from the Plan itself. The principal risk is that neighbourhood working could unintentionally widen inequalities if equal approaches were applied to populations with different levels of need, or if geographical, digital, transport, communication or accessibility barriers reduced access for particular groups. The Plan therefore combines universal and targeted approaches, retains flexibility for citywide or specialist provision where this is more appropriate, and requires future detailed service changes to consider their own impacts. This is consistent with the NHS HIOW assessment, which also cautions that reduced service utilisation alone should not be assumed to represent improved health or equality without considering outcomes, access and experience.
How are you going to measure/check the impact of your proposal?	The Plan includes a neighbourhood outcomes framework comprising: • healthy life expectancy and inequality in healthy life expectancy as the overarching population outcome; • resident-reported health and ability to take care of their health; • relevant Public Health Outcomes Framework, Portsmouth Local Outcomes Framework and Health and Care Portsmouth measures, selected according to neighbourhood priorities; and • relevant NHS and partner measures showing the contribution of neighbourhood delivery. Outcomes will therefore be monitored at both Portsmouth and neighbourhood level, with measures varying where necessary to reflect different population priorities. The two common resident measures across neighbourhoods are:

	• How good or bad is your health today? • How good or bad are you at taking care of your health? Neighbourhood priorities and associated measures will be reviewed as population need, inequalities, service use and resident experience change.
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Income

This section is partly applicable to my policy	
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Income deprivation and poverty - will it consider income deprivation and reduce poverty?

Please consider the following

- How will it support those vulnerable to falling into poverty; e.g., households where no one is in work and lone parent households?
- How will it consider the needs of low-income communities, households and individuals?
- How will it support those unable to work?
- How will it support those with no or low educational qualifications?

If you want more information contact Mark.Sage@portsmouthcc.gov.uk or go to:

Health and Wellbeing Strategy - Portsmouth City Council

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	Income deprivation and affordability are important wider determinants of health in Portsmouth. The Health and Wellbeing Strategy identifies poverty as one of the underlying factors shaping health and wellbeing, and recognises that social inequalities contribute to differences in health outcomes. Resident engagement has also identified affordability as affecting people's ability to make healthy choices, including the cost of food, transport, activities, housing, bills and heating. Residents have highlighted that the issue is not always the absence of support or opportunities, but whether they are genuinely affordable and accessible. The Neighbourhood Health Plan does not replace existing Portsmouth policies, services or programmes addressing poverty, welfare, employment or financial hardship. Its relevance is through the way neighbourhood priorities are identified and acted upon. Where income deprivation or affordability is shown to be materially affecting the health and wellbeing of a priority population, the neighbourhood approach will: • make the health impact visible through population intelligence and resident insight; • recognise income and cost of living alongside
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	clinical and other wider determinants when setting neighbourhood priorities; • connect residents more effectively with existing Local Authority, VCSE and community support through the community connection layer; and • connect identified issues to the organisations and partnerships holding the relevant policy and delivery levers. The Plan explicitly recognises that the balance of action on wider determinants, including income and cost of living, will differ between neighbourhoods according to population need, inequalities and community insight.
How are you going to measure/check the impact of your proposal?	The Neighbourhood Health Plan will not create separate poverty or income-deprivation performance measures. Income deprivation will be considered through neighbourhood population profiles, JSNA information and resident insight when priorities are set and reviewed. The community connection layer, including neighbourhood Help Desks, will also provide information on the number and broad type of contacts and support needs raised by residents, including where affordability or financial circumstances affect access to health, wellbeing or community support. Detailed monitoring of poverty, income, welfare and employment outcomes will remain within the existing Portsmouth strategies, services and partnership arrangements responsible for those areas.

Carbon emissions

This section is only partially applicable to my policy	
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Carbon emissions - will it reduce carbon emissions?

Please consider the following

If you want more information contact kristina.downey@portsmouthcc.gov.uk or go to: [Climate Action](#).

- How will it reduce greenhouse gas emissions during its full design life? How will it reduce energy consumption?
- How will it substitute high carbon energy or fossil fuels with lower carbon energy?
- How will it reduce emissions from any goods, materials and services the project requires?
- How will it reduce wastage and maximise re-use and recycling?
- How will it encourage and support residents to reduce carbon emissions?

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts and maximise any positive impacts?	The Neighbourhood Health Plan is not a carbon reduction strategy and does not directly determine transport, buildings, energy use or procurement. There is, however, a limited potential positive impact where neighbourhood working enables people to access appropriate support closer to home, reduces unnecessary journeys between services and takes account of how residents travel when planning access. The Plan also recognises active travel and air quality as wider determinants of health within the Portsmouth Health and Wellbeing Strategy. Where neighbourhood delivery arrangements are developed, partners should therefore consider opportunities to minimise unnecessary travel and support access by walking, cycling and public transport where this is practical and equitable. Any future service, estate or delivery changes with a material carbon impact would be assessed through the relevant organisational planning and impact-assessment processes rather than through the Neighbourhood Health Plan itself.
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How are you going to measure/check the impact of your proposal?	The Neighbourhood Health Plan will not introduce separate carbon-emissions measures. Where changes to neighbourhood delivery affect travel patterns, service locations or estates, any material carbon impact will be considered through the existing monitoring and sustainability arrangements of the responsible organisation. Resident feedback on travel and access will continue to inform neighbourhood planning, including whether support is practically accessible by public transport, walking or other means.

Energy

This section is not applicable to my policy	
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Energy use - will it reduce energy use?

Please consider the following

- 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 Tristan.Thorn@portsmouthcc.gov.uk or go to:

The Portsmouth Plan

Energy and water at home

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	
How are you going to measure/check the impact of your proposal?	

Climate change

This section is not applicable to my policy	
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Climate change adaptation- will it build resilience to the impacts of climate change?

Please consider the following

- Have you understood the climate change risks to your projects full design life? How
 - will the policy/proposal build resilience to sea level rise, extreme rainfall and flood rise in the city?
 - How will the policy/proposal build resilience to increasing temperatures, heatwaves and droughts in the city?
-

If you want more information contact kristina.downey@portsmouthcc.gov.uk or go to:

[Portsmouth preparations for climate change](#)

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts and maximise any positive impacts?	
How are you going to measure/check the impact of your proposal?	

Natural environment

This section is partly applicable to my policy	
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Natural environment - will it ensure public spaces are greener, more sustainable and well- maintained?

Please consider the following

- 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 greeningportsmouth@portsmouthcc.gov.uk or go to:

[Solent Recreation Mitigation Strategy](#)

[The Portsmouth Plan](#)

[Greening Portsmouth Strategy.](#)

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	Resident engagement has identified the quality of the local environment, including green space, cleanliness and access to pleasant outdoor places, as factors affecting health and wellbeing. People described these as influencing physical activity, social connection and whether they feel able to make use of their neighbourhood. The Neighbourhood Health Plan does not replace existing environmental, parks, biodiversity or public-realm strategies and services. Its relevance is through neighbourhood priority-setting. Where access to or quality of the natural environment is shown to be materially affecting the health and wellbeing of a population, the neighbourhood approach can make that impact visible through resident insight and connect it to the organisations and partnerships responsible for the relevant environmental or public-realm action. The Plan does not itself propose changes to habitats, biodiversity or natural sites.
How are you going to measure/check the	The Neighbourhood Health Plan will not introduce separate natural-environment or biodiversity measures.

impact of your proposal?	Relevant issues will continue to be captured through resident and community insight where they affect neighbourhood health priorities. Detailed monitoring of green space, biodiversity, habitats and the public realm will remain within the existing Portsmouth strategies and services responsible for those areas
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Air quality

This section is partly applicable to my policy	
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Will it improve air quality?

Please consider the following

- How will it reduce the number of motor vehicle traffic in the city?
- How will it reduce emissions of key pollutants, eg Nitrogen Dioxide (NO₂) and particulate matter (PM₁₀ and PM_{2.5})?
- How will it discourage the idling of motor vehicles?
- How will it reduce reliance on private motor vehicles for transport?

If you want more information contact cleanerair@portsmouthcc.gov.uk or go to: [Cleaner Air Portsmouth](#)

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	Air quality is recognised within Portsmouth's Health and Wellbeing Strategy as one of the wider factors affecting health, alongside active travel. Resident engagement has also identified traffic, pollution and the quality of the local environment as factors affecting how people experience their neighbourhoods and their ability to be active locally. The Neighbourhood Health Plan does not replace existing transport or air-quality policies and plans and does not itself set measures to reduce vehicle traffic, emissions or idling. Its relevance is through neighbourhood priority-setting. Where air quality or traffic is shown to be materially affecting the health and wellbeing of a population, the neighbourhood approach can make that impact visible through population intelligence and resident insight and connect it to the organisations and partnerships responsible for action. Neighbourhood planning may also support access to services and community support by walking, cycling or public transport where this is practical and equitable.
How are you going to measure/check the impact of your proposal?	The Neighbourhood Health Plan will not introduce separate air-quality measures. Air-quality and traffic-related concerns may be captured through neighbourhood population intelligence and resident feedback where they affect health priorities. Detailed monitoring of air quality, emissions and traffic will remain within the existing Portsmouth strategies and

	services responsible for those areas.
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Transport

This section is applicable to my policy	
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Will it make transport more sustainable and safer for the whole community?

Please consider the following

- How will it prioritise the safety and experience of pedestrians, cyclists and public transport users over private motor vehicles?
- How will it allocate street space fairly to ensure people (including children, the elderly and those with disabilities) can travel and gather safely in the area?
- How will it increase the proportion of journeys made using sustainable and active transport?
- How will it encourage the use of low emission and/or electric vehicles, when travelling sustainably or actively is not possible?

If you want more information contact transportplan@portsmouthcc.gov.uk or go to: [Local Transport Plan 4](#)

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	Transport has a direct relationship with whether neighbourhood health support is practically accessible to residents. Community engagement has identified transport and travel as important local issues, and the specific 2026 neighbourhood engagement has tested how far residents are willing or able to travel and what they expect to access within their neighbourhood. The equality evidence also identifies transport as a potential barrier to accessing health and care. People who can travel by car generally have better access, while public transport can present greater difficulties; people living in deprived communities are also less likely to have access to a car. Accessibility therefore needs to consider actual travel patterns, public transport and mobility needs rather than geographical distance alone. The Neighbourhood Health Plan does not replace Portsmouth's existing transport, active travel or road-safety policies and plans, and it will not itself determine street allocation, transport infrastructure or the uptake of low-emission vehicles. Its relevance is through: • taking transport and accessibility into account when confirming neighbourhood footprints and planning
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	where support can be accessed; • seeking to make appropriate health, care and community support available closer to residents where this is practical; • considering the needs of people who do not have access to a private vehicle, including older and disabled residents and people living in more deprived communities; • supporting walking, cycling and public transport access where this is practical and equitable; and • connecting transport barriers identified through neighbourhood intelligence and resident feedback to the organisations and partnerships responsible for transport planning and delivery. This is consistent with the established Portsmouth approach that neighbourhood geography needs to take account of the wider infrastructure, including transport, rather than simply drawing boundaries around populations.
How are you going to measure/check the impact of your proposal?	The Neighbourhood Health Plan will not introduce separate transport performance measures. Travel and accessibility will continue to be considered through resident feedback, community engagement and neighbourhood planning, including whether people can realistically access the support intended for their neighbourhood. Transport-related contacts and barriers identified through neighbourhood Help Desks and community connection activity will also provide ongoing local insight. Detailed monitoring of sustainable transport, active travel, road safety and public transport use will remain within the existing Portsmouth transport strategies and services responsible for those areas.

Waste management

This section is not applicable to my policy	
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Waste management - will it increase recycling and reduce the production of waste?

Please consider the following

- 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 David.Emmett@portsmouthcc.gov.uk

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	
How are you going to measure/check the impact of your proposal?	

Culture and heritage

This section is partly applicable to my policy	
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Culture and heritage - will it promote, protect and enhance our culture and heritage?

Please consider the following

- How will it protect areas of cultural value?
- How will it protect listed buildings?
- How will it support the Creative Industries and Creative Practitioners based in Portsmouth?
- How will it make Portsmouth a city people want to live in and visit?

If you want more information contact Claire.Looney@portsmouthcc.gov.uk or go to: [The Portsmouth Plan](#)

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	Resident engagement has identified community activities, community spaces and opportunities to connect with others as important to health and wellbeing. Earlier neighbourhood work has also shown that residents value local identity, familiar places and the assets already present within their communities. The Neighbourhood Health Plan does not replace existing culture, heritage or creative-industry strategies and does not itself protect listed buildings, conserve heritage assets or commission creative industries. Its relevance is through neighbourhood health and community connection. Where access to cultural, leisure or community activities contributes to wellbeing, social connection or reducing isolation, the neighbourhood approach can: • recognise these as part of the community assets available within a neighbourhood; • improve information and navigation so residents are more aware of opportunities available locally; • connect people to appropriate community groups, activities and spaces through Help Desks, Community Connectors and related roles; and • reflect local identity, culture and the places residents value when understanding neighbourhoods and setting priorities. This is consistent with the Plan's wider approach of
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	building on existing community strengths and recognising that people may identify with communities based on culture, faith or shared experience as well as geography. There is no identified impact on heritage buildings or sites, or direct impact on Portsmouth's creative industries.
How are you going to measure/check the impact of your proposal?	The Neighbourhood Health Plan will not introduce separate culture or heritage performance measures. Relevant information will be captured through resident feedback, community asset mapping and the number and broad type of contacts through neighbourhood Help Desks and community connection activity, including connections to local groups, activities and community assets. Detailed monitoring of heritage, cultural participation and the creative economy will remain within the existing Portsmouth strategies and services responsible for those areas.

Employment and opportunities

This section is partly applicable to my policy	
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Employment and opportunities - will it promote the development of a skilled workforce?

Please consider the following

- How will it improve qualifications and skills for local How
- will it reduce unemployment?
- How will it create high quality jobs?
- How will it improve earnings?

If you want more information contact Jane.Lamer@portsmouthcc.gov.uk or go to:
[Portsmouth economic development and regeneration strategy](#)

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	Employment, skills and opportunities are recognised as wider determinants of health. Resident engagement has also identified employment, learning and opportunities as factors that can affect wellbeing and people's ability to participate in their communities. The Neighbourhood Health Plan does not replace existing employment, skills, education or economic development policies and programmes, and it does not itself create jobs, set pay levels or deliver qualifications. Its relevance is through neighbourhood priority-setting and community connection. Where employment, skills or lack of opportunity is shown to be materially affecting the health and wellbeing of a priority population, the neighbourhood approach can: • make the relationship between poor health, unemployment and opportunity visible through local intelligence and resident insight; • connect residents to existing employment, skills, volunteering and learning support through Help Desks, Community Connectors and other community routes; • recognise employment and skills as part of wider prevention where poor health is a barrier to participation; and • connect identified issues to the organisations and partnerships responsible for employment, education, skills and economic development.
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	This is consistent with the neighbourhood approach of considering employment alongside other wider determinants when identifying local priorities, while retaining responsibility for delivery within the appropriate existing services and partnerships.
How are you going to measure/check the impact of your proposal?	The Neighbourhood Health Plan will not introduce separate employment or skills performance measures. Relevant issues will be captured through resident feedback, neighbourhood intelligence and the number and broad type of contacts through Help Desks and community connection activity, including referrals or signposting to employment, learning, volunteering and skills support. Detailed monitoring of unemployment, qualifications, earnings and job creation will remain within the existing Portsmouth strategies and services responsible for those areas.

Economy

This section is partly applicable to my policy	
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Economy - will it encourage businesses to invest in the city, support sustainable growth and regeneration?

Please consider the following

- 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 Jane.Lamer@portsmouthcc.gov.uk or go to:
[Portsmouth economic development and regeneration strategy](#)

Please expand on the impact your policy/proposal will have, and how you propose to mitigate any negative impacts?	The Neighbourhood Health Plan is not an economic development or regeneration strategy and does not directly seek to attract business investment, develop key industries or create employment. There is, however, a limited relationship between population health and the local economy. Improving health, wellbeing and independence can support people's ability to participate in work and community life, while employment and economic circumstances are recognised within the Plan as wider determinants of health. The neighbourhood approach also recognises local businesses alongside community organisations, schools, faith organisations and other local assets that contribute to healthy and connected communities. Where economic circumstances are shown to affect the health and wellbeing of a priority population, neighbourhood health can make that relationship visible and connect it to the organisations and partnerships responsible for economic development, employment and regeneration. The Plan does not replace existing Portsmouth economic-development strategies or programmes.
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How are you going to measure/check the impact of your proposal?	The Neighbourhood Health Plan will not introduce separate economic-growth, business-investment or regeneration measures. Any relevant economic issues affecting neighbourhood health will be considered through population intelligence and resident insight. Detailed monitoring of economic growth, business investment and employment will remain within the existing Portsmouth strategies and services responsible for those areas.
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Social value

This section is applicable to my policy	
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Each year the council distributes public funding and needs to ensure that value for money is achieved, across a wide range of services and functions. There is both obligation and opportunity to ensure that the public funding leverages social and local value for the benefit of local people, businesses and our environment. We have a legal obligation to consider the social good that could come from the procurement of services before they embark upon it. We need to consider the wider impact of the services delivered. Our [Social Value Policy](#) provides more information.

For Portsmouth City Council, Social Value is the lasting and positive impact that we create through the way in which we act to shape a resilient future, for our local and regional communities, businesses and environment.

Please explain how your policy, service, function, project or strategy delivers Social Value	The Neighbourhood Health Plan is intended to increase the value generated from the collective resources already invested in Portsmouth by organising them more effectively around local populations, priorities and outcomes rather than creating an additional organisational or service layer. It supports social value by: • strengthening community capacity and local assets, recognising residents, community groups, faith organisations, schools, local businesses and VCSE organisations as contributors to health and wellbeing rather than simply recipients of services; • investing in community connection infrastructure, including neighbourhood Help Desks, Community Connectors, Community Champions and improved information about local services and community assets; • supporting the VCSE sector as a delivery and co-
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	design partner, bringing local knowledge, trusted relationships, specialist support and resident insight into neighbourhood health; • prioritising prevention and earlier intervention, helping resources to be used before needs escalate and supporting people to remain healthy, independent and connected; • using population intelligence and community insight to target collective action and investment towards populations and neighbourhoods where it can have the greatest impact; and • building on existing local provision and community strengths, rather than unnecessarily duplicating services or creating new structures. The Plan therefore seeks to create lasting local value through better health and wellbeing, stronger communities, increased participation and connection, reduced inequalities and more effective use of public and community resources. Where future commissioning or procurement decisions arise from neighbourhood priorities, the relevant organisations will continue to apply their existing statutory procurement and Social Value requirements.
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Feedback

We would be grateful if you could answer the following questions to help us ensure that the form is fit for purpose. Your opinion as the end-user is crucial.

Following completion of the form, do you feel that your project is better informed and various impacts have been thoroughly considered?	
Enter your email address so we can contact you to discuss this	
Please give details	
Please explain why and advise us on any further support you might need, for example training or changes to the form	

Summary

Who was involved in the Integrated impact assessment?	
Name of person completing this form	
Date of completion	

Submit the form to download a copy of your answers. Please check the information carefully before submitting as it will not be possible to amend later.

Equality Impact Assessment

Please complete the template by following the instructions in each box. If you would like support in completing this form, please contact the ICB Inclusion Team who may be emailed at: hiowicb-hsi.equalityimpact@nhs.net

Audit Trail:

For EIA Author to Complete:

Title of policy, project or proposal:
Portsmouth Neighbourhood Health Plan (including Proposed Health Neighbourhood Footprints)
Lead Author: Bernie Allen, Deputy Director Partnership Commissioning - Portsmouth
Directorate: Medical and Neighbourhood
Exec Sponsor: Dr Lara Alloway

For Inclusion and Sustainability Team to Complete:

Date submitted:
EIA Panel Date: 07/09/2026
Panel approved: 08/09/2026

Equality Impact Assessment

Part A

Q1 What are the intended outcomes of this policy, project or proposal?

The Portsmouth Neighbourhood Health Plan (including Proposed Health Neighbourhood Footprints) is being developed in response to the national Neighbourhood Health Framework, which defines neighbourhood health as putting the person at the centre of health and care by organising services to work together for a defined population. The national aims include improving health and care outcomes, reducing health inequalities, supporting people to stay well at home, strengthening prevention and proactive care, strengthening primary and community services, and improving working between the NHS, local government, public health, social care, the voluntary, community and social enterprise sector (VCSE) and other partners.

The proposed Health Neighbourhood Footprints provide the population geography around which neighbourhood-level need, inequalities, outcomes, planning and the future development of integrated neighbourhood working can be organised. Nationally, ICBs and Health and Wellbeing Boards are required during 2026/27 to agree neighbourhood footprints around natural communities for the future development of Integrated Neighbourhood Teams (INTs); the national framework does not mandate a single neighbourhood size and states that the size and shape of neighbourhoods should be agreed locally with local authorities and HWBs.

Based on the national framework and the direction previously reported to Portsmouth Health and Wellbeing Board, the intended outcomes are to:

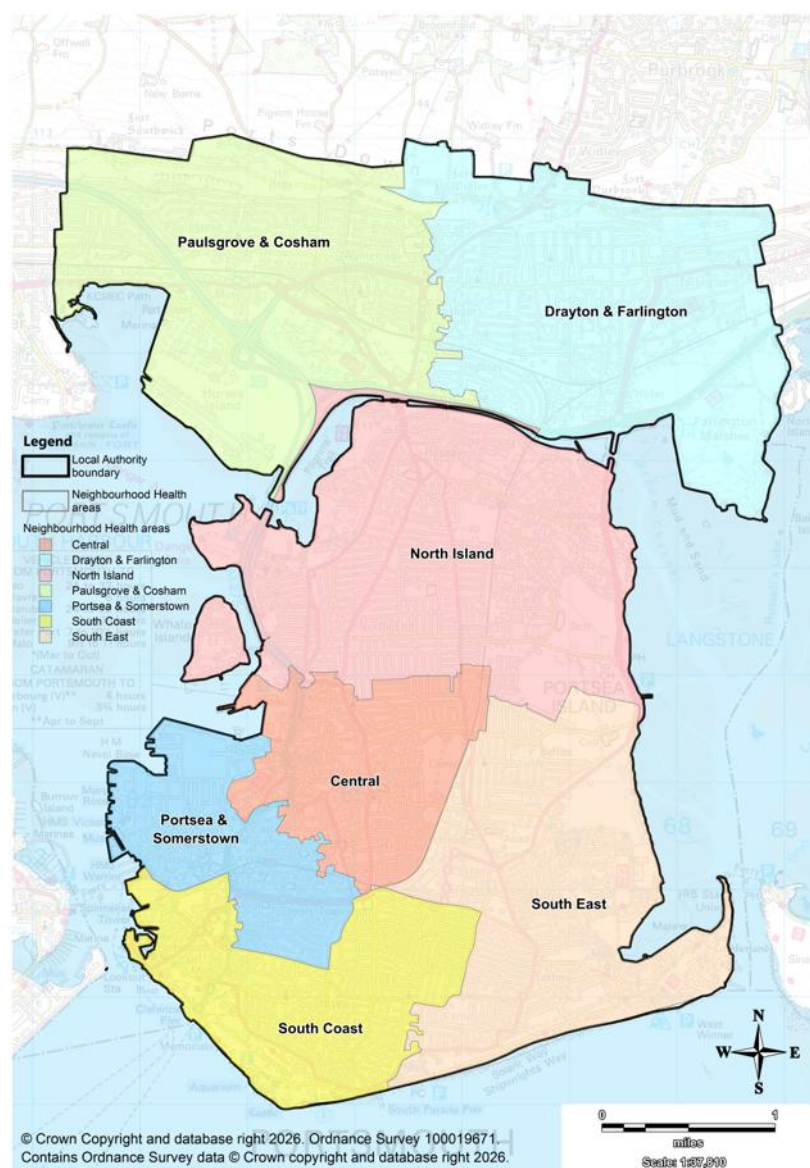
- establish agreed Health Neighbourhood Footprints which reflect, as far as practicable, natural communities and provide a meaningful shared population basis for understanding need, inequalities, outcomes and future neighbourhood planning;
- improve health outcomes and reduce health inequalities by enabling a stronger focus on prevention, earlier intervention and proactive care;
- enable population health intelligence to be considered at a sufficiently local level to identify variation in health need, access, experience and outcomes between and within communities;
- identify and respond to populations experiencing the poorest health outcomes or greatest barriers to accessing care, rather than relying solely on citywide averages;
- support the development of integrated neighbourhood approaches for high-priority cohorts, with services working together around the person and population rather than organisational boundaries;
- strengthen the relationship between primary care, community services, specialist services, public health, adult and children's social care, VCSE organisations and wider community assets;
- improve access, continuity, coordination and navigation, particularly for people with longer-term, complex or multiple needs;
- support more people to remain well and independent within their homes and communities and reduce avoidable escalation into urgent, emergency and hospital care; and

- establish shared outcomes and measures through which the Health and Wellbeing Board and partners can assess whether neighbourhood health is improving population outcomes, reducing inequalities and improving resident experience over time.

These intentions are consistent with the previous Portsmouth HWB position, which described the strategic requirements as agreeing neighbourhood outcomes grounded in the JSNA/JLHWS, aligning partners around one neighbourhood approach and ensuring that plans reflect local need and inequalities, including how underserved groups are identified and addressed.

The national framework identifies high-priority cohorts including people with frailty, care-home residents, housebound people, people approaching end of life, people with cardiovascular disease, diabetes, COPD, dementia or mental health conditions, children and young people, and any additional cohorts identified locally. It also requires HWBs, ICBs and local authorities to agree additional local outcomes which address health inequalities and priorities identified through the JSNA.

The proposed neighbourhoods are shown below:



Population Health Profile:

Paulsgrove and Cosham:

Life expectancy M/F: 77.9 / 81.4 years — similar
Premature mortality: 417.2 per 100,000 — similar
Preventable mortality: 211.2 per 100,000 — similar
All-cause emergency admissions: 14,152 per 100,000 — worse
5+ LTC: 3.2% — worse
Poor self-reported health: 7.5% — worse

Population: 21k

Initial Neighbourhood Priority: Consistent, trusted local access to prevention and coordinated support, particularly for children, families and people with long-term conditions, with fewer hand-offs and better transport, sensory and navigation support.

Drayton & Farlington:

Life expectancy M/F: 80.8 / 85.5 years — better
Premature mortality: 246.0 per 100,000 — better
Preventable mortality: 103.8 per 100,000 — better
All-cause emergency admissions: 9,631 per 100,000 — better
5+ LTC: 1.8% — better
Poor self-reported health: 3.8% — better

Population: 23k

Neighbourhood Priority: Helping an older population stay healthy and independent through accessible local support, with shorter journeys, strong primary care links, transport and community connection.

North Island:

Life expectancy M/F: 79.4 / 83.4 years — similar
Premature mortality: 344.9 per 100,000 — similar
Preventable mortality: 154.9 per 100,000 — similar
All-cause emergency admissions: 11,876 per 100,000 — similar
5+ LTC: 2.4% — similar
Poor self-reported health: 5.3% — better

Population: 40k

Neighbourhood Priority: Healthy ageing and targeted prevention in communities where poorer outcomes are hidden by neighbourhood averages, supported by accessible services and strong community connections.

Central:

Life expectancy M/F: 74.5 / 80.0 years — both worse
Premature mortality: 581.2 per 100,000 — worse
Preventable mortality: 316.4 per 100,000 — worse
All-cause emergency admissions: 15,368 per 100,000 — worse
5+ LTC: 3.7% — worse
Poor self-reported health: 8.7% — worse

Population: 35k

Neighbourhood Priority: Earlier, easier-to-access prevention and long-term condition support, tackling practical barriers such as transport, affordability, safety and navigation that contribute to poorer outcomes and avoidable deterioration.

Portsea and Somerstown:

Life expectancy M/F: 72.4 / 78.2 years — worse
 Premature mortality: 693.4 per 100,000 — worse
 Preventable mortality: 347.2 per 100,000 — worse
 All-cause emergency admissions: 17,351 per 100,000 — worse
 5+ LTC: 3.9% — worse
 Poor self-reported health: 10.7% — worse

Population: 22k

Neighbourhood Priority: Accessible prevention and early intervention for long-term conditions through trusted community routes, with better coordination and practical support around transport, digital access and wider social needs.

South East:

Life expectancy M/F: 78.9 / 84.3 years — similar / better
 Premature mortality: 329.7 per 100,000 — better
 Preventable mortality: 166.5 per 100,000 — similar
 All-cause emergency admissions: 10,910 per 100,000 — better
 5+ LTC: 2.2% — better
 Poor self-reported health: 5.0% — better

Population: 35k

Neighbourhood Priority: Healthy ageing with targeted prevention for alcohol-related risk and asthma, supported by accessible local services and community-based prevention.

South Coast

Life expectancy M/F: 78.9 / 82.2 years — similar
 Premature mortality: 362.2 per 100,000 — similar
 Preventable mortality: 159.4 per 100,000 — similar
 All-cause emergency admissions: 10,327 per 100,000 — better
 5+ LTC: 1.8% — better
 Poor self-reported health: 5.1% — better

Population: 39k

Neighbourhood Priority: Targeted prevention around alcohol and mental wellbeing, connected to accessible community support and action on safety, affordability and housing-related pressures.

Integrated neighbourhood working

Portsmouth's neighbourhood approach builds on a substantial existing base of integrated working rather than requiring a wholly new delivery model. Through Health and Care Portsmouth, partners already work across primary care, community and mental health services, adult and children's social care, Public Health, acute services and the VCSE sector. The Neighbourhood Health Plan provides the common population, priority and delivery framework around which these contributions will increasingly align.

The delivery model has three connected elements:

- a **neighbourhood organising function**, providing the capability to turn agreed priorities into coordinated action;
- a **community connection layer**, providing accessible routes into support and connecting residents, communities and services; and
- **provider and professional delivery**, through the existing organisations, services and teams responsible for health, care and wider support.

The organising function sits between strategic priorities and delivery. It brings together relevant intelligence, partners, improvement activity and delivery support to progress neighbourhood priorities, address barriers across organisational boundaries and track delivery and outcomes. P3 provides the partnership governance and decision-making above the organising function, with Health and Care Portsmouth providing Place partnership oversight. The organising function will initially be hosted by NHS Hampshire and Isle of Wight; its detailed scope, capability and resource arrangements will be developed through implementation.

This model does not create a new statutory body or provider organisation and does not transfer statutory, commissioning, financial, professional or operational responsibilities between organisations. Existing organisations remain accountable for the services and functions for which they are responsible.

The future contractual form of NHS-commissioned neighbourhood services is, however, not yet settled nationally. NHS England is currently consulting on proposed Single Neighbourhood Provider (SNP) and Multi-Neighbourhood Provider (MNP) contracting models; the consultation closes on 10 September 2026, after which proposals will be reviewed and further consultation on the final detail is expected later in 2026. Given the local timetable, the outcome will therefore not be known before the final EQIA and HWBB paper are submitted on 11 September or before the HWBB decision on 23 September.

This uncertainty does not affect the neighbourhood priorities or proposed Health Neighbourhood Footprints being considered by HWBB, which provide the population and partnership framework for neighbourhood health irrespective of the eventual NHS contracting mechanism.

It may, however, influence the future organisational and contractual arrangements through which NHS-commissioned neighbourhood services are delivered, including how those arrangements interface with Portsmouth's neighbourhood organising function.

Any material equality implications arising from that subsequent delivery or contracting model will need to be assessed when the national position and local implementation arrangements are sufficiently defined.

Q2 How will those outcomes be achieved?

The outcomes will be pursued through a population-based approach which combines evidence about health need, inequalities, service access and utilisation with resident and community insight, and uses this to inform neighbourhood planning, commissioning and delivery.

The national framework requires neighbourhood health to develop incrementally. During 2026/27, the minimum foundations include agreeing neighbourhood footprints around natural communities; establishing INTs focused on high-priority clinical cohorts; addressing unwarranted variation in general practice access; strengthening neighbourhood urgent, rehabilitation and reablement capacity to reduce avoidable non-elective activity; aligning Better Care Fund arrangements; and establishing appropriate data-sharing arrangements to support identification and evaluation.

Within Portsmouth, this is being progressed through:

Population and neighbourhood intelligence

Neighbourhood profiles, the JSNA, population health intelligence, service-use information, resident insight and professional knowledge are used together to identify differences in need, inequalities and opportunities for prevention and earlier intervention. No single source of evidence determines a neighbourhood priority.

Neighbourhood footprints informed by resident insight

A specific engagement and co-production programme was delivered through the Better Care Fund, led by HIVE Portsmouth working with the HDRC and Community Researchers. The work reported to the HWB included exploring how residents define neighbourhood, how far they are willing to travel for services, where boundaries should sit, what neighbourhoods should be called and what residents value in their local areas.

Priority clinical cohort identification and proactive care

Population health intelligence and risk stratification will support the identification of populations experiencing higher need or inequality and those who may benefit from earlier, more proactive or coordinated support. The Portsmouth Plan identifies initial priority populations including people living with frailty; people at risk of or living with cardiovascular disease; people with multiple long-term conditions; people with complex health and social needs; people who are housebound or living in care homes; people approaching the end of life; and people with repeated or potentially avoidable use of urgent and emergency care.

These priorities do not define the whole neighbourhood offer. Neighbourhood health is an all-age approach, combining universal provision with proportionate and targeted responses according to population need, inequalities and barriers to access. The balance of priorities will vary between neighbourhoods according to population need, inequalities, resident insight and the evidence available.

Prevention and earlier intervention

The approach seeks to identify opportunities to intervene before needs escalate and to strengthen local alternatives to reactive or hospital-based care. This is consistent with the national framework's emphasis on prevention, proactive care management and stronger primary and community services.

Neighbourhood organising function

A neighbourhood organising function will provide the capability to translate agreed population priorities into coordinated action. Its role is to bring together the relevant partners, intelligence, existing activity and resources around shared neighbourhood priorities and outcomes, support improvement across organisational boundaries and identify issues requiring wider partnership or organisational action.

Community connection

A community connection layer will provide accessible routes between residents, communities and health, care and wider support. It will strengthen access, navigation and connection to community assets, while ensuring that barriers, unmet need and community experience inform neighbourhood planning and improvement.

Provider and professional delivery

Neighbourhood health will continue to be delivered through the existing organisations, services and professionals responsible for health, care and wider support. The neighbourhood approach is

intended to strengthen alignment and coordination around shared populations, priorities and outcomes rather than create a separate provider model.

Outcomes and evaluation

Portsmouth has been developing an approach combining national measures with locally agreed outcomes. Previous HWB work proposed that measures should reflect neighbourhood need and inequalities, track progress for high-priority cohorts and demonstrate movement towards prevention, proactive care and reduced reliance on hospital-based care.

IMPACTS TO BE EVALUATED DURING IMPLEMENTATION

Detailed service, workforce, commissioning, contractual and resource arrangements will continue to develop through implementation. Where these result in material changes to service locations, eligibility, access routes or delivery arrangements, the equality implications will be assessed through the governance of the organisation responsible for that change.

Q3 Who will be affected by this policy, project or proposal?

The Portsmouth Neighbourhood Health Plan and proposed Health Neighbourhood Footprints have the potential to affect all Portsmouth residents and communities, because they establish a population framework through which neighbourhood health needs, priorities, outcomes and increasingly service planning and delivery will be considered.

The impact will not be identical across all groups. The evidence indicates that health need, access to care, patterns of service use and health outcomes vary considerably according to age, deprivation, disability, ethnicity, long-term conditions and other individual and community circumstances.

The Plan is explicitly all-age and inclusive. It applies across the life course and combines universal neighbourhood approaches with proportionate and targeted responses according to need, inequality and barriers to access. Particular consideration is therefore required for populations experiencing poorer outcomes, greater disadvantage, complex needs or difficulty accessing support, including:

- people living in the most deprived communities;
- children, young people and families experiencing disadvantage;
- working-age adults with long-term conditions, mental ill health or other circumstances affecting health and independence;
- older people, including people living with frailty;
- people who are housebound or living in care homes;
- people approaching the end of life;
- people with multiple long-term conditions or complex health and social needs;
- disabled people;
- people with learning disabilities and neurodivergent people;
- people with mental health needs;
- people experiencing homelessness, multiple disadvantage or other inclusion-health needs;
- carers and families;
- people experiencing digital, transport, language, communication or other barriers to access;
- people from ethnic minority communities; and

- other populations identified through neighbourhood-level population intelligence, equality evidence or community insight; and
- other locally significant populations identified through the Portsmouth JSNA, population health intelligence or community engagement.

The ICB Insights Summary demonstrates why this differentiated approach is necessary. Although average health outcomes across Hampshire and Isle of Wight can appear comparatively positive, the analysis identifies deep and persistent inequalities and concentrations of social and economic factors associated with poorer health.

It also identifies significant variation in long-term conditions, mental health need and behavioural health risks, and reports that inclusion-health populations may underuse primary and preventive care and use urgent and emergency services when needs have become more acute.

The proposed footprints themselves create a specific equality consideration. They will define the geographical populations through which neighbourhood need and outcomes are increasingly understood. The assessment therefore needs to consider whether the proposed boundaries:

- support identification of communities experiencing inequality;
- reflect natural communities and resident experience as far as practicable;
- risk obscuring smaller populations experiencing disadvantage within a larger neighbourhood;
- create or exacerbate barriers relating to travel or access;
- interact appropriately with other service geographies, including primary care; and
- enable rather than inhibit equitable planning across the city.

However, there is no intention that the adoption of the footprints themselves changes individual entitlement, eligibility or access to an existing service.

The Plan also has the potential to affect NHS, local authority, primary care, VCSE and other staff and organisations involved in commissioning, planning or delivering neighbourhood services as integrated working develops.

IMPACTS TO BE EVALUATED DURING IMPLEMENTATION

The distribution of protected characteristics and inclusion-health populations within and across the proposed footprints needs to be tested using the final neighbourhood profiles

Defined workforce impacts have not yet been identified. These should be assessed as future delivery arrangements become clearer.

Q4 What evidence have you considered, with reference to data sets, research, and insight, both national and local?

1. National Neighbourhood Health Framework

The principal national policy source is the Neighbourhood Health Framework, published by the Department of Health and Social Care and NHS England on 17 March 2026. The framework defines neighbourhood health, establishes national goals and metrics, describes the roles of ICBs, local authorities and HWBs, and sets out the process for developing neighbourhood health services.

Of particular relevance to this EQIA, the framework:

- identifies improvement in health outcomes and reduction in health inequalities as central aims of neighbourhood health;
- requires a defined-population approach;
- places emphasis on prevention and proactive care;
- identifies high-priority national cohorts while allowing local areas to identify additional populations;
- requires local priorities and outcomes to address inequalities identified through the JSNA;
- requires neighbourhood footprints to be agreed around natural communities;
- expects local government, the NHS, communities and wider partners to work together through HWBs; and
- recognises that neighbourhood health development will be incremental and should evolve in response to local evidence and learning.

2. NHS Hampshire and Isle of Wight Insights Summary – July 2026

The assessment has considered the NHS Hampshire and Isle of Wight Insights Summary – Part A: The needs of our population and Part B: The provision of local services and how this aligns to need. They provide predominantly Hampshire and Isle of Wight-level evidence, although some analysis identifies Portsmouth specifically. They are therefore being used to identify potential equality issues requiring consideration rather than being treated as the final assessment of differential impact within Portsmouth.

Deprivation and health inequalities

The insights identify socio-economic disadvantage as unevenly distributed across HIOW, with higher levels concentrated in Portsmouth, Southampton, Gosport, Havant and the Isle of Wight, alongside smaller pockets elsewhere. Landport in Portsmouth is identified in the document as the neighbourhood with the highest Index of Multiple Deprivation score across the HIOW geography.

The same analysis describes deprivation as associated with differences in smoking prevalence, cardiovascular disease and emergency admissions, hypertension, cancer diagnosis, severe mental illness and children's emergency care.

This evidence suggests that equal provision across neighbourhoods would not necessarily produce equitable outcomes. The Plan therefore needs to retain the ability to respond differentially to population need.

Age and the life course

The evidence identifies an ageing HIOW population but notes that Portsmouth retains a comparatively younger population structure while also experiencing growth in the population aged 65 and over.

Children and young people are also a significant equality consideration. The analysis reports that around 30% of Portsmouth children and young people live in neighbourhoods within the most deprived 20% nationally. It identifies associations between disadvantage and mental ill-health, multimorbidity, obesity and barriers to accessing healthcare.

This supports consideration of equality across the whole life course rather than treating neighbourhood health primarily as an older-person model.

Disability, dementia, neurodivergence and complex needs

The insights identify particular access difficulties affecting older people, disabled people, housebound people, neurodivergent people, people without internet access and people requiring interpreters or alternative communication methods.

The evidence also identifies people with combinations of severe mental illness, autism or ADHD and significant physical healthcare needs as experiencing gaps across existing provision.

This indicates a need to test whether neighbourhood arrangements improve rather than further fragment access for people whose needs cross existing organisational or professional boundaries.

Race, ethnicity, nationality and language

The population analysis identifies Portsmouth, Southampton and Rushmoor as the most ethnically diverse local authority areas within HIOW, with diversity above the England average, and reports increasing diversity across the wider population.

Language and translation difficulties are separately identified as barriers to accessing services, particularly for older people with limited English proficiency.

This indicates a need to consider communication, interpretation, culturally appropriate access and the demographic profile of individual neighbourhoods.

[Detailed Portsmouth neighbourhood-level analysis by ethnicity and language has not yet been provided for this assessment.](#)

Digital exclusion

Digital exclusion is a significant potential access issue.

The insights identify Portsmouth as one of the HIOW areas with the highest risk of digital exclusion. Older people and disabled people are identified as more likely to face barriers to internet access or digital devices, and the analysis states that non-digital access routes remain important to prevent digital transformation exacerbating inequalities.

This is relevant to future neighbourhood service design. An increase in digital access should not automatically be treated as an equality benefit unless non-digital routes and appropriate support remain available.

Transport and physical accessibility

Transport is also identified as a barrier.

The insights report that people who are able to travel by car generally have relatively good access to services, whereas public transport presents greater difficulties. Households in conurbations and deprived communities are less likely to have access to a car or van, and the analysis specifically identifies low car access in communities near Portsmouth.

This means that the accessibility of proposed neighbourhood arrangements should be assessed using actual travel patterns, public transport, mobility needs and resident behaviour rather than geographical distance alone.

Primary care access

The service insights identify significant variation in same-day urgent and routine primary care access across HIOW and state that the current primary care and neighbourhood model has not yet sufficiently overcome inequalities in access and outcomes.

This is directly relevant to neighbourhood health because the national framework requires action during 2026/27 to tackle unwarranted variation and improve general practice access.

Access, continuity, navigation and experience

The service insights identify fragmented pathways and weak coordination between services. They report that patients and families can be required to act as coordinators themselves, repeat their story and navigate unclear pathways, with digital and communication barriers also reported.

This evidence supports the potential equality benefit of better integrated neighbourhood working, particularly for people using multiple services. Whether this benefit is achieved will need to be evaluated through resident experience as neighbourhood arrangements develop.

Preventable and avoidable hospital use

The insights identify potentially avoidable use of acute care associated with ambulatory-care-sensitive conditions and variation by age and deprivation. The strongest age-standardised inequality described in the analysis is among people aged 60–75 living in the most deprived communities.

This supports the neighbourhood focus on prevention and proactive care. However, reduced hospital utilisation alone should not be assumed to represent an equality benefit; future evaluation should also consider health outcomes, access, experience and whether appropriate community alternatives were available.

Maternity

The insights identify deprivation as an important driver of inequality in maternity care, including differences in early booking and outcomes. They also identify ethnicity as a relevant consideration, while cautioning that small-number data requires careful interpretation.

This evidence should inform the consideration of pregnancy and maternity within Part B, but the current evidence does not establish the impact of the proposed Portsmouth footprints on maternity services.

3. Portsmouth JSNA and Joint Local Health and Wellbeing Strategy

The Portsmouth Health and Wellbeing Strategy 2022–2030 provides the overarching place-based strategic framework for improving health and wellbeing in Portsmouth. It was developed by the Health and Wellbeing Board using an evidence-led approach to identify the underlying factors within the city that have a significant impact on health and wellbeing. The Strategy is explicitly intended to underpin commissioning decisions across the NHS, local authority and other agencies and to provide evidence and direction for wider policy and decision-making across the city.

The Strategy's overarching ambition is for Portsmouth to be “a healthy and happy city” in which people have the education, care and support they need for their physical and mental health. It recognises that population needs differ and describes a combination of universal and targeted approaches, with more intensive support directed towards smaller populations experiencing the greatest need or most significant challenges.

Rather than focusing solely on individual health services or conditions, the Strategy identifies five underlying “causes of the causes” which shape health and wellbeing in Portsmouth:

- poverty;
- educational attainment;
- positive relationships;
- active travel and air quality; and
- housing.

These priorities reflect the Strategy's recognition that creating the conditions for good health requires action on the wider social, economic and environmental determinants of health as well as the provision of health and care services. The Strategy particularly identifies the relationship between social inequalities, wider determinants and differences in health outcomes, recognising that health inequalities are likely to persist while underlying social inequalities remain.

Equality is an explicit part of the Strategy's approach. It recognises that deprivation is one of a number of persistent inequalities which can limit the opportunities of individuals and communities and commits partners to equality, diversity and inclusion and to the delivery of fair and equitable services across Portsmouth's communities.

The Strategy also provides an important basis for the neighbourhood approach because it emphasises community development and local strengths, describing work with local people, groups and organisations to build independence and self-reliance and to develop solutions with communities rather than relying solely on traditional service responses. It also includes an expectation that services should be commissioned and delivered in a joined-up way so that they are responsive to local need.

The Strategy was informed by population evidence, including the ONS Health Index. At the time the Strategy was prepared, that evidence showed a relationship between deprivation and poorer population health in Portsmouth and identified particular challenges across health outcomes and the wider determinants of health. The Strategy identifies the Joint Strategic Needs Assessment (JSNA), alongside other public health intelligence, as a core part of the knowledge and evidence supporting the work of the Health and Wellbeing Board.

The Strategy therefore provides a clear strategic basis for the Portsmouth Neighbourhood Health Plan to:

- maintain a strong focus on reducing inequalities rather than improving population averages alone;
- consider health need alongside the wider determinants of health;
- combine universal neighbourhood provision with targeted responses where populations experience greater need or disadvantage;
- strengthen community-based and locally responsive approaches;
- align health and care commissioning with wider Portsmouth priorities; and
- assess whether neighbourhood arrangements contribute to fairer outcomes across different communities.

The detailed Portsmouth JSNA evidence has not been reproduced within this draft EQIA.

4. Health and Care Portsmouth approach to integrated neighbourhood working

The Health and Care Portsmouth Strategic Approach to Integrated Neighbourhood Working provides an important source of local strategic evidence for the development of the Neighbourhood Health Plan. It sets out the established Portsmouth vision, principles and intended direction for integrated neighbourhood working, including the development of Integrated Neighbourhood Teams.

The approach is explicitly grounded in the principle that local services should reflect the diversity of Portsmouth's communities and needs, be delivered as locally as appropriate, be designed from the perspective of the person using them, remove barriers to access and involve residents in service design. It also identifies equality, evidence, integration, prevention, participation, accountability and partnership as core principles for place-based working.

This provides a local strategic foundation for the Neighbourhood Health Plan by establishing that neighbourhood working should be shaped by population need and evidence, seek to reduce inequalities, integrate services around individuals and families, and actively involve residents in the development of local approaches.

5. Portsmouth neighbourhood engagement and co-production

Community insight forms part of the evidence base for the Portsmouth Neighbourhood Health Plan and proposed Health Neighbourhood Footprints. During 2026, HIVE Portsmouth, working with the Health Determinants Research Collaboration and Community Researchers, undertook targeted engagement to understand how residents experience their neighbourhoods and what matters to them in relation to health, wellbeing and access to support.

The findings identify five consistent themes:

- **place and environment**, including transport, traffic and parking, cleanliness and the public realm, green space, housing and environmental quality;
- **practical access to support**, including not only whether services are available but transport, mobility, opening times, affordability, information and digital exclusion;
- **community connection and local infrastructure**, including community centres and hubs, groups, activities, youth provision and opportunities for social connection;
- **safety**, including antisocial behaviour, crime, drugs and whether residents feel able to use local spaces and participate in community life; and
- **affordability**, including the cost of activities, food, transport, housing, bills and heating.

The engagement therefore provides important evidence about the conditions residents associate with health and wellbeing and the factors that influence whether support can actually be accessed and used. These findings are considered alongside the JSNA, population health intelligence, service-use information and professional evidence in developing neighbourhood priorities and testing the proposed neighbourhood approach

INFORMATION NOT YET AVAILABLE / TO CONFIRM

- Complete participant demographic information is not yet available to assess the representativeness of the engagement across relevant protected characteristics and inclusion-health groups.
- The available engagement evidence is stronger in relation to what residents value within neighbourhoods and the factors affecting health and access than in establishing precise preferences for neighbourhood names, boundaries or acceptable travel distances. Proposed footprints should therefore continue to be considered using community insight alongside population health, JSNA and other evidence rather than being determined by engagement evidence alone.

Q5 How have, or will, stakeholders be involved in gathering evidence or testing the evidence available?

The Portsmouth Neighbourhood Health Plan has been developed through established **Health and Care Portsmouth (HCP)** partnership arrangements, involving the NHS, Portsmouth City Council, primary care, NHS providers and HIVE Portsmouth. HCP's agreed approach to neighbourhood working is based on integration, reducing inequalities, evidence of local need, prevention and

resident participation, including a commitment to involve people in designing services and to work with communities to develop locally responsive approaches.

This builds on existing experience of integrated and community-based working in Portsmouth, including work undertaken through the National Neighbourhood Health Implementation Programme (NNHIP). This has included primary care, community and social care, mental health, VCSE organisations and other partners, alongside asset-based community development and co-production activity in communities experiencing higher levels of deprivation. Existing neighbourhood activity has included Paulsgrove, Portsea, Landport, Buckland and Somerstown and has used community-based approaches to understand local need and reach residents who may not engage through traditional services.

For the specific development of the proposed Health Neighbourhood Footprints, a community consultation and co-production approach has been developed with HIVE Portsmouth, the Health Determinants Research Collaboration (HDRC) and Community Researchers. The work has tested:

- how residents define their neighbourhood and where they consider neighbourhood boundaries to sit;
- how far people are willing or able to travel for services;
- which services people would expect to access locally and which they would expect to travel further for; and
- what residents value within their neighbourhood.

The methodology used a mixture of approaches to broaden participation, including co-producing the consultation questions with residents, face-to-face neighbourhood surveys, area focus groups, asset mapping and interactive mapping of proposed boundaries. Digital engagement is supplemented by physical postcards and post boxes for people without access to smartphones. The approach also explicitly seeks to gather views across different areas and demographics of Portsmouth.

This community evidence has been considered alongside population and health intelligence and professional and partner insight in developing and testing the proposed footprints and neighbourhood approach.

IMPACTS TO BE EVALUATED DURING IMPLEMENTATION

Where the completed engagement identifies gaps in representation, these will be addressed through proportionate further engagement or other evidence gathering rather than assuming no differential impact.

Part B

Protected Characteristics ([see Equality Act 2010](#)):

Please use this section to provide due regard to the need to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations between communities

Age:

All evidence indicates that Portsmouth has needs across the whole life course. While the population remains comparatively younger than some other parts of Hampshire and Isle of Wight, the number of people aged 65 and over is increasing. Children and young people are also an important consideration: the ICB Insights Summary identifies that around 30% of Portsmouth children and young people live in neighbourhoods within the most deprived 20% nationally, with disadvantage associated with poorer physical and mental health outcomes.

Neighbourhood health has the potential to have a positive impact across age groups by enabling need to be identified more locally, strengthening prevention and earlier intervention and bringing services together around residents. Existing Portsmouth models demonstrate neighbourhood and integrated approaches for frailty, palliative care, children and families, including multidisciplinary working and Family Hubs.

Particular potential benefits exist for older people living with frailty, multiple long-term conditions or social isolation through more coordinated support, prevention and a stronger focus on independence. However, neighbourhood health should not become predominantly an older-person model. The Plan's outcomes, population intelligence and future service development will need to remain responsive to children, young people, working-age adults and older people.

Older and disabled people are also identified as being more likely to experience digital exclusion, and transport can create barriers to access. The Plan explicitly provides for non-digital routes, transport considerations, physical accessibility and reasonable adjustments.

Evidence still required: the final age profile of each proposed neighbourhood and the age profile of participants in the neighbourhood engagement should be reviewed when available.

Race, Ethnicity, Nationality:

Portsmouth is one of the more ethnically diverse local authority areas within Hampshire and Isle of Wight, and the population is becoming increasingly diverse. The evidence also identifies language and translation as potential barriers to accessing services, particularly for some people with limited English proficiency.

Neighbourhood health has the potential to advance equality by enabling partners to understand the different populations within each neighbourhood more clearly and to respond to variation in need, access and experience. Existing Portsmouth neighbourhood work provides examples of using trusted community organisations, Community Champions and local settings to engage communities who may be less well reached through conventional service routes.

There remains a risk that neighbourhood-level averages could obscure smaller ethnic, nationality or language groups, or that services could be less accessible where communication, interpretation,

cultural appropriateness or trust are not adequately addressed. Geographic neighbourhoods may also cut across communities defined by culture, nationality, language, faith or shared identity and should not be assumed to represent those communities in themselves.

The Neighbourhood Health Plan includes explicit safeguards against these risks. Neighbourhood delivery is expected to consider language, communication and interpretation requirements, cultural appropriateness and trusted community routes, and to use targeted outreach where people are unlikely to access support through conventional routes. The Plan also makes clear that neighbourhood geography should not be applied rigidly where this would disadvantage a population and that appropriate citywide, specialist or other provision should remain accessible where this better meets need.

Neighbourhood population intelligence should therefore be used at sufficient granularity to identify differences within, as well as between, neighbourhoods. Equality monitoring should consider access, experience and outcomes by ethnicity and other relevant characteristics where the data allows, rather than assuming that a neighbourhood-level average represents all communities within that area.

Evidence still required: detailed neighbourhood-level information on ethnicity, nationality and language is not yet available for all seven neighbourhoods. Complete participant demographic information from the 2026 neighbourhood engagement is also not yet available to assess representation across these groups. These sources will be reviewed when available and any material gaps reflected in the final assessment.

Sex:

The available evidence identifies differences in health need, experience and access associated with sex. The Trailblazer evidence identifies differences in healthy life expectancy between men and women, while existing HCP work demonstrates that some groups of women experience particular barriers which require tailored approaches.

For example, Portsmouth's work with women experiencing substance use identifies the interaction of trauma, domestic abuse, caring responsibilities, isolation, mental health, homelessness and other factors, and recognises that mixed-sex or fragmented provision may itself create barriers. Project W provides an existing example of a locally co-produced women-only model bringing multiple services together around those needs.

Neighbourhood health therefore has potential to advance equality by enabling sex-specific needs and intersecting inequalities to be recognised within population planning, rather than assuming that the same model will meet everyone's needs equally.

No direct adverse impact arising from approval of the footprints has been identified. However, future neighbourhood planning will need to retain sufficient flexibility for sex-specific interventions where the evidence supports them and should assess outcomes by sex where appropriate.

Evidence still required: sex-disaggregated neighbourhood profiles and engagement findings will be reviewed when available.

Sexual Orientation:

The evidence reviewed for this EQIA does not currently provide sufficient specific Portsmouth neighbourhood-level information to assess differential impact by sexual orientation.

The Plan's emphasis on person-centred care, reducing barriers, community participation and locally responsive provision creates the potential for neighbourhood approaches to respond more effectively to differing needs where these are identified. However, this potential benefit should not

be assumed in the absence of evidence about the experience or representation of lesbian, gay and bisexual residents within the proposed neighbourhoods or engagement undertaken.

No direct adverse impact from adoption of the Plan or footprints has been identified on the evidence currently available.

Evidence gap: the final engagement findings will be reviewed for representation and relevant insight relating to sexual orientation. Where this evidence remains limited, this should be recorded and proportionate further engagement or evidence gathering considered.

Religion or Belief:

Portsmouth's existing neighbourhood and community development work includes engagement with faith communities, and adult social care community activity has specifically included work with global majority and faith communities.

The emphasis within the Plan on community assets, VCSE partnerships and working through trusted local settings has the potential to improve engagement with communities where faith organisations form part of local support networks.

However, the evidence currently available does not establish a specific differential impact of the proposed footprints by religion or belief. It will be important not to assume that geographic neighbourhoods necessarily reflect faith communities or networks.

Evidence gap: the demographic profile and final community engagement findings will be reviewed for relevant evidence by religion or belief. No direct adverse impact has been identified at this stage.

Disability, Dementia and Carers

The available evidence identifies clear existing inequalities affecting disabled people, people living with dementia, housebound people, neurodivergent people and people whose physical, mental health or other needs cross existing service boundaries. Digital exclusion, communication needs, transport and physical accessibility are all relevant to whether people can access and benefit from support.

Neighbourhood health has the potential to advance equality of opportunity by improving coordination between services, reducing unnecessary hand-offs, identifying need earlier and providing more accessible routes into health, care and community support. This is particularly relevant to people living with disability, dementia, frailty or long-term conditions, and to people who rely on several services to remain independent.

Portsmouth already has examples of integrated approaches designed around these needs, including integrated learning disability services, dementia support through community hubs, multidisciplinary approaches to frailty and neurodiversity, and Room One, which was developed with autistic and neurodiverse residents to provide accessible community support without requiring formal diagnosis as the route to assistance.

The Neighbourhood Health Plan includes explicit safeguards intended to reduce the risk that neighbourhood arrangements create additional barriers. These include consideration of physical accessibility and reasonable adjustments; language, communication and interpretation requirements; digital exclusion and continued non-digital routes; transport and practical accessibility; targeted outreach where people are unlikely to access services through conventional routes; and continuity and coordination where needs cross more than one service or organisation.

The Plan also makes clear that neighbourhood geography will not be applied rigidly where this would disadvantage a population. Some specialist pathways, services and population groups will appropriately operate across several neighbourhoods, citywide or at Hampshire and Isle of Wight level, with neighbourhood working intended to improve connections into that provision rather than require it to be recreated locally.

Evidence still required: final neighbourhood-level information on disability, dementia and related needs, together with participant demographic information from the neighbourhood engagement, will be reviewed when available.

IMPACTS TO BE EVALUATED DURING IMPLEMENTATION

Specific impacts on carers will continue to be considered as neighbourhood delivery arrangements develop.

Gender Identity and Gender Reassignment:

The evidence currently reviewed does not provide sufficient specific information to determine the differential impact of the proposed Portsmouth Neighbourhood Health Plan or footprints on trans people or people undergoing gender reassignment.

The principles of person-centred care, reducing barriers to access, co-production and equality provide an appropriate basis for responding to differing needs where identified, but a positive impact cannot be assumed without evidence.

No direct adverse impact has been identified from approval of the Plan or footprints themselves.

Evidence gap: the final community engagement and available population evidence should be reviewed for relevant insight. Where evidence remains limited, this should be recorded rather than interpreted as evidence of no impact.

Pregnancy and Maternity:

Pregnancy and maternity are relevant to neighbourhood planning both in their own right and through their relationship with early years and family support.

The evidence considered in Part A identifies deprivation and ethnicity as factors associated with inequalities in maternity access and outcomes. Portsmouth's existing integrated working also includes Family Hubs and Start for Life, bringing together council, NHS and VCSE partners to support families from pregnancy through the early years. The Health and Wellbeing Strategy also identifies early identification and support for vulnerable women and families during pregnancy and the early years as a local priority.

Neighbourhood health has the potential to strengthen connections between maternity, primary care, public health, children's services, Family Hubs and wider community support and therefore improve earlier access and continuity.

However, the proposed neighbourhood footprints should not be assumed to represent the appropriate delivery footprint for all maternity services, some of which will necessarily operate at a wider scale. The current Plan does not change maternity service provision.

IMPACTS TO BE EVALUATED DURING IMPLEMENTATION

The current evidence does not establish a differential impact of the proposed neighbourhood boundaries on pregnant people or maternity service access. This will be reviewed as neighbourhood implementation becomes more specific.

Marriage and civil partnership (*Note: This protected characteristic is only relevant to the need to eliminate discrimination within employment*)

his protected characteristic is relevant to the Public Sector Equality Duty in relation to eliminating discrimination in employment.

The Portsmouth Neighbourhood Health Plan and proposed footprints do not currently make changes to employment terms, workforce structures or employment arrangements. No differential impact has therefore been identified at this stage.

If future neighbourhood delivery models result in material workforce or organisational change, the equality implications should be assessed as part of those specific proposals.

Other Groups (see [Inclusion Health](#) and [Core20Plus5](#))

Armed Forces community (serving Armed Forces personnel, their families, reservists, and veterans)

The Armed Forces community is a significant part of Portsmouth's population and identity. Portsmouth City Council estimates that more than 37,000 people living in the city are part of the Armed Forces community, including serving personnel, veterans, reservists and immediate family members — around 18% of the population. In November 2022 this included an estimated 9,278 veterans, 7,600 regular serving personnel based in Portsmouth and 943 service children registered in Portsmouth schools.

Portsmouth City Council first signed the Armed Forces Covenant in 2012 and reaffirmed its commitment in 2022. The local commitment reflects the principle that members of the Armed Forces community should not experience disadvantage in accessing public services compared with other citizens, while recognising that additional or different support may sometimes be appropriate. The Council also works through the Solent Armed Forces Covenant Partnership, providing a partnership mechanism for understanding the needs of serving personnel, veterans and families and strengthening local delivery of the Covenant.

There is already dedicated community infrastructure within Portsmouth. Veterans Outreach Support (VOS) is based at the Royal Maritime Hotel in Portsmouth and provides welfare, wellbeing and mental health support for UK Armed Forces and Merchant Navy veterans, as well as spouses, partners and carers. Its offer includes psychological support, substance misuse support, welfare assistance, social and peer-support activity, with veterans and family members able to approach the service directly without an external referral. VOS works with NHS and other statutory and charitable partners and provides an established, trusted route into support for the local veteran community. Portsmouth City Council specifically identifies VOS within its local health and wellbeing offer for the Armed Forces community.

The Neighbourhood Health Plan therefore has the potential for a positive impact by improving connections between neighbourhood health, existing Armed Forces support, primary and community care and wider health, housing and wellbeing services. The neighbourhood approach should build on existing specialist and trusted provision such as VOS rather than duplicate or inadvertently fragment it.

The proposed Health Neighbourhood Footprints do not change entitlement to existing services or specialist Armed Forces provision. However, implementation should recognise that the Armed Forces community may have needs and patterns of service use which do not align neatly to neighbourhood geography, including serving personnel and families whose

circumstances may change through posting or transition from service. The principle of organising around neighbourhood populations should therefore not create additional barriers to accessing city-wide, specialist or Armed Forces-specific support.

IMPACTS TO BE EVALUATED DURING IMPLEMENTATION

Neighbourhood-specific evidence is not yet available on the distribution of serving personnel, veterans and Armed Forces families across the proposed footprints or their representation within the neighbourhood engagement. This will be reviewed as neighbourhood delivery develops, including whether any local arrangements create unintended barriers to accessing citywide, specialist or Armed Forces-specific support. Links with existing Armed Forces Covenant arrangements and trusted provision such as VOS should be maintained through implementation.

Care Leavers

Children in care and care-experienced young people are an important population for the Neighbourhood Health Plan. Portsmouth's Children's Trust arrangements include the Corporate Parenting Strategy as a key component of the city's approach to improving outcomes for children and young people. Current council material continues to identify delivery of the Children's Trust Plan and the Corporate Parenting Strategy as linked strategic responsibilities.

Portsmouth's current Corporate Parenting Strategy was co-developed with children cared for by the Council and care-experienced young adults. It identifies six priorities covering voice and participation; relationships; education and employment; safe and stable homes; emotional and physical health and wellbeing; and preparation for adult life. The strategy is explicitly framed around the Council and its partners acting as corporate parents and improving outcomes for both children in care and care-experienced young people.

There is a clear health inequalities dimension. Local Health and Care Portsmouth information notes that looked-after children and care leavers are around four times more likely to have an emotional or mental health need than their non-looked-after peers, and that local authorities, healthcare commissioners and providers have responsibilities to ensure their health needs are assessed and addressed.

The potential impact of the Neighbourhood Health Plan is therefore positive, particularly where neighbourhood working improves coordination between health, children's social care, education, mental health, primary care and community support and provides earlier, more accessible routes to help. This is consistent with Portsmouth's wider Children's Trust approach to joined-up working and with the Corporate Parenting Strategy's focus on physical and emotional wellbeing.

For care-experienced young adults, Portsmouth also has an established local offer covering health and wellbeing alongside housing, relationships, finances, education, employment and support for young people who are pregnant or parents. Support extends into early adulthood; the Council reported in October 2025 that it was supporting around 320 care-experienced young people aged 18–25 through personal advisers and dedicated services.

There are, however, specific considerations for implementation. Neighbourhood geography should not become a barrier to continuity of support for children in care or care leavers. Children cared for by Portsmouth may live in different types of placement, including foster, kinship and residential arrangements, and their important relationships, education and health services may not align neatly with the neighbourhood in which they are physically living. The

neighbourhood approach should therefore complement, rather than replace, existing corporate parenting, looked-after children's health and care-leaver arrangements.

IMPACTS TO BE EVALUATED DURING IMPLEMENTATION

Neighbourhood-specific evidence is not yet available on the distribution of children in care and care leavers across the proposed Health Neighbourhood Footprints, their representation within the neighbourhood engagement, or any specific issues identified through Corporate Parenting arrangements.

These impacts will be reviewed as neighbourhood delivery develops, including whether geographical arrangements affect continuity, access or coordination for children in care and care-experienced young people whose placements, education, relationships or services may cross neighbourhood boundaries. Relevant insight from Children's Trust and Corporate Parenting arrangements should be incorporated into implementation and future review of the EIA.

Other identified groups

The neighbourhood approach needs to recognise that not every meaningful "neighbourhood" or community is defined by geography. Portsmouth's approach to integrated neighbourhood working explicitly recognises that support should align with how people identify and with areas of need and inequity, rather than solely with geographical or organisational boundaries. Cohorts may therefore require different models of support and different combinations of resources.

This is particularly relevant to people experiencing homelessness, multiple disadvantage and complex or overlapping needs. Portsmouth City Council's work on complex needs identifies people whose circumstances may include homelessness, drug or alcohol problems, poor mental health and involvement with the criminal justice system. It recognises that services organised around one issue at a time can result in people missing the help they need and describes a move towards more joined-up, person-focused support across health, housing, police and other organisations.

The Portsmouth Complex Needs Intervention provides further local evidence of why this matters. The review identified fragmented referral, assessment and case-management arrangements; people having to repeat their story; people becoming lost or disengaging from services; standardised responses that did not fit individual need; and barriers created by geography, timescales and eligibility criteria. The redesigned Portsmouth Access Team model therefore starts with the person rather than a single service: eligibility is based principally on being a Portsmouth adult with multiple presenting needs, with a shared workflow sitting above individual organisational processes so that agencies can work together around the individual. Its stated purpose is simply to help the person obtain the support that is right for them.

The case material illustrates the overlapping characteristics that may be present within this population, including homelessness and rough sleeping, substance dependence, mental ill-health, disability and physical illness, care experience, criminal justice involvement, domestic abuse, exploitation, trafficking, sex work, no recourse to public funds and difficulties communicating with or trusting statutory services.

For these populations, the relevant neighbourhood may therefore be a community of shared need, identity or experience rather than the place in which someone happens to live at a particular point in time. Portsmouth already uses this principle in other areas. Room One provides a community-based model organised around autistic and neurodiverse people, while Project W was co-designed as a trusted women-only offer for women experiencing multiple

disadvantage. These approaches sit alongside geographically based neighbourhood working rather than being replaced by it.

The potential equality impact of the Neighbourhood Health Plan is therefore positive, provided that the proposed geographical footprints are used as a framework for understanding population need and organising local assets without becoming rigid boundaries around access or delivery. The model should retain the ability to identify and organise support around communities and cohorts whose needs cross geographical neighbourhoods, including:

- people experiencing homelessness or rough sleeping;
- people experiencing multiple disadvantage or complex needs;
- people affected by substance dependence;
- people involved with the criminal justice system;
- refugees, asylum seekers and people with no recourse to public funds;
- people experiencing domestic abuse, exploitation or sex work;
- people whose identity or shared experience creates a meaningful community of need; and
- other inclusion-health populations identified through JSNA, population intelligence or community insight.

There is a potential adverse impact if future neighbourhood delivery is interpreted too narrowly as “services for people who live within this boundary”, particularly for people who are transient, homeless, move between accommodation, access trusted services elsewhere in the city or require specialist city-wide provision. Portsmouth’s existing Rough Sleeping Hub and accommodation pathway similarly provide city-wide access to housing, health and other support rather than organising assistance solely according to an individual’s local residential neighbourhood.

The equality principle for implementation should therefore be that geographical neighbourhoods strengthen local population planning, but do not displace non-geographical communities of need or existing specialist and trusted provision. Where evidence demonstrates that a cohort benefits from a city-wide, identity-based, needs-based or specialist model, the neighbourhood framework should enable connection to that provision rather than require it to be replicated within each geographical footprint.

IMPACTS TO BE EVALUATED DURING IMPLEMENTATION

Neighbourhood-specific evidence is not yet available on the distribution of inclusion-health populations across the proposed Health Neighbourhood Footprints or their representation within the neighbourhood engagement. This includes people experiencing homelessness or rough sleeping, multiple disadvantage, substance dependence, criminal justice involvement, domestic abuse, exploitation, no recourse to public funds and other groups whose needs may not align neatly with geographical neighbourhoods.

Implementation will therefore need to test whether neighbourhood arrangements create any unintended barriers for people without stable accommodation, people whose lives cross neighbourhood boundaries or people whose most meaningful point of connection is based on identity, shared need or trusted specialist provision rather than place. Where evidence supports citywide, specialist or needs-based approaches, neighbourhood arrangements should enable access to that provision rather than require it to be replicated within each footprint.

Meeting psychological needs

Mental health and psychological wellbeing are significant considerations within the evidence base. The ICB Insights Summary identifies substantial variation in mental health need, including severe mental illness, and identifies gaps where mental and physical health or neurodivergent needs cross existing service boundaries.

Portsmouth already has examples of integrated and community-based approaches, including the Mental Health Hub, mental health facilitators within primary care, Project W, neurodiversity provision and wider community support. The NNHIP evidence records that the Mental Health Hub was co-produced with the Mental Health Lived Experience Network.

Neighbourhood health has the potential to improve psychological wellbeing through:

- earlier identification and intervention;
- easier access to local and community support;
- better integration between physical health, mental health, social care and wider determinants;
- reduced fragmentation and repeated navigation between services; and
- stronger community connection and reduced isolation.

Existing Portsmouth evidence also identifies loneliness and social isolation as relevant wellbeing issues across the population.

No direct adverse impact of approving the Plan or footprints has been identified. Future delivery should, however, ensure that neighbourhood arrangements complement rather than fragment specialist mental health pathways and that people with psychological or trauma-related needs are considered in the accessibility and design of local provision.

IMPACTS TO BE EVALUATED DURING IMPLEMENTATION

Neighbourhood-level evidence on mental health need, access and experience is not yet sufficiently developed to assess differential impact across all proposed footprints. Relevant findings from neighbourhood population profiles, community engagement and service-use information should therefore be reviewed as implementation progresses.

Implementation should also evaluate whether neighbourhood arrangements improve access, continuity and coordination for people with mental health and psychological needs, including where physical health, social care, neurodivergence or wider determinants are also relevant. Particular attention should be given to whether local arrangements complement rather than fragment specialist mental health pathways and whether accessibility, trusted routes and continuity are maintained for people with psychological or trauma-related needs..

Final Summary:

Positive impacts Where there is evidence, provide a summary of the positive impact the policy, project or proposal will have for each protected characteristic, and any other relevant group or policy consideration. This should include outlining how equal opportunities will be advanced and good relations fostered between different groups.

The Portsmouth Neighbourhood Health Plan has the potential to make a positive contribution to equality of opportunity and reducing health inequalities by establishing a more population-based and locally responsive approach to planning health and care.

Potential positive impacts include:

- using neighbourhood-level intelligence to identify differences in need, access and outcomes which may be obscured within citywide averages;
- enabling universal services to be complemented by more targeted responses for populations experiencing greater need or poorer outcomes;
- strengthening prevention and earlier intervention;
- improving coordination between health, social care, public health, primary care and VCSE services;
- providing more accessible and trusted community routes to support;
- strengthening community participation and co-production;
- supporting independence and reducing avoidable deterioration; and
- enabling outcomes and inequalities to be monitored at neighbourhood and cohort level.

These potential benefits are consistent with existing Portsmouth experience of integrated and community-based working and with the proposed direction of the city's neighbourhood health model.

Negative impacts Where there is evidence provide a summary of negative impacts for each protected characteristic and any other relevant group or policy consideration. If the evidence shows that the policy, project or proposal will or may result in discrimination, harassment or victimisation this **must be** outlined.

No direct discriminatory or adverse impact has been identified from approval of the Neighbourhood Health Plan or proposed footprints themselves. The Plan does not make immediate changes to individual service eligibility, entitlement or access.

There are, however, potential equality risks which will need to be managed through implementation:

- larger neighbourhood populations could obscure smaller communities experiencing significant inequality;
- neighbourhood boundaries may not correspond with the way every community identifies itself or accesses services;
- future delivery arrangements could create unintended barriers if geography is applied too rigidly;
- digital, transport, physical accessibility, language and communication barriers could result in unequal access;

- a predominant focus on particular cohorts, such as older people or frailty, could unintentionally under-represent other life stages or populations;
- some protected characteristics currently have significantly less evidence available than others; and
- the final community engagement and neighbourhood demographic profiles are not yet available to test all identified impacts.

The eventual contractual or organisational form through which NHS neighbourhood services are delivered is not determined by this Plan. Any future material changes to commissioned services, service locations, workforce, estates, eligibility or delivery arrangements should therefore be subject to further equality assessment when those proposals are sufficiently developed.

Action Plan:

Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.

Action	Person responsible	By date	Progress/ review (Add new actions if required)
Incorporate the final neighbourhood population profiles and review the distribution of protected characteristics, deprivation and relevant inclusion-health populations across the proposed footprints.	Bernie Allen in collaboration with NHS HIOW & PCC Analytics Teams	01/09/2026	Partially complete. Neighbourhood evidence is available but the full final profile set is still being completed. Any residual gaps will be carried into implementation review.
Review the final neighbourhood engagement findings, including participant demographics where available, and identify any communities or characteristics which are under-represented.	Bernie Allen in collaboration with PCC / Hive Community Engagement team	01/09/2026	Substantive engagement themes are now reflected in the EQIA. Participant demographic and representativeness information remains incomplete
Where material gaps in representation or evidence remain, undertake proportionate targeted engagement or obtain additional evidence rather than recording an absence of impact.	Bernie Allen in collaboration with NHS HIOW & PCC colleagues	Ongoing	Triggered where the evidence identifies an unresolved equality issue or where delivery changes require further testing.
Ensure neighbourhood implementation continues to consider transport, digital exclusion, physical accessibility, communication/language requirements and non-digital routes to support.	Relevant commissioning / service lead	Ongoing through implementation	To be reflected in future neighbourhood/service design.

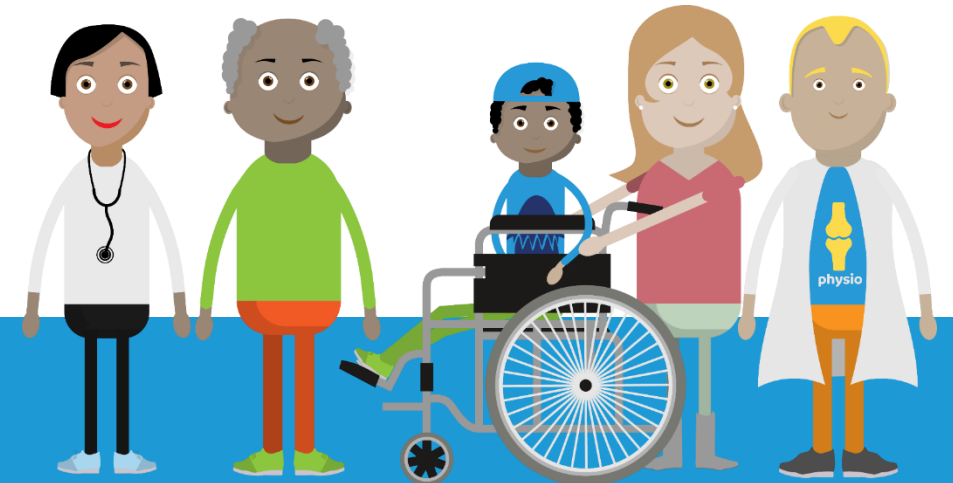
Hampshire and Isle of Wight

Ensure the outcome reporting evolves to monitoring access, experience and outcomes at neighbourhood level and, where data allows, assess whether impacts differ between population groups.	Bernie Allen in collaboration with NHS HIOW & PCC Analytics Teams	Initial version to be ready 01/09/2026 but ongoing	Outcomes framework is established at strategic level; baselines, final measures and reporting arrangements continue to develop.
Require further EQIA where subsequent neighbourhood implementation results in material changes to commissioned services, service locations, estates, workforce, eligibility or organisational/contractual arrangements	Relevant commissioning / service lead	At the point individual proposals are developed	Current EQIA assesses the Plan and proposed footprints, not future detailed service changes.
<i>Review implementation impacts for populations where neighbourhood-specific evidence remains limited, including the Armed Forces community, care leavers, inclusion-health populations and people with psychological needs, drawing on relevant specialist partnership and service intelligence.</i>	<i>Neighbourhood implementation leads with relevant specialist partners</i>	<i>During implementation</i>	<i>To be incorporated into implementation review and future refresh of the EQIA.</i>

Portsmouth Neighbourhood Health Strategic Plan 2026 to 2029

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Portsmouth Health and Wellbeing Board

23 September 2026



What is the Health and Wellbeing Board being asked to consider today?

Approve the Portsmouth Neighbourhood Health Strategic Plan 2026–2029 as the city's strategic framework for neighbourhood health.

Approve the seven Neighbourhood Health Areas as the common geographies for understanding population need, inequalities, priorities and outcomes.

Endorse the proposed delivery and governance approach, using the Organise–Connect–Deliver model through existing Portsmouth partnership arrangements, with statutory responsibilities remaining with individual organisations.

Support the phased implementation approach to March 2029, including development of the detailed operating arrangements, neighbourhood priorities and measures through existing governance.

The timeline

During 2026/27, partners need to establish the foundations

Neighbourhoods – the populations and communities around which we organise.

Priorities – the outcomes and population needs that require collective action.

Delivery approach – how we organise, connect and deliver around those priorities.

Accountability – who leads, who contributes and how progress is overseen.

In 2027/28 the emphasis moves to implementation and alignment:

Alignment of Public Health, Adult and Children's Social Care, Housing and wider local priorities where this improves neighbourhood outcomes.

Progress on the three NHS reform agendas: routine care, proactive care and alternatives to hospital.

Throughout 2028/29, the emphasis moves to demonstrating impact

Demonstrate improvement against locally agreed outcomes, including health inequalities, independence, prevention, wider determinants and community outcomes.

Achieve the March 2029 NHS outcome targets

Improved health and care outcomes
Reduced health inequalities

To be measured by:

- Helping people stay well at home
- Reducing non-elective admissions and bed days for people living with frailty
- Improving end-of-life identification and place of care
- Improving diagnosis and treatment of long-term conditions
- Improving completion of diabetes care processes
- Improving access and outcomes for children and young people

We are here

Integrated Neighbourhood Working in Portsmouth

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.



What are neighbourhoods actually trying to improve?



Overarching outcome: Improve healthy life expectancy & Reduce inequalities in healthy life expectancy between communities

The combined engagement therefore supports five strategic principles for delivery:

- Use the seven neighbourhoods as organising geographies, not rigid service boundaries;
- Build the community connection layer around a network of trusted existing places and relationships, rather than assuming one building per neighbourhood;
- Make early help, information, navigation and prevention locally accessible, while allowing specialist provision to operate at the scale that makes sense;
- Provide face-to-face, telephone, printed and digital routes, recognising practical barriers to access; and
- Prioritise continuity and connection into professional services, so residents receive a useful next step rather than another hand-off.

Common citywide focus

- Prevention and earlier intervention
- Maintaining independence and avoiding deterioration
- Improving health confidence and ability to manage health
- Better access to joined-up support

Initial priority populations / needs

- Cardiovascular disease
- Frailty and healthy ageing
- Multiple long-term conditions
- Complex health and social needs
- Populations experiencing the poorest outcomes or greatest inequalities

Neighbourhood priorities will then vary according to local need

- Strong community connection, activities and local support
- Safe, clean and healthy local environments
- Feeling safe and able to participate in community life
- Being able to find and use health, care and community support
- Affordable access to the things that support health and wellbeing

Your Health Survey: resident health activation findings



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1. Current self-rated health

How good or bad is your health today, on a scale of 1 to 10
(1 = very poor, 10 = excellent)?

Mean health score: 6.1 / 10

Median: 6



417 valid responses; 3 responses recorded 0 and were excluded from scale analysis.

2. Taking care of personal health

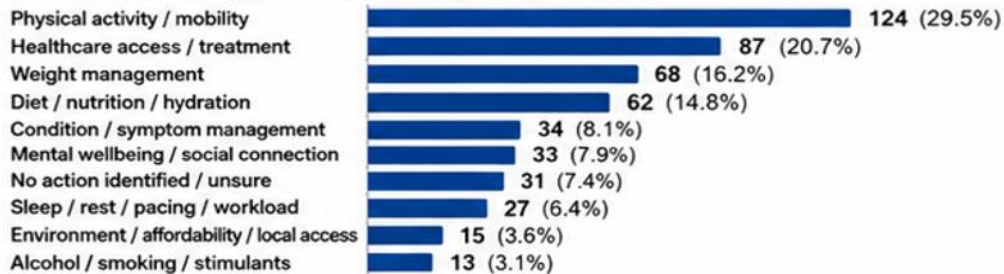
How good or bad are you at taking care of your health?



83.8% said they are quite or very good at taking care of their health.

3. What residents said could improve their health

What is the one thing you could do to improve your health?



Free-text responses were thematically coded. Categories are non-exclusive, so totals do not sum to 420.

4. Relationship between current health and self-management

Average health score by self-reported ability to take care of health

Very good	7.2
Quite good	6.2
Not very good	4.6
Very bad	3.4



Among respondents rating their health 1–3, **44 of 68 (65%)** still described themselves as quite or very good at taking care of their health.

5. Combined view of health and self-management



Higher health = self-rated health 7–10. Lower health = 1–6. Positive self-management = very good or quite good.



Respondent profile / caveats

- Among respondents providing a specific age, around 74% were aged 55+
- Respondents with a limiting condition reported lower average health (4.9) than those without one (7.2)
- The survey reflects self-reported perceptions

How Residents Understand Neighbourhoods

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Participants' lived neighbourhoods were shaped by relationships, activities, familiar places and routes that they could realistically use.



The value of local health support changes according to the type of need.

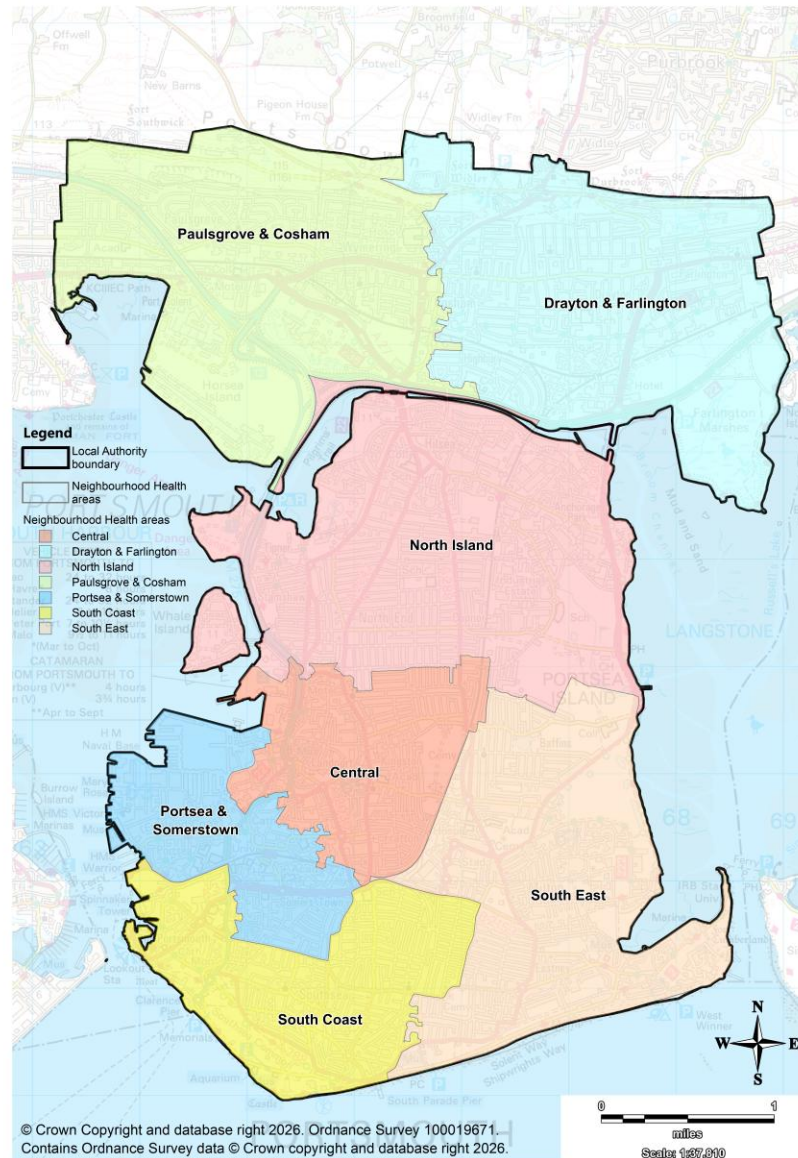
Physical proximity does not automatically mean accessibility.

The strongest message is that local health support works best when people can reach it, understand it, trust the people involved and leave knowing what happens next.

What do we mean by a Portsmouth neighbourhood?



- A defined local population and community – based on how people live, identify and connect, not simply organisational boundaries.
- A common geographic reference point – giving partners a shared basis for understanding need, inequalities, assets and outcomes.
- Locally meaningful, not one-size-fits-all – neighbourhoods should reflect natural communities, local identity and practical access to support.
- Flexible enough to respond to different needs – some priorities may be neighbourhood-wide; others may focus on particular cohorts or communities within or across neighbourhoods.
- Not the same as a PCN footprint – GP registered populations remain important for delivery, but do not determine Portsmouth's civic neighbourhood geography.
- A basis for collective action – enabling partners to organise around the same populations, priorities and outcomes while retaining existing statutory and organisational responsibilities.



Design rules:
Approximately 50,000 people

Align to a single health and wellbeing board (HWB) area the public can recognise, and GPs, trusts, local authority partners and VCSE services can see their teams working together in.

Are mutually exclusive and nest within/coterminous with district boundaries.

Aggregate Census 2021 Lower Super Output Area (LSOA21) geographies which are consistent ONS geographic units for place-based data enabling consistent trend analysis and area comparisons.

Paulsgrove and Cosham



Population Health Profile

- Slightly older and less ethnically diverse than Portsmouth, with further growth expected among older residents, particularly those aged 85+.
- Significant deprivation, including around a quarter of residents in the most deprived national decile and high child poverty.
- Children and young people show particular challenges, including Year 6 obesity, under-five emergency admissions and self-harm admissions.
- Adult smoking, obesity, diabetes, multiple long-term conditions and poor self-reported health are higher.
- All-cause and COPD emergency admissions are higher, although life expectancy and most mortality measures remain broadly similar to Portsmouth; substantial variation exists within the neighbourhood.

Life expectancy M/F: 77.9 / 81.4 years
— similar

Premature mortality: 417.2 per 100,000
— similar

Preventable mortality: 211.2 per 100,000 — similar

All-cause emergency admissions: 14,152 per 100,000 — worse

5+ LTC: 3.2% — worse

Poor self-reported health: 7.5% — worse

Population: 21k

Neighbourhood Priority: Consistent, trusted local access to prevention and coordinated support, particularly for children, families and people with long-term conditions, with fewer hand-offs and better transport, sensory and navigation support.

Community Engagement

- Residents saw neighbourhoods as shaped by trusted places and relationships. Cosham highlighted human contact and navigation barriers; Paulsgrove highlighted strong local identity, accessibility and continuity.
- Community-based access was supported and clear that it must connect directly into professional services rather than become another point of referral.

Priorities

- A trusted, consistent local access point connected directly to professional health and care support.
- Practical accessibility — transport, mobility and sensory needs, with face-to-face, printed and digital routes.
- Strong community connection, with continuity rather than short-lived initiatives.

Drayton & Farlington



Population Health Profile

- A substantially older population: more than one in five residents are 65+ and around 4% are 85+.
- Comparatively favourable socioeconomic circumstances, with no population in the most deprived national decile; air quality is the main less-favourable wider-determinant indicator.
- Smoking, obesity, unhealthy alcohol use, COPD, diabetes, severe mental illness and multiple long-term conditions are generally lower than Portsmouth.
- All-cause and several condition-specific emergency admissions are lower.
- Life expectancy is significantly higher and premature and preventable mortality lower; healthy ageing and maintaining independence therefore emerge as the main future population challenge.

Life expectancy M/F: 80.8 / 85.5 years
— better

Premature mortality: 246.0 per 100,000
— better

Preventable mortality: 103.8 per 100,000 — better

All-cause emergency admissions: 9,631 per 100,000 — better

5+ LTC: 1.8% — better

Poor self-reported health: 3.8% — better

Population: 23k

Community Engagement

- Drayton residents preferred shorter journeys, with mobility, transport and parking shaping access.
- GPs and pharmacies remained important, alongside social activity, local amenities, cleaner streets and infrastructure that keeps pace with development.

Priorities

- Accessible local GP, pharmacy, information and early support.
- Transport, parking, mobility and practical accessibility.
- Community and wider infrastructure that supports healthy ageing and keeps pace with local development

Neighbourhood Priority: Helping an older population stay healthy and independent through accessible local support, with shorter journeys, strong primary care links, transport and community connection.

North Island



Population Health Profile

- Has higher proportions of both children and older people than the rest of Portsmouth, with particularly strong projected growth in the older population.
- Overall socioeconomic profile is comparatively favourable and none of the population is in the most deprived national decile.
- The Children and Young People deprivation sub-domain and air quality are less favourable despite the otherwise positive deprivation profile.
- Most long-term-condition prevalence and emergency-use indicators are similar to Portsmouth; self-reported poor health is lower.
- Life expectancy and mortality are broadly similar, but neighbourhood averages mask pockets of poorer outcomes within individual communities.

Life expectancy M/F: 79.4 / 83.4 years
— similar

Premature mortality: 344.9 per 100,000
— similar

Preventable mortality: 154.9 per 100,000 — similar

All-cause emergency admissions: 11,876 per 100,000 — similar

5+ LTC: 2.4% — similar

Poor self-reported health: 5.3% — better

Population: 40k

Neighbourhood Priority: Healthy ageing and targeted prevention in communities where poorer outcomes are hidden by neighbourhood averages, supported by accessible services and strong community connections.

Community Engagement

- There is no separate North Island focus-group output in the material supplied.
- The defensible community evidence is therefore the citywide survey: residents see health as shaped by accessibility, community infrastructure and wider conditions such as transport, safety, public realm and affordability, rather than healthcare alone..

Priorities (until locally tested)

- Transport, traffic, parking and active travel.
- Access to health services.
- Safety, antisocial behaviour, drugs and crime.

Population Health Profile

- Young, diverse and very densely populated, with a higher proportion of children and young people than Portsmouth overall.
- Experiences some of the highest deprivation in the city: almost half of residents live in the most deprived national decile, with particularly high child poverty, unemployment and income deprivation, crime, fuel poverty and overcrowding.
- Smoking, obesity, asthma, COPD, diabetes and multiple long-term conditions are all higher than the Portsmouth average.
- Emergency hospital admissions are higher across a wide range of conditions.
- Life expectancy is lower and premature, preventable, cardiovascular and respiratory mortality are substantially worse than Portsmouth.

Life expectancy M/F: 74.5 / 80.0 years
— both worse

Premature mortality: 581.2 per 100,000
— worse

Preventable mortality: 316.4 per 100,000 — worse

All-cause emergency admissions: 15,368 per 100,000 — worse

5+ LTC: 3.7% — worse

Poor self-reported health: 8.7% — worse

Population: 35k

Community Engagement

- Central residents highlighted practical access, transport, safety, public realm, community connection and affordability as important to health.
- Wider evidence also suggests poorer outcomes may reflect barriers to treatment, mobility and coordinated support rather than lack of motivation.

.Priorities

- Safety, antisocial behaviour, drugs and crime.
- Accessible local GP, pharmacy, information and early support.
- Practical accessibility to services improving quality of life (fitness etc)

Neighbourhood Priority: Earlier, easier-to-access prevention and long-term condition support, tackling practical barriers such as transport, affordability, safety and navigation that contribute to poorer outcomes and avoidable deterioration.

Portsea and Somerstown



Population Health Profile

- Young, diverse and densely populated, with a substantial student population and significant high-rise housing.
- Around one quarter of residents live in the most deprived national decile; child poverty, income and employment deprivation, fuel poverty, overcrowding and crime are all significant.
- Smoking, obesity, diabetes, COPD, severe mental illness and multiple long-term conditions are higher than Portsmouth.
- Emergency admissions are higher for all causes and several major conditions.
- Life expectancy is markedly lower and premature, preventable, CVD, cancer, COPD and alcohol-related mortality are worse.

Life expectancy M/F: 72.4 / 78.2 years
— worse

Premature mortality: 693.4 per 100,000
— worse

Preventable mortality: 347.2 per 100,000 — worse

All-cause emergency admissions: 17,351 per 100,000 — worse

5+ LTC: 3.9% — worse

Poor self-reported health: 10.7% — worse

Population: 22k

Community Engagement

- Residents highlighted healthcare access, community spaces and activities, transport, food and shopping, digital inclusion and opportunities to learn or volunteer.
- Across the engagement, trusted relationships, community assets and support that is easy to access and well coordinated were consistent themes.

Priorities

- Accessible health and wellbeing support.
- Community spaces, activities and social connection.
- Practical accessibility to services including addressing transport issues.

Neighbourhood Priority: Accessible prevention and early intervention for long-term conditions through trusted community routes, with better coordination and practical support around transport, digital access and wider social needs.

South Coast



- **Population Health Profile**

- Densely populated and ethnically diverse, with a substantial student population and shared accommodation; the number of older residents is expected to grow.
- Overall deprivation is comparatively favourable, although crime, fuel poverty and overcrowding are worse than Portsmouth.
- Smoking and obesity are lower, but unhealthy alcohol use is higher.
- Several long-term conditions are less prevalent, although severe mental illness is higher.
- Emergency admissions are generally lower and life expectancy/mortality broadly similar; alcohol, mental health and specific wider determinants stand out as areas requiring attention.

Life expectancy M/F: 78.9 / 82.2 years

— similar

Premature mortality: 362.2 per 100,000

— similar

Preventable mortality: 159.4 per

100,000 — similar

All-cause emergency admissions:

10,327 per 100,000 — better

5+ LTC: 1.8% — better

Poor self-reported health: 5.1% — better

Population: 39k

- **Community Engagement**

- There is no separate South Coast focus-group output in the supplied material.
- The citywide engagement therefore provides the current resident lens: accessibility depends on transport, mobility, information, cost and digital inclusion; community infrastructure and social connection matter.
- Neighbourhood delivery needs to connect residents to existing support rather than assume all services should be physically recreated locally..

- **Priorities**

- Accessible health and wellbeing support.
- Community spaces, activities and social connection.
- Practical accessibility to services including addressing transport issues.

Neighbourhood Priority: Targeted prevention around alcohol and mental wellbeing, connected to accessible community support and action on safety, affordability and housing-related pressures.

South East



Population Health Profile

- Mixed-age population but with more older residents than Portsmouth and substantial projected growth among people aged 85+.
- Generally favourable deprivation, income, employment, child-poverty, fuel-poverty and overcrowding measures.
- Smoking and obesity are lower than Portsmouth.
- Unhealthy alcohol use and asthma are higher; most other long-term-condition indicators are similar and multiple LTC prevalence is lower.
- All-cause and COPD emergency admissions are lower, female life expectancy is higher and overall mortality outcomes are positive; healthy ageing and targeted prevention are the principal themes.

Life expectancy M/F: 78.9 / 84.3 years
— similar / better

Premature mortality: 329.7 per 100,000
— better

Preventable mortality: 166.5 per 100,000 — similar

All-cause emergency admissions: 10,910 per 100,000 — better

5+ LTC: 2.2% — better

Poor self-reported health: 5.0% — better

Population: 35k

Neighbourhood Priority: Healthy ageing with targeted prevention for alcohol-related risk and asthma, supported by accessible local services and community-based prevention.

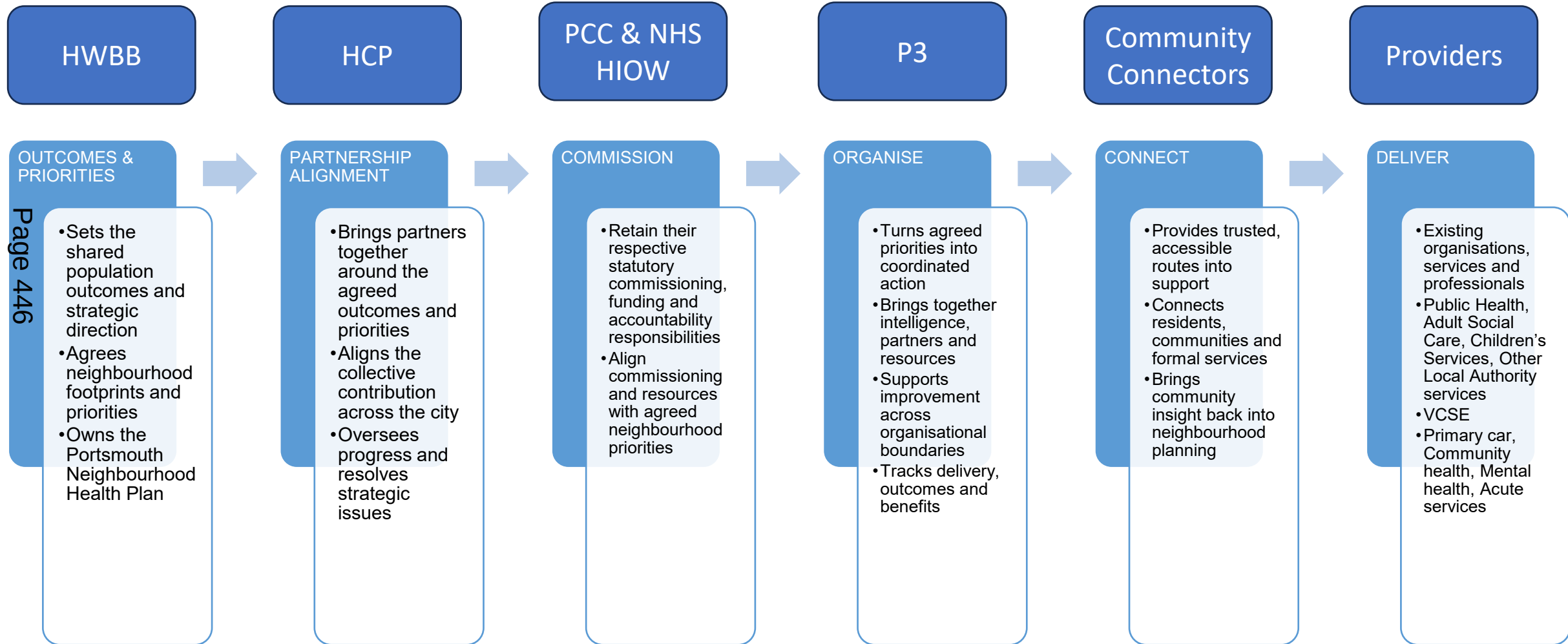
Community Engagement

- There is no separate South East focus-group output in the supplied material.
- The citywide engagement therefore provides the current resident lens: accessibility depends on transport, mobility, information, cost and digital inclusion; community infrastructure and social connection matter.
- Neighbourhood delivery needs to connect residents to existing support rather than assume all services should be physically recreated locally..

Priorities

- Accessible health and wellbeing support.
- Community spaces, activities and social connection.
- Practical accessibility to services including addressing transport issues.

The Portsmouth proposal on a page



How Portsmouth turns priorities into delivery

Evolve P3 into the neighbourhood organising / Integrator function

- Build on the existing Portsmouth Provider Partnership rather than create a new organisation.
- Give P3 the capability to translate neighbourhood priorities into coordinated action.
- Bring together intelligence, partners, resources and improvement activity around agreed populations and outcomes.
- Develop clearer decision rights, accountability and responsibility for tracking benefits

Build the community connection layer

- Create a citywide approach connecting residents, communities and formal services.
- Build from existing Help Desks, Community Wellbeing Hubs, connectors, social prescribing, Community Champions and VCSE capacity.
- Combine universal access with targeted navigation for priority populations.
- Identify funding sources for development and sustainable delivery.

Organise and align existing delivery as we go

- Existing organisations and professionals continue to deliver their statutory and operational responsibilities.
- Commissioning, services and resources increasingly align around agreed neighbourhood populations and priorities.
- Improve interfaces and remove duplication rather than wait for wholesale service redesign.

Pilot community wellbeing hubs*

- Building on work already happening in city
- Extension of HIVE Community Helpdesks
- Shaping the Hubs* around the needs of residents
- Building a flexible, adaptable approach – with NHS, public health, adult social care, VCSE partners and residents



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Developing 3 pilot Hubs* (October 2026-March 2027):



Portsea



Paulsgrove



VCSE-led (SPARK community space)

Agenda Item 12



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)

Title of meeting:	Health & Wellbeing Board
Date of meeting:	23 September 2026
Subject:	Integrated Care Partnership Update
Report by:	Mathew Johnstone
Cabinet Member:	Councillor Matthew Winnington, Cabinet Member for Community Wellbeing, Health and Care
Wards affected:	All
Key decision:	No
Full Council decision:	No

1. Purpose of report

- 1.1 To update the Health and Wellbeing Board on the Integrated Care Partnership Joint Committee Meetings and the ICP Assemblies.

2. Recommendations

- 2.1 To provide an update to the Health and Wellbeing Board and for members to provide any feedback or discussion points to be taken to the next ICP Joint Committee Members or to help delivery of future ICP Assemblies.

3. Background

- 3.1 The Hampshire and Isle of Wight Integrated Care Partnership is a statutory joint committee bringing together a broad range of partners. The Integrated Care Partnership is responsible for setting the strategy for health and care in Hampshire and the Isle of Wight. A chair of one of the Health and Wellbeing Boards is nominated to be co-chair of the Integrated Care Partnership joint committee, which meets three times a year.
- 3.2 The current chairs are Councillor Matthew Winnington, Portsmouth City Council, and Simon Bryant, Director of Public Health, Hampshire County Council. In addition to the joint committee meetings, the Integrated Care Partnership holds assemblies three times a year on different topics involving a wide range of



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partners from across Hampshire and the Isle of Wight. The aim of this report is to provide an update on the work and upcoming changes to the Integrated Care Partnership, in response to national policy developments, acknowledging the vital links with the Portsmouth Health and Wellbeing Board.

4. ICP Joint Committee

4.1 The next ICP Joint Committee will take place on 13 October 2026. This is to take place on the Isle of Wight.

4.2 The agenda for that meeting will focus on:

- Work and Health - Following the ICP Assembly on 8 July, a cross-system working group was established, bringing together representatives from organisations across the system. The group is focused on developing proposals and identifying opportunities for ICP members to improve access to employment for people experiencing health-related barriers to work.
- Neighbourhoods - Reflections from the national neighbourhood visit, alongside collaborating with partners to share case studies and practical examples demonstrating how this approach is being implemented across our four places.
- Prevention and Inequalities Board Update - Provide an overview of the Board, including how it can better support and add value to the ICP's priorities and work.

5. Integrated Care Partnership Assembly

5.1 On 8 July, the Integrated Care Partnership (ICP) Assembly brought together partners from across the system to explore the role of our anchor institutions in supporting people with health-related barriers to gain, remain in, and thrive in employment.

5.2 The session focused on how our collective influence as anchor institutions can improve employment outcomes for people with health-related barriers. Partners shared examples of existing work, explored opportunities to strengthen collaboration, and identified where a more coordinated system approach could add value. As Work and Health is one of the ICP's three strategic priorities, the Assembly represented an important opportunity to progress this agenda and support delivery of our shared ambitions.

5.3 A small cross-system working group will be established to develop proposals ahead of the next **ICP Joint Committee** meeting in October. The group will:



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- Develop a set of recommended actions and opportunities for collaboration across partner organisations.
- Present options for ICP members to consider and agree at the Joint Committee.
- Support the development and delivery of system-wide approaches that contribute to disability employment initiatives, including **Get Britain Working**, and improve opportunities for people with health-related barriers to enter and remain in employment.

5.4 Future ICP Assembly topics are to be agreed with Joint Committee members. Possible next assembly topics - Not in Education, Employment, or Training (NEET). It describes young people, typically aged 16-24 who are not working, going to school, or enrolled in job training programs. There are over one million NEETs and is forecast to reach 1.25 million within five years. The NHS plays an important role, not only as a large employer, but also in supporting these young people to be health ready to look for and maintain employment

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Signed by: Mathew Johnstone
Associate Director of Strategy and System Development
Hampshire and Isle of Wight Integrated Care Board

Appendices:

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

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Signed by:

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