Somerset Health and Wellbeing Partnership

Working together for a healthier Somerset

NHS Somerset

SOMERSET LIFESTYLE SURVEY 2009

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1 EXECUTIVE SUMMARY

1.1 The lifestyles that we lead play a significant role in our health. Our eating and drinking habits, smoking, lack of physical activity and many other behaviours can have a significant impact on our risk of developing conditions such as cardiovascular disease, cancer, osteoporosis, obesity, Type 2 diabetes and some mild to moderate mental health problems.

1.2 It is important for health improvement and health service planning that we understand trends in the lifestyle behaviours of people locally and therefore the prevalence of risk of disease.

1.3 A lifestyle survey is done every 5-6 years to investigate the lifestyles of people living in Somerset. The 2009 Lifestyle Survey used a self-completion questionnaire that was posted to 7,560 individuals randomly selected from people aged 16-74 years in Somerset. The survey achieved a response rate of 48.6%.

1.4 The following bullet points provide a summary of the results obtained in the survey.

Physical Activity

- 24% of participants reported taking less than one session of moderate or strenuous activity in the previous week and 39% reported taking three or more sessions

Food

- 52% of people reported that they did not use salt in cooking the foods they ate. This is significantly higher than the 2002 Lifestyle Survey where only 40.8% used no salt. Similarly, the proportion of people adding salt at the table was also found to have reduced, with 58.5% in this survey reporting adding no salt compared to 46.8% in 2002

- 61% of participants had consumed five or more portions of fruit and vegetables on the previous day and as such met the Five-a-Day recommendations. 12% more women than men consumed at least five portions per day. There was a trend for older people to eat more fruit and vegetables

- 47% of the participants used low fat spread, 26% used butter and 5% did not use any butter or spread. There was also a change observed in the fat content of milk consumed; semi-skimmed milk was the most popular and was used by 68% of participants

Healthy Weight

- Body Mass Index (BMI) calculations showed that 42% of participants were the “normal weight”. In total, 33.3% were classed as being overweight and 16% were classed as obese. 1.9% were classed as morbidly obese

Smoking

- 18% of participants were current smokers and 35% had at some stage smoked but no longer did so. The remainder had never smoked. There were fewer current smokers than there were nationally

- 9% more males than females reported being, or having been, a smoker. Older people were less likely to be current smokers and there was an association with social gradient, with more people in the most deprived areas reporting being a current smoker

- 30% reported being a contented smoker. 29% of people were planning to stop and 7% were in the process of stopping

- the most popular form of smoking cessation support was from a health professional at 27%, followed by support from friends and relatives which 20% of those who had tried to give up smoking had received. However, about 60% said that they did not receive any support in their attempt to give up smoking

Alcohol Use

- 52% of participants said they drank alcohol once a week or more. The most popular alcoholic drink was wine, with 43% of participants saying they had drunk it in the last seven days. The next most popular were ordinary strength beer/cider both at 24% and spirits at 20%

- 26% of people overall were drinking at unsafe weekly levels, (31% of males and 21% of females). 56% of males and 39% of females were drinking unsafe daily levels of alcohol

Preventing Accidents

- overall 20% of participants had fallen in the last 12 months and of these 4.2% had visited their general practitioner or went to a hospital as a result

- 13% of respondents were on four or more medications per day. A surprising amount (20%) said that they could not rise from a chair of knee-height without using their arms. Both of these are significant risk factors for falling

Sun Safety

- the most popular measure of sun safety was to wear sunglasses; about half the respondents said they wore them. Almost half used sunscreen, but almost twice as many women as men would use it. Approximately a third stated they would cover up, a third would stay inside and a fifth would wear a hat

- there was a lack of knowledge around sun safety, including the appropriate use of sunscreen and common signs and symptoms of skin cancer

Mental Health

- 17.5% of participants scored four or more on the General Health Questionnaire-12 (GHQ-12); a higher proportion of females than males reached this score. This was especially pronounced in the 16-24 year age category where almost twice as many females than males scored four or more, (27.4% compared to 15.5%)

- the proportion of people reporting some lack of social support on the Social Support Scale was 23% and 22% reported a severe lack of social support

- 42% reporting feeling isolated. Males and females reported similar levels of any isolation, but there was a suggestion that more females experienced more intense isolation. There was also a decrease in perceived social isolation with age. Those aged over 55 reported being very connected with their communities more than twice as often as those aged less than 25

2 INTRODUCTION

2.1 The way we live our lives has a significant impact on our health and wellbeing. There is good evidence available that demonstrates the impact of an unhealthy lifestyle. This increases the risk of conditions such as cardiovascular disease, stroke, diabetes and obesity. Encouraging and supporting individuals to live a healthier life is the cornerstone of preventing diseases which result in reduced life expectancy and account for a significant proportion of inequalities in health in Somerset.

2.2 The aim of the Somerset Lifestyle Survey is to investigate the lifestyles led by adults in Somerset between the ages of 16 and 74 years. This will provide valuable information on the prevalence of risk factors associated with major health conditions experienced in the county, such as cardiovascular disease, mental health problems and musculoskeletal problems.

2.3 This report outlines the methods used and details the findings of the 2009 Lifestyle Survey. The previous survey, carried out in 2002, was conducted for both Dorset and Somerset. Where it is possible to do so, comparisons have been made between the Somerset results for 2002 and 2009.

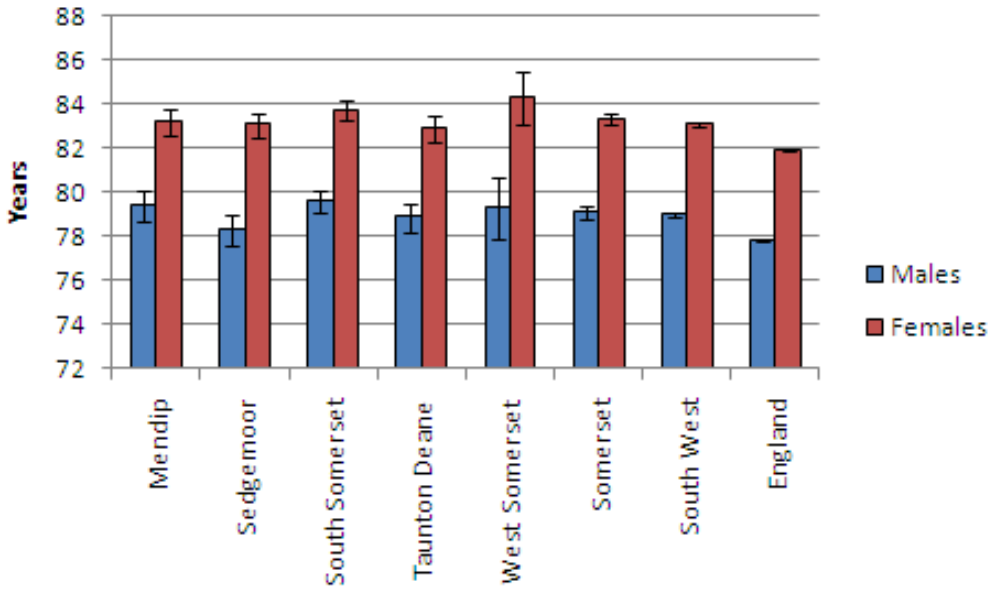
3 BACKGROUND

3.1 To provide some context to the results presented in this report, this section provides a brief summary of the current overall health status of the population of Somerset. For a more detailed description see the Somerset Joint Strategic Needs Assessment (JSNA)[1].

Life Expectancy

3.2 As indicated in Figure 1, the population of Somerset is relatively healthy in terms of life expectancy and prosperity, although there are pockets of deprivation within some of the larger towns and in isolated rural areas.

Figure 1: Life expectancy at birth 2006-2008

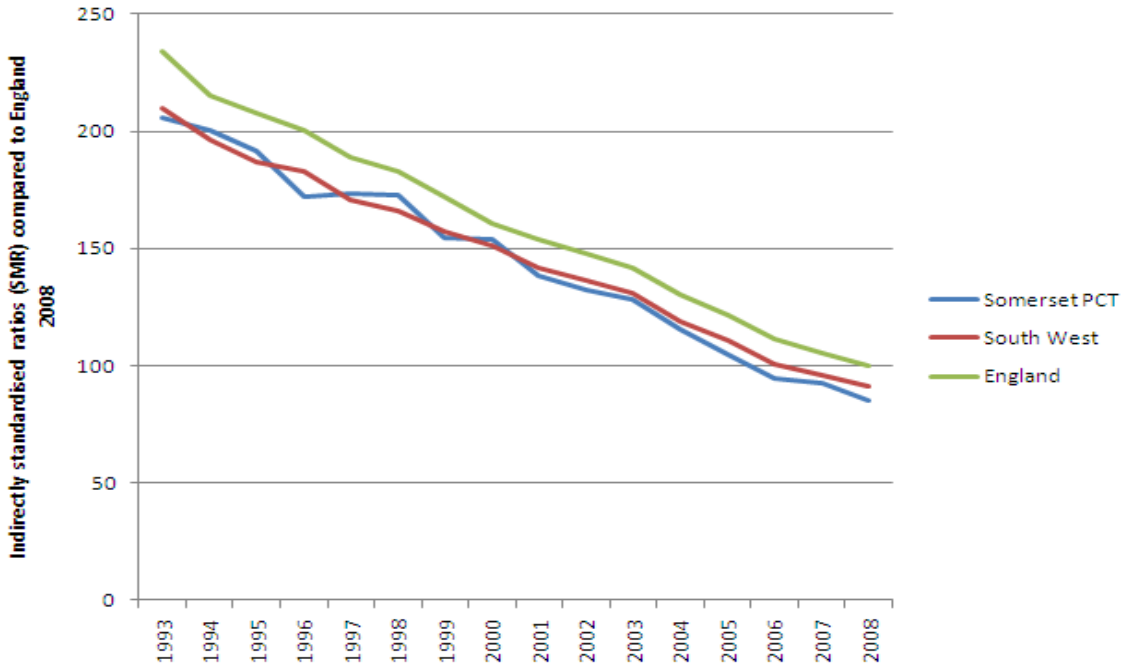


Coronary Heart Disease

3.3 Whilst some people are predisposed towards developing heart disease, due to inherited genetic factors, the condition is largely preventable by maintaining a healthy and active lifestyle. Lifestyle risk factors for coronary heart disease (CHD) include smoking, poor eating habits, physical inactivity, obesity and excessive alcohol consumption.

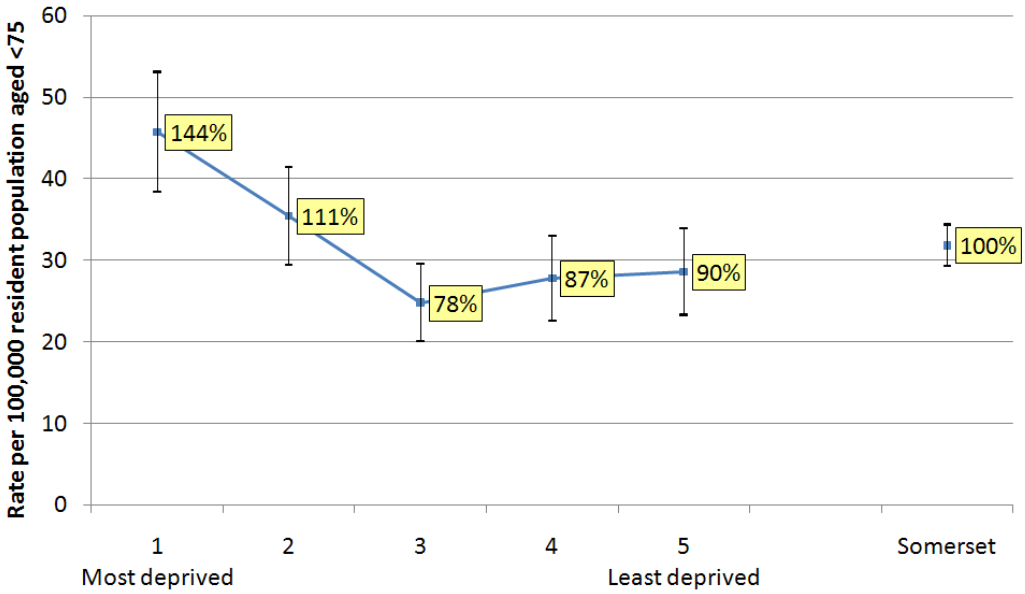
3.4 Despite being largely preventable, CHD still causes more deaths in Somerset than any other disease. Mortality rates from CHD have gradually decreased over the past ten years (Figure 2), largely due to advances in medical intervention.

Figure 2: Trends in mortality from CHD



3.5 There is, however, a strong association between deaths from heart disease and deprivation, as seen in Figure 3. This is likely to reflect inequalities in lifestyle risk factors experienced across the social gradient.

Figure 3: Deaths from CHD for those aged <75, 2006-8



Stroke

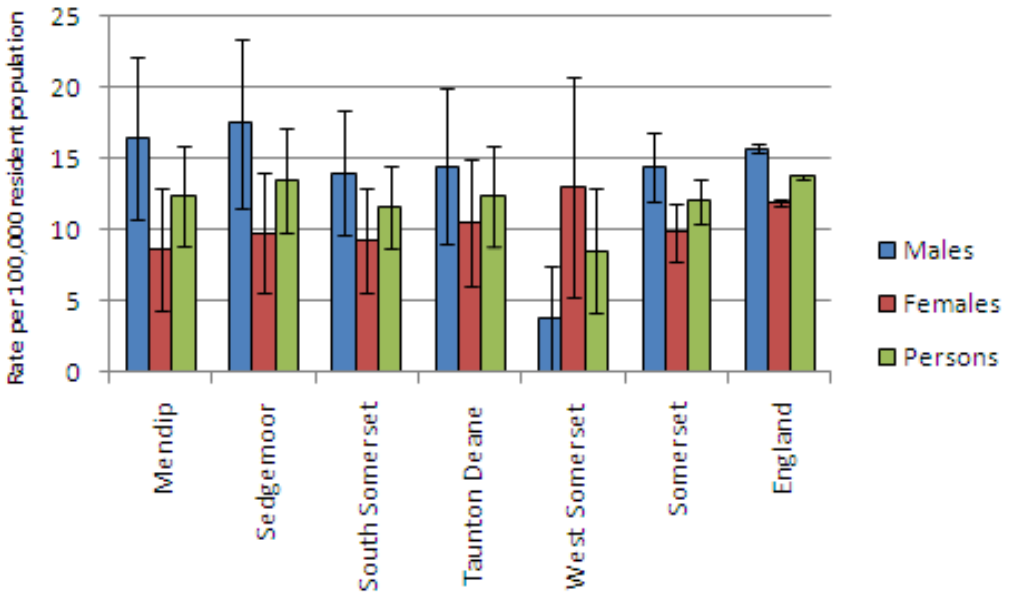
3.6 The same lifestyle behaviours are also risk factors for stroke. Stroke is the third most common cause of death in England and Wales and is the main cause of acquired disability in adults. Many strokes are preventable, most

are treatable and the harm done by stroke can be greatly reduced by acting quickly on important warning signs.

3.7 Stroke prevalence in Somerset is 2.1% compared to 1.9% for the South West and 1.6% for England. Occurrence of stroke, however, is more common among older people and therefore would be expected to be higher in Somerset due to the demographic profile.

3.8 The age standardised premature death rate from stroke is 12.1 per 100,000 population for Somerset (2006-2008), compared to 13.7 for England (Figure 4). This lower death rate suggests effective health care is currently being provided. However, it should be noted that the currently high and increasing average age of the population in Somerset means that actual numbers are considerable and likely to increase in the future.

Figure 4: Directly standardised mortality rate for stroke <75 years, 2006-2008



Diabetes

3.9 The Quality and Outcomes Framework (QOF) data 2008/09 suggests that 4.1% of the Somerset population have diabetes. This is significantly lower than the England average of 4.3%. However, the rate in West Somerset is significantly higher.

3.10 Of the known population with diabetes in Somerset, 10.5% have Type 1 and 89.5% have Type 2. Type 1 generally occurs early in life, commonly during early teens through to mid to late twenties. Type 2 is generally diagnosed in those aged over 50.

3.11 Modelled estimates suggest that there may be up to 21% (almost 5,000 people) with undiagnosed diabetes in the Somerset population. However,

there are some reservations about applying the model to small populations, particularly when there are larger numbers of people aged over 65.

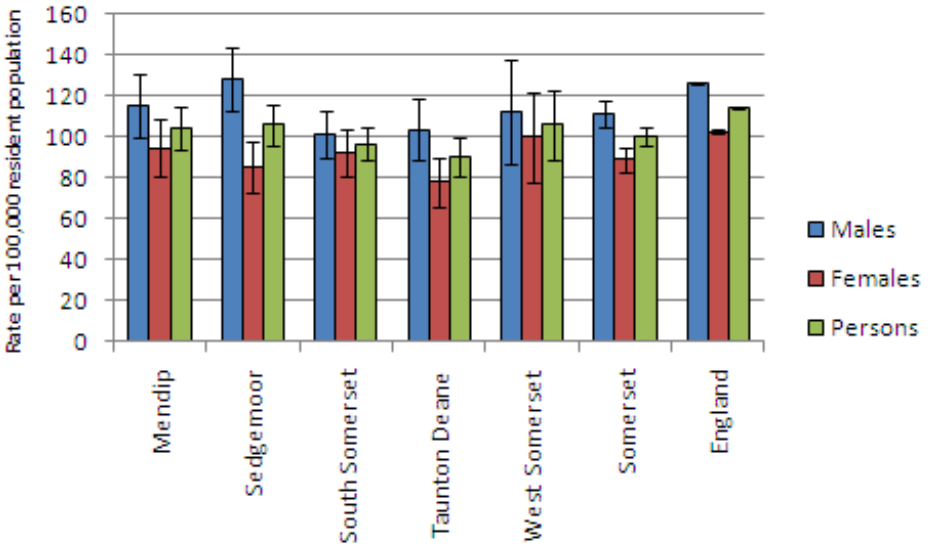
3.12 Two prominent risk factors for Type 2 diabetes are increasing age and levels of obesity. The Office for National Statistics (ONS) population projections indicate that the population of Somerset is set to rise overall and the proportion aged over 65 will rise rapidly over the next 20 years. Similarly, national and local trends are showing an increase in the prevalence of overweight and obesity thereby increasing the likelihood of increased rates of Type 2 diabetes in the future.

Cancer

3.13 The incidence of cancer continues to rise due to the ageing population and this is predicted to increase by approximately one third between 2001 and 2020.

3.14 Currently, one in three people will be diagnosed with cancer at some time in their life and cancers account for around one quarter of deaths in Somerset. In 2006/08 there were a total of 4,391 deaths from cancer in Somerset. Of these deaths, 741 were from lung cancer, 503 from colorectal cancer and 341 from breast cancer. During 2006/08 in Somerset the age standardised premature mortality rate from all cancers per 100,000 population was 99.9, significantly lower than the national rate of 114.0, as shown in Figure 5.

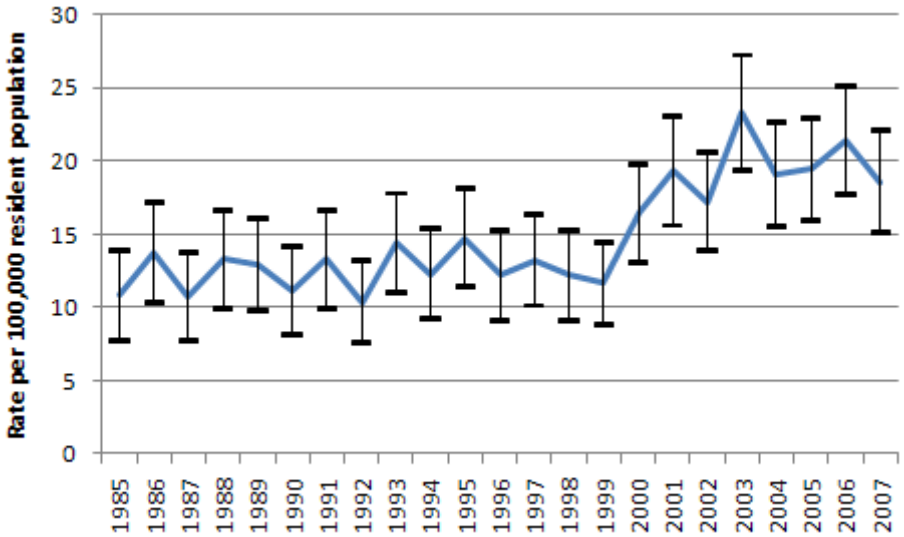
Figure 5: Directly standardised mortality rate for cancer <75 years, 2006-2008



3.15 The causes of some cancers remain unknown. However, over half of all cases of cancer could be prevented through changes of lifestyle such as quitting smoking, avoiding excessive ultraviolet exposure, maintaining a healthy weight and avoiding excessive alcohol consumption.

3.16 Skin cancer incidence in Somerset has been rising, particularly since 1999.

Figure 6: Incidence of malignant melanoma in Somerset



Mental Health

3.17 Mental health problems are extremely common: one in six adults will have a mental health problem at any one time and for half of these people the problem will last longer than a year. The most common conditions are anxiety, depression and stress. Half of those with such common mental health problems are limited by their condition and around one fifth are disabled by it.

3.18 It has been estimated that around 11.5% (or about one in 10) adults in the South West may have a mental health problem at any particular time and an estimated 7.4% (or about one in 14) adults will have a significant problem that is likely to require treatment. These percentages do not differ significantly from the England average (13.2% and 7.3% respectively).

3.19 The amount of mental ill health presenting at a GP practice will be strongly linked with the general characteristics of the practice population. Indicators of social deprivation such as unemployment and homelessness are associated with higher levels of mental ill health. The prevalence rate of people on the depression register across 75 Somerset GP practices is 10%, representing 53, 652 people. This is compared to an England wide prevalence rate of 8.1%.

3.19 Mental health is not simply the absence of mental illness. It is a positive state of wellbeing. Promoting mental health and wellbeing can positively affect almost every area of a person's life: education, employment, family and relationships. It can help people achieve their potential, realise their ambitions, deal with challenges, work productively and contribute to their community and society.

4 METHODS

Aim

4.1 The 2009 Lifestyle Survey is the latest of a series of surveys conducted over the past 20 years. The survey aims to investigate the lifestyle behaviours of adults aged 16 to 74 years in Somerset which would be expected to have an impact on health.

4.2 As far as possible, the methods used for the 2009 Lifestyle Survey were the same as in previous surveys to see whether there have been changes in behaviour over time.

Data Collection

4.3 As in previous years, the survey used a self-reported postal questionnaire to collect the data. The questionnaire was sent with a covering letter/information sheet and pre-paid reply envelope to a sample of named individuals in October 2009. Press releases and local radio interviews on the survey were undertaken when the questionnaires were posted, to generate public interest and maximise the response rate. A dedicated answerphone was set up to take calls for any queries from the public. A postcard reminder was sent to non-responders after three weeks and a second questionnaire, covering letter and pre-paid reply envelope were sent after a further three weeks. This timescale was slightly longer than in other surveys (previously two weeks) due to the Royal Mail postal workers strikes. There was a request for one questionnaire to be translated. It was agreed with the participant to complete the questionnaire face to face with the help of an interpreter.

4.4 Questions within the survey focused primarily on known behavioural lifestyle risk factors such as:

- smoking
- diet
- alcohol consumption
- physical activity

4.5 All questions from the most recent survey (2002) were reviewed by the Public Health team for relevance and reworded, replaced or removed as appropriate to current national and local policy. Where possible, questions for the survey were kept consistent with previous years. The demographic questions relating to ethnicity and employment were selected as these will be used for the 2011 Census. Some data was therefore not directly comparable to previous surveys. In addition to the questions used in previous lifestyle surveys, questions were also included on sun exposure.

There were 51 questions in total, with a further space for additional comments. A full copy of the questionnaire can be seen in Appendix 1.

4.6 The questionnaire was generated using a data capture computer software programme called Formic Fusion^{PRO} (version no. 5.2.011). It was the first year this method of data capture had been used; previous years had relied on manual entering of data. This enabled responses to be tracked through a barcode on the questionnaire and enabled questionnaires to be scanned and an initial data validation process to take place. A further manual cleaning process then took place to validate the data.

The Sample

4.7 The population covered by the survey was defined as the people living in Somerset who were aged 16 to 74. A sample of 7,560 people was randomly generated from the general practice register. This amounted to 1.9% of the registered Somerset population aged 16 to 74. This was checked against the demographics of the Somerset population and found to be representative. Before each mailout, the Weekly Death Certificate download from the Somerset Registry Offices and the Office for National Statistics (ONS) Primary Care Mortality Database were checked against the sample. The questionnaire of anyone who had died was removed from the sample.

Response Rate

4.8 Following two reminders, administrative checks and data validation, 3,613 records were available for analysis. A small proportion of the questionnaires failed to reach their intended individual, as the person could not be successfully contacted because they had died or moved away. An additional proportion could not be filled out because the recipient was too infirm. When these were discounted from the initial number sent, the final response rate was 48.6%. This is slightly lower than in previous years, with responses varying from 53% in 1997 to 63% in 2002.

4.9 Response rates were very similar across the county and the distribution of the responses was very similar to the distribution of people in the whole population.

Table 1: Response rates, by Local Authority area

Local Authority	% of total response	% of SOMERSET in Local Authority	Local Authority response rate
Mendip	20%	21%	47%
Sedgemoor	21%	22%	48%
South Somerset	31%	30%	50%
Taunton Deane	21%	21%	48%
West Somerset	7%	7%	51%

4.10 The degree to which the sample is representative of the population (how well respondents reflect the population) is a product of both the validity of the initial sample and the survey response. Indicators that can be used to assess this representativeness are age and gender, social class and area of residence[Σ].

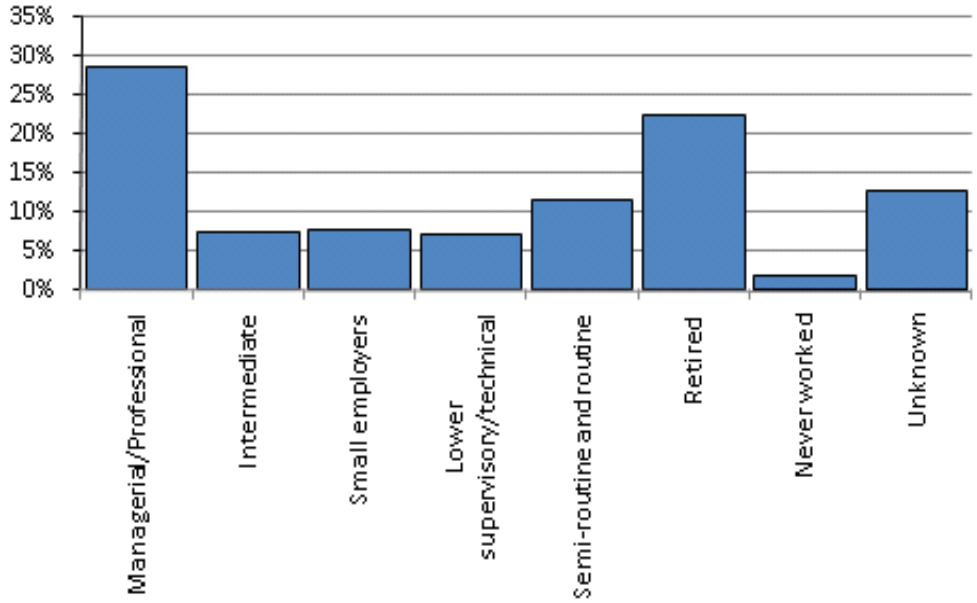
4.11 The original sample for the survey was 50% male and 50 % female. Of those that responded, 43.2% were male and 56.8% were female.

4.12 Social class was classified using the National Statistics Socio-economic Classification (NS-SEC). NS-SEC has replaced previous social classifications at a national level and has been constructed to measure employment relations and conditions of occupations. Conceptually, these are central to showing the structure of socio-economic positions in modern societies and helping to explain variations in social behaviour and other social phenomena. It has also been reasonably validated both as a measure and as a good predictor of health and educational outcomes. NS-SEC is derived from occupation and employment status information and refers to the respondent's last or current main job. The five-class self-coded version was used for simplicity in this survey and the national comparison data with eight classes has been combined in line with the method in the NS-SEC User Manual[2].

4.13 Figure 7 shows the proportion of responders in each social class. Those who retired more than two years ago and those who have never worked cannot be classified. The last employment was used for those who retired less than two years ago. Of those who could be classified the most common result was Managerial and Professional at 46%, with the second highest category being Semi-routine or Routine occupations at 18%. These differ from the Somerset population averages (at Census 2001), which suggest that about 30% of the population are classified as Managerial and Professional and 26% are Semi-routine or Routine. This may reflect those people who are most likely to respond to this type of survey.

[Σ] In the following tables, counts may not add up to the total number of responses due to incompleteness of some demographic data

Figure 7: National Statistics Socio-economic Classification (NS-SEC) of respondents



4.14 The largest proportion of responses to the survey was obtained from those aged 55-64 years, who accounted for 25% of respondents. Only 9% of respondents were in the 16-24 and 25-34 categories. Response rates increased with age, from 28% in the youngest age group up to 74% in those aged 65-74 as seen in Table 2.

Table 2: Breakdown of response rates, by age

Age group	% of total response	% of SOMERSET in age group	Age group response rate
16-24	9%	15%	28%
25-34	9%	14%	32%
35-44	15%	19%	41%
45-54	20%	19%	50%
55-64	25%	19%	62%
65-74	23%	14%	74%

4.15 As response rates varied between age/gender groups, the data was weighted using the age/gender structure of the whole Somerset population ("standardised").

4.16 Weighting levels were calculated from response rates in age/gender groups using the ONS population projected for Somerset in mid-2009. With weighting applied the survey achieved response proportions of 50.1% male and 49.9% female. The average, un-weighted age for a respondent was 51 years, with a minimum age of 15 years and a maximum of 76 years. (These are just outside the age groups chosen, probably as a result of

slight errors in recording birth date on the GP registration and a birthday). The application of weighting gave an average age of 45 years.

4.17 All data, tables and graphs in this report represent these weighted proportions. In cases where comparisons with other data sets have been made and it was possible, the same weighting measures have been applied to ensure a standardised result (for example, all data is weighted to the Somerset 2009 population). This includes the Somerset results from the 2002 Dorset and Somerset Lifestyle Survey. Where results have been given for the earlier Somerset Lifestyle surveys, they have been standardised to the 2002 Dorset and Somerset population (and so are not strictly comparable with the more recent data).

4.18 Local Authority results have also been age standardised to reveal general trends. While this does allow for comparisons between Local Authorities with populations of differing ages, it does mean that individual Local Authority results might be unreflective of the true response.

5 RESULTS - PERSONAL DETAILS

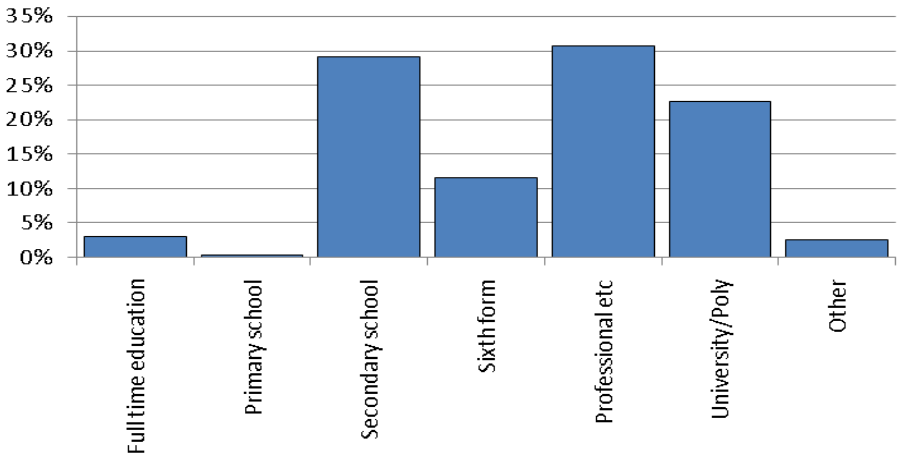
Summary of Results

- 54% of participants were in paid employment and 18% were fully retired. Unemployed and able to work accounted for 5% of respondents
- 31% reported having a professional or technical qualification. 23% reported a university degree as their highest qualification, with 29% being qualified to secondary school level
- 22% of participants reported having been diagnosed with high blood pressure and 16% with high cholesterol. The cumulative occurrences of these conditions over time means that there is a higher prevalence with age. 10% reported having a physical disability

Formal Education

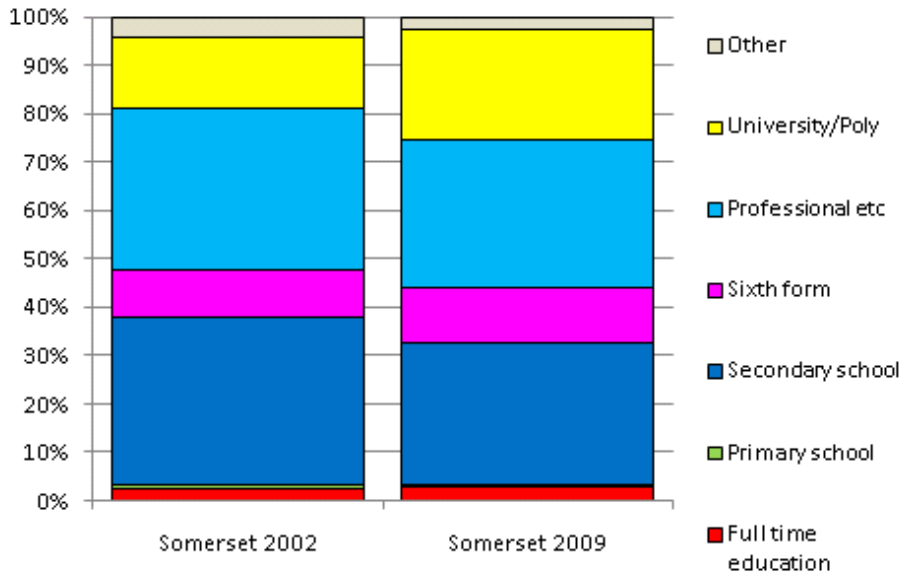
5.1 Level of educational attainment has been shown to have a significant impact on health and is an important determinant of inequalities in health. Participants were asked to report the highest level of education they had completed. Professional or technical qualification was highest at 31%, which was followed by secondary school at 29%. There was a difference of 6.5% between this and the next most frequent response, a university degree at 23%. This shows a marked change from the 2002 Lifestyle Survey, when 14% of participants had completed a university degree, 36% had completed to secondary school level and 1.5% had completed primary school.

Figure 8: Highest level of completed education



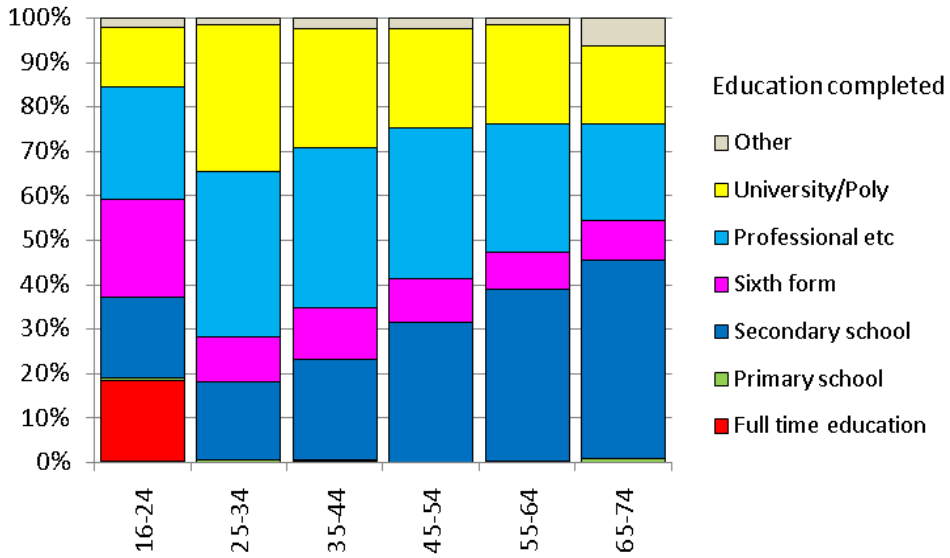
5.2 A further difference from the 2002 Lifestyle Survey was the gender differences observed. In 2002, females had lower rates of university degrees and professional qualifications. However, very little gender difference was observed in the 2009 Lifestyle Survey.

Figure 9: Comparison of the highest levels of completed education 2002 and 2009



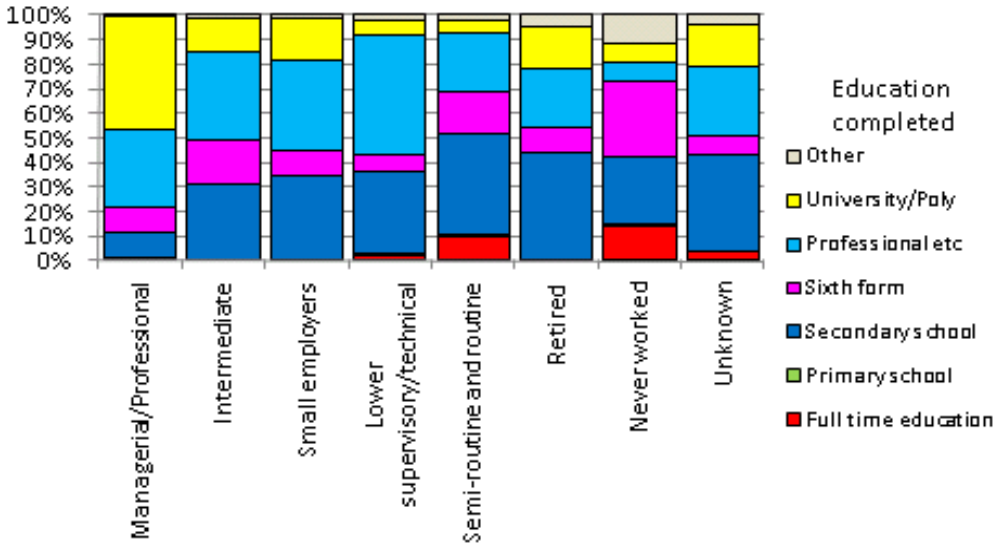
5.3 It should be noted that a proportion of participants would still be in some form of education and as such, the final level of education achieved would be expected to rise slightly. This is most apparent in Figure 10, where the results for the 16-24 years category do not follow the clear trend for an increased level of education with age, mainly due to the large proportion still in full-time education.

Figure 10: Highest level of completed education, by age group



5.4 There were differing levels of education apparent in the data across the social gradient, as might be expected. For instance, there was a larger proportion of managerial/professional people with a university degree.

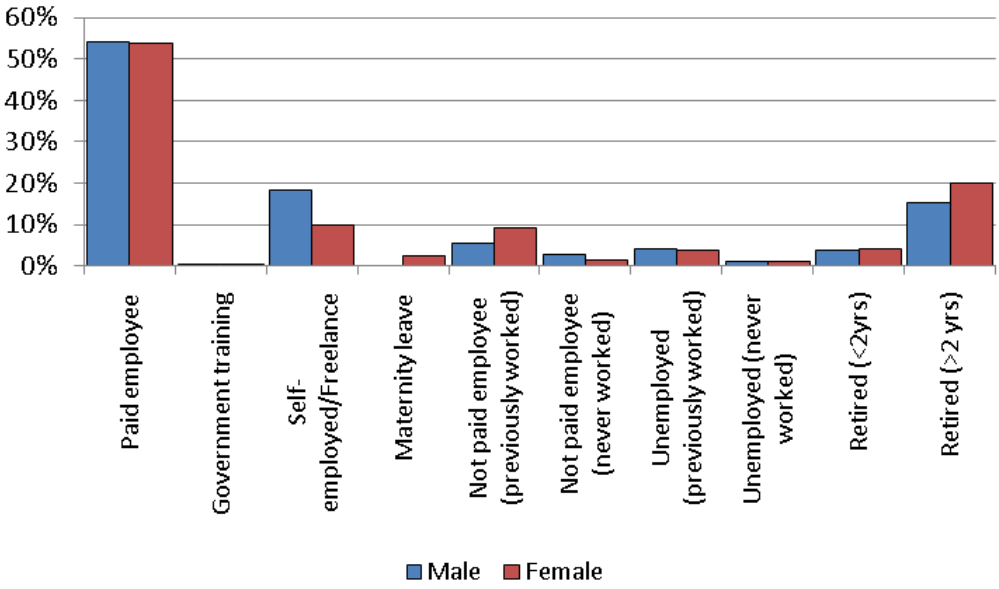
Figure 11: Highest level of completed education, by social class



Employment

5.5 Participants were asked whether or not they were currently in paid employment. The following results exclude those who were still in full time education. 54% of those who responded stated that they were in paid employment, 18% stated they had been retired for more than two years, 5% were unemployed and 3% had never worked. These figures represent self classification by a participant and do not necessarily indicate those who are claiming unemployment benefit and as such they cannot be accurately compared to national figures. Only 0.4% reported they were on a government employment/training scheme.

Figure 12: Employment, by gender



5.6 The proportion of women in paid employment was similar to that of men. Men were almost twice as likely to be self employed or freelance (18.5% compared to 9.8%). 3.7% of men said they had never worked compared to 2.1% of women.

Medical Conditions

5.7 The 2009 Lifestyle Survey investigated the personal health of participants. People were presented with a list of common conditions and asked whether a doctor had told them that they have, or have had, any of them.

5.8 Table 3 shows that the most common condition which had been diagnosed and communicated to the patient was high blood pressure, with 22% of participants reporting this. The next was high cholesterol at 16%. The lowest was stroke, with only 1.4% of people reporting this condition. It should be noted that this question specifically refers to a condition that a participant currently has or has survived – for example, more than 1.4% of people will have experienced a stroke, but some will not have survived the experience.

Table 3: Reported diagnosed conditions

Condition	Lifestyle %	QOF - Somerset %	England %
Hypertension	22.0	15.4	28.4
Stroke*	1.4	2.1	1.6
Coronary Heart Disease*	3.9	3.9	4.2
Diabetes*	4.9	5.0	4.8
High cholesterol	15.6		

* England data for 2006

5.9 GPs keep registers in their practices of patients with certain conditions. 15.4% of patients registered with Somerset doctors are on the hypertensive disease register (compared with 22.0% in the survey with high blood pressure), 2.1% of patients are on the stroke register (compared with 1.4% in the survey), 3.9% are on the CHD register (compared with 3.9% with angina and/or heart attack) and 5.0% are on the diabetes register (compared to 4.9%). The comparisons are not exact as most registers are for all age groups and not just those aged 16-74. The diabetes register rate is per population aged 17 and over. Results from the Health Survey for England[3] are also very similar to those from the 2009 Lifestyle Survey.

5.10 In general, the prevalence of these conditions is greatest in the most deprived areas. One exception is for high cholesterol, where the highest rate is for those in the least deprived areas. The prevalence of diabetes is about 80% higher in the most deprived areas compared to the other areas. Comparing the number of cases of diabetes registered in practices also shows a gradient with deprivation. However, there are only 14% more in the most deprived area practices. This is probably because practices draw patients from a range of areas, not all of which are equally deprived, so the effects are evened out.

Disabilities

5.11 Participants were asked whether or not they suffered from any disabilities (Table 4). The most commonly reported type of disability was physical disability with 10% of participants suffering from such a condition. The least reported disability was speech impairment at 1%. 63% stated they had no disabilities.

Table 4: Proportion of respondents reporting a disability

Disability	Yes %
Physical	10.1
Learning	3.7
Visual	9.0
Hearing	8.3
Speech	1.2
Mental Health	4.2
No disabilities	63.3

6 RESULTS - PHYSICAL ACTIVITY, FOOD AND HEALTHY WEIGHT

Summary of Results

- 24% of participants reported taking less than one session of moderate or strenuous activity in the previous week and 39% reported taking three or more sessions
- males generally took far more strenuous and moderate physical activity than females (49.9% for males and 28.6% for females)
- inactivity increased with increasing age and increasing Body Mass Index (BMI)
- 17% of participants were following a diet at the time of the survey. The most popular was a slimming diet at 8%
- 52% said they did not use salt in cooking the foods they ate. This is significantly higher than the 2002 Lifestyle Survey where only 40.8% used no salt
- the proportion of people adding salt at the table was also found to have reduced, with 58.5% in this survey reporting adding no salt compared to 46.8% in 2002. More males than females were found to add salt at the table
- 61% of participants had consumed five or more portions of fruit and vegetables on the previous day and so met the Five-a-Day recommendations. 12% more women than men consumed at least five portions per day. There was a trend for older people to eat more fruit and vegetables
- 47% of the participants used low fat spread, approximately 26% used butter and 5% did not use any butter or spread. There were no significant differences in the type of spread used between men and women or by social gradient. However, there was a trend for older people to be more likely to use low fat spread
- semi-skimmed milk was the most popular type of milk and was used by 68% of participants. The next most popular was skimmed milk at 15%
- clear trends can be seen in the reduction of use of full fat milk and butter since the 1992 survey
- BMI calculations showed that 42% of participants were the “normal weight”. In total, 33.3% were classed as being overweight and 16% were classed as obese. 1.9% were classed as morbidly obese

- 61% in the underweight category considered themselves "about the right weight" with 5% considering themselves overweight. For those who were within the normal weight category, 27% considered themselves "a little overweight"

- at the opposite end of the scale, 40% of those in the obese and morbidly obese categories considered themselves "a little overweight", a further 3% identified themselves as "about the right weight" and 1% considered themselves "underweight"

Physical Activity

6.1 The human body is designed to move and needs physical activity to maintain a healthy state. However, only a minority of people are sufficiently active. Over the past 30 years physical activity levels in the UK have been declining.

6.2 With increasing advancements in technology, manual labour has decreased and there is an over reliance on cars to get around. Miles travelled by cycling and walking have decreased significantly and miles travelled by car have increased 70% over the past 25 years. The average adult is now sedentary for six hours a day and watches 2.8 hours of television on a weekday, more at weekends.

6.3 Recommendations for adults have focused on regular moderate activity, with five 30-minute periods of at least moderate activity recommended per week. It is now widely acknowledged that lack of exercise stands as a major independent risk factor for CHD, as well as contributing to other risk factors such as obesity.

6.4 The Active People Survey 2009[4] is designed to collect information on sports participation amongst a locally representative sample of adults aged 16 and over, living in England. It is a telephone survey and is focused on sport and active recreation and thus does not include walking or cycling to work or activities such as DIY and gardening. The results are therefore not directly comparable with the 2009 Lifestyle Survey. The Active People Survey 2009[4] showed that in Somerset only about 21% of adults took part in at least three sessions of activity per week with each session lasting at least 30 minutes. Over half of Somerset adults surveyed stated that they had not participated in any regular activity.

6.5 This question was identical to the one in the 2002 Lifestyle Survey, the results of which provided the baseline data for the Local Area Agreement Stretch Target for physical activity agreed for Somerset. The question is based on the Godin and Shepherd Leisure-Time Exercise Questionnaire[5]. Participants were asked to record how many times a week they did activity that was classified under the following three intensity levels for more than 15 minutes:

- strenuous activity (such as sport/exercise/hard manual labour)

- moderate activity (such as physical recreation/leisure activities/manual work)

- mild activity (such as physical hobbies/light recreation)

6.6 In order to calculate the total number of sessions of activity of at least moderate level undertaken by participants each week, the total number of sessions of 15 minutes of moderate and vigorous activity was calculated. This was then divided by two to give the number of sessions of 30 minutes activity per week. The final number was then rounded down to reflect whole numbers of sessions. The same method was used in 2002. If participants had recorded activity levels in at least one of the boxes they were assumed to have zero for blank boxes. Where participants had not recorded any activity levels at all, they were removed from the analysis.

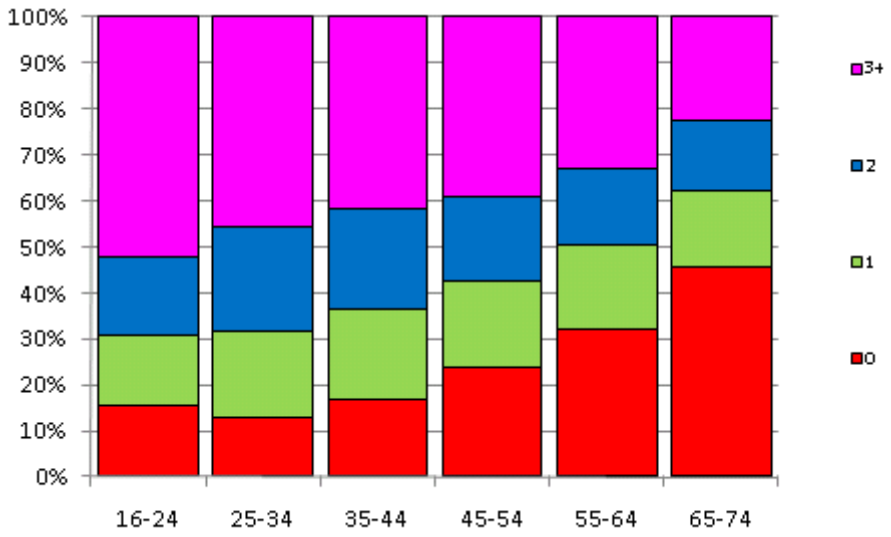
6.7 Across all respondents the average participation for each of these three groups was 2.2 sessions of strenuous activity, 3.7 sessions of moderate activity and 4.5 sessions of mild activity.

6.8 24% of participants reported taking less than one session of moderate or strenuous activity in the previous week and 39% reported taking three or more sessions (49.9% for males and 28.6% for females). Very little difference was found between the 2002 and 2009 Lifestyle Survey results for physical activity levels, as shown in Figure 13.

Figure 13: Comparison of physical activity levels 2002 and 2009

6.9 Males reported participating in more strenuous and moderate physical activity than women and activity levels were found to decrease with increasing age. This was also consistent with the results of the 2002 Lifestyle Survey and the Active People Survey 2009[4].

Figure 14: Number of activity sessions of more than 30 minutes per week, by age group

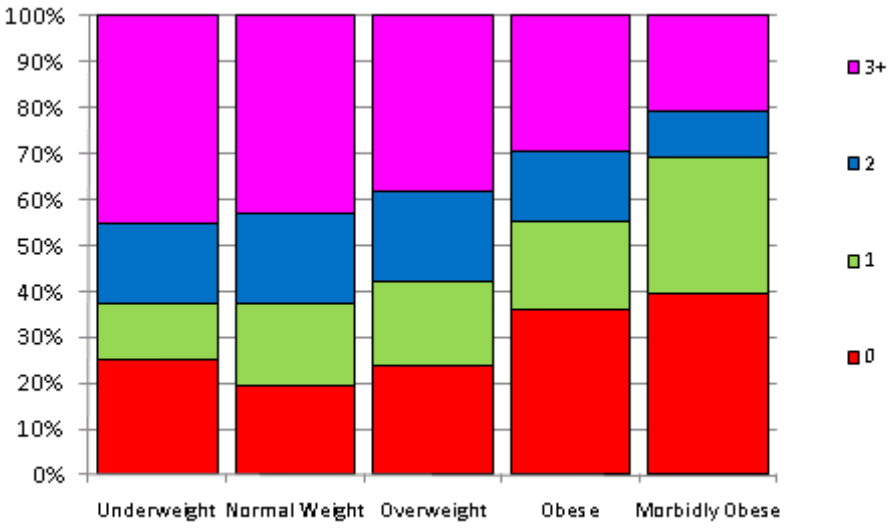


6.10 Very little difference was found in activity across the social gradient, whereas the Active People Survey 2009[4] shows an increase in activity in the managerial and professional classifications.

6.11 There was very little difference between Local Authority areas.

6.12 However, there was a strong association found between physical activity participation and BMI, with people in the obese and morbidly obese categories reporting significantly less physical activity than those reporting a normal weight.

Figure 15: Number of activity sessions of more than 30 minutes per week, by BMI category



Food

6.13 The health benefits of meeting nutritional guidelines are estimated to prevent 70,000 premature deaths a year. Poor diet is estimated to account for a third of all cancer cases and a further third of all cases of cardiovascular disease[6]. Diet-related chronic disease is estimated to cost the NHS £7 billion a year, including direct treatment costs, state benefits and loss of earnings[7].

6.14 The type and choice of food has expanded in recent years. Most people have access to food from a variety of outlets including supermarkets, discount stores, local shops and a wide range of takeaway restaurants. The development of front of pack labelling now provides consumers with the opportunity to choose healthier foods and identify and limit foods high in fat, sugar and salt.

6.15 Food prices have risen steadily over the last two years and this exerts extra pressure on household budgets but particularly on those of low income families. UK households spend an average of £36.32 per person per week, which is 11% of expenditure for an average household. This equates to 17% for a low income household[8]. This will affect the range and type of food purchased and consumed.

6.16 Participants were asked whether or not they followed a number of specific diets. 17% of participants were following diets at the time of the survey. The most popular form of diet was slimming diets, which were being followed by 8% of participants, while only 2% reported they were following a medical diet. It is important to note that many of the 3% who selected "other specific diet" might have had diets that could be classed as medical diets. As shown in Figure 16, 13% more women than men were following specific diets, four times more women were following a slimming diet and two-and-a-half-times more women ate a vegetarian/vegan diet.

Figure 16: Diets, by gender

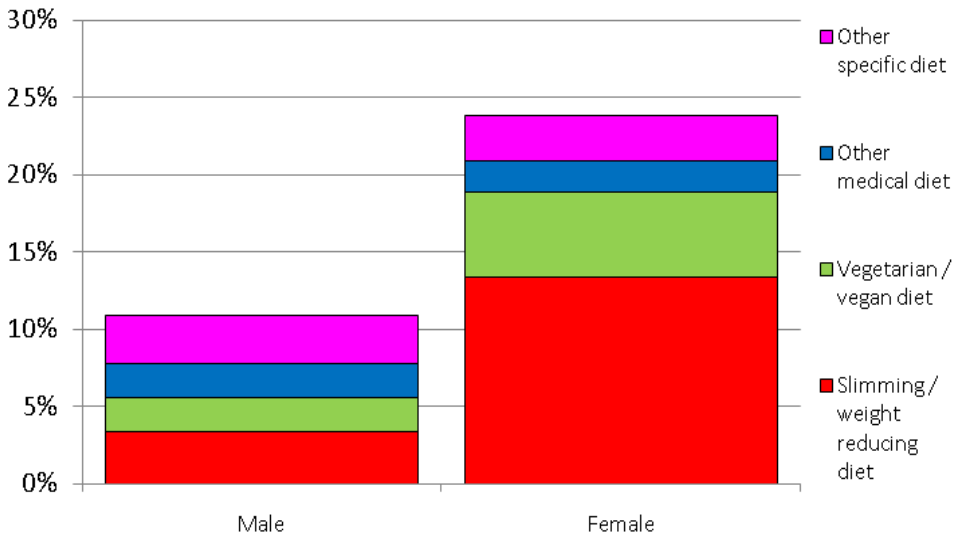
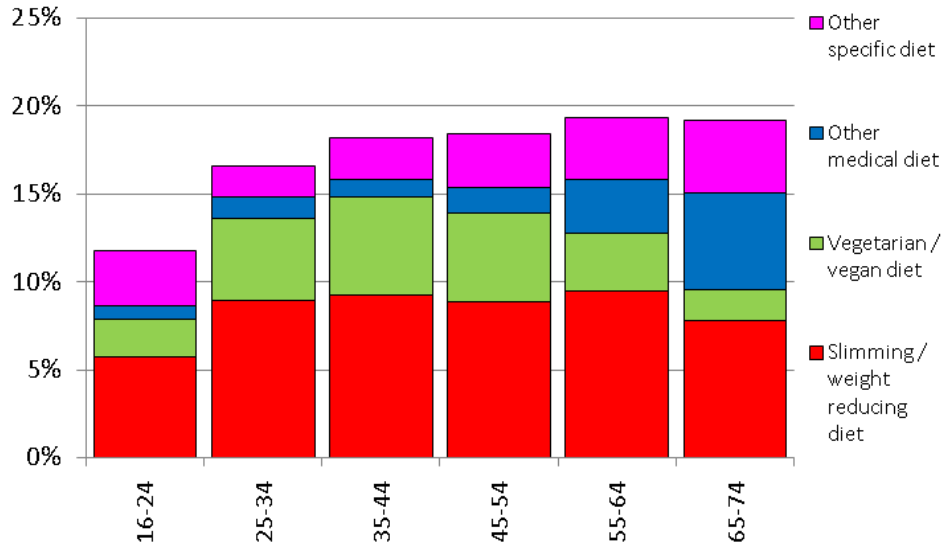
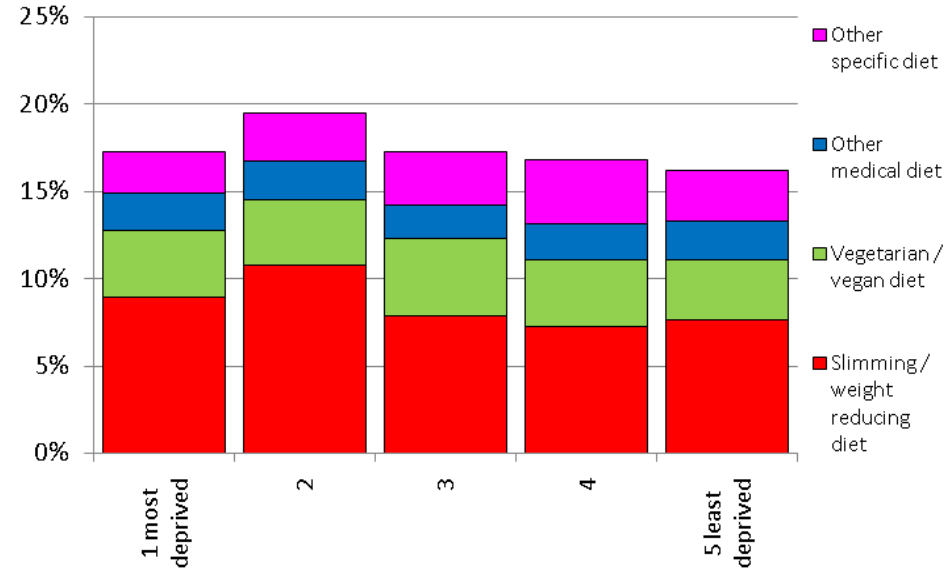


Figure 17: Diets, by age group



6.17 The proportion following a medical diet increased with age. Vegetarian/ vegan diets were less reported in the youngest and oldest age groups, but slimming diets were followed by between 8% and 9% of people for all age groups apart from the youngest.

Figure 18: Diets, by deprivation of area of residence



6.18 There were slight differences in social gradient, with the proportion of people reported as following a slimming diet being slightly higher in the two most deprived groups. There was however very little difference across the five Local Authority areas.

Salt

6.19 Questions included in the food section of the survey investigated the prevalence of salt being used in cooking and being added to meals at the table. Just over half (52%) of the respondents said that they did not use salt in cooking at all. This was significantly higher than the results from the 2002 Lifestyle Survey which showed only 40.8% of people used no salt in cooking.

6.20 A number of trends can be seen in those people who did report using salt in cooking. The results show there is an association with age, with progressively more people reporting using salt as age increases. There was also an association with social gradients with an increase in salt usage in cooking as deprivation increased. Usage in the most deprived group was 49% and in the least deprived group it was 41%. Salt was also more likely to be added during cooking in West Somerset than other Local Authority areas in the county.

6.21 The practice of adding salt at the table was also asked in the survey. 58.5% of responders reported that they did not add salt to their food at the table. Again this result shows a reduction in the use of salt from the 2002 Lifestyle Survey which showed only 46.9% did not add salt to their food at the table. Use of salt at the table was higher in males than females. No associations were found with age, social gradient or Local Authority area.

Table 5: Proportion of people reporting adding salt at the table, by gender

Salt added at table	Male %	Female %	Total %
No	52.5	64.3	58.5
When the food is not salty enough	38.6	32.1	35.3
Almost always before tasting	8.8	3.6	6.2

Fruit and Vegetables

6.22 Participants were asked to state how many portions of fruit and vegetables they ate the previous day. Blank responses were assumed to be zero.

6.23 The Five-a-Day campaign has been a priority in the Government's strategy to reduce early deaths from cancer and CHD through improved diet and nutrition. Current recommendations are that everyone should eat at least five portions of a variety of fruit and vegetables each day.

6.24 Within the five portions a day, fruit/vegetable juice drinks and baked beans count as one portion no matter how many times they are consumed throughout the day. Therefore extra portions of juice or baked beans have been removed from the data to give the total portions consumed per day. This was also done in the 2002 Lifestyle Survey.

6.25 On average, people ate 5.3 portions a day, the same as had been reported in the 2002 Lifestyle Survey. More detail about the fruit and vegetables eaten can be seen in Figures 19 and 20.

Figure 19: Proportion of people eating different numbers of portions of fruit and vegetables

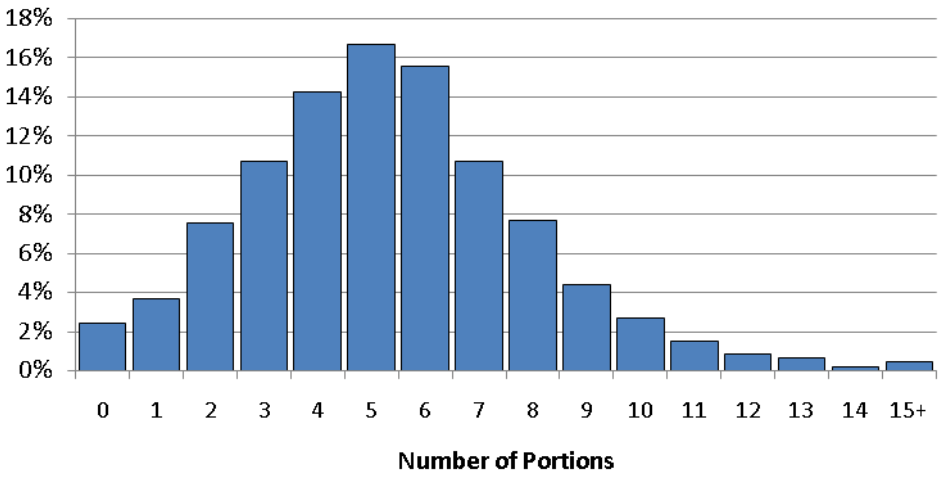
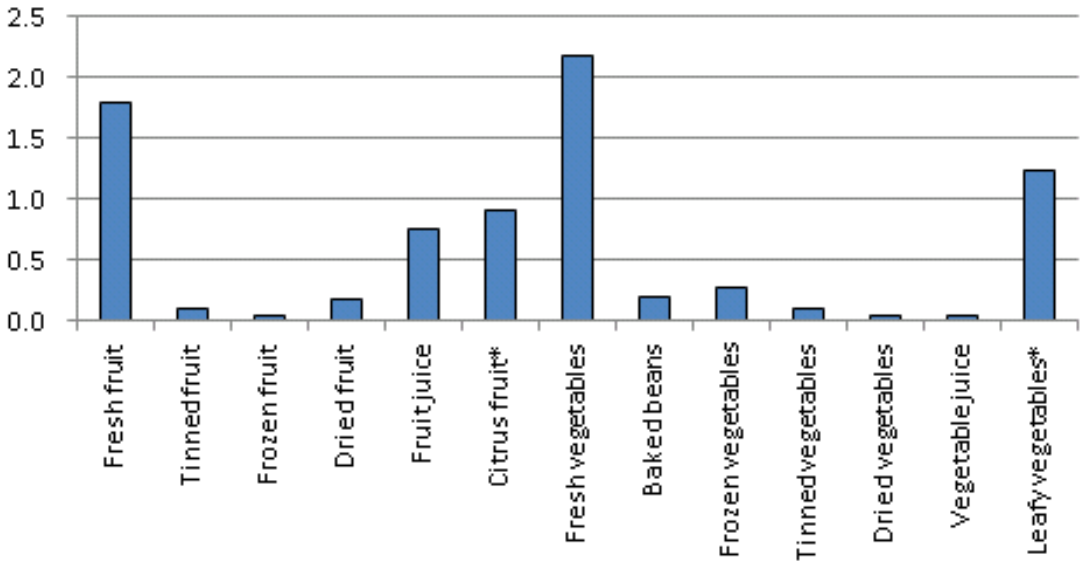


Figure 20: Average portions of fruit and vegetables consumed per day



* Portions per person who filled in the question

6.26 The proportion of people who reported eating five or more portions was not consistent across the sample. A total of 61% of participants had consumed five or more portions of fruit and vegetables on the previous day. This represents a slight increase from the 2002 Lifestyle Survey where 59.2% of people reported eating Five-a-Day. A gender difference can be seen in the data with 12% more women than men consuming five or more portions per day. There is also a gradual increase in fruit and vegetable consumption

with increasing age as shown in Figure 21. Similarly, fewer people living in areas of higher social need reported eating Five-a-Day (see Figure 22).

Figure 21: Proportion of people consuming five or more portions per day, by age group

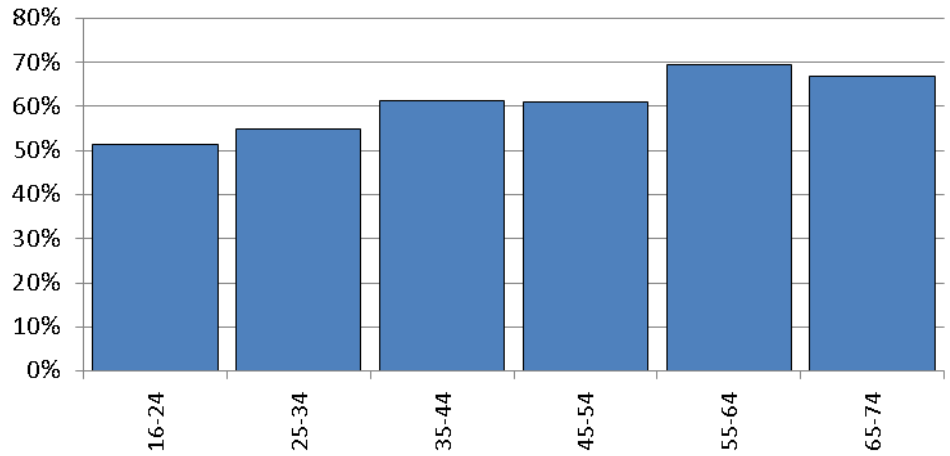
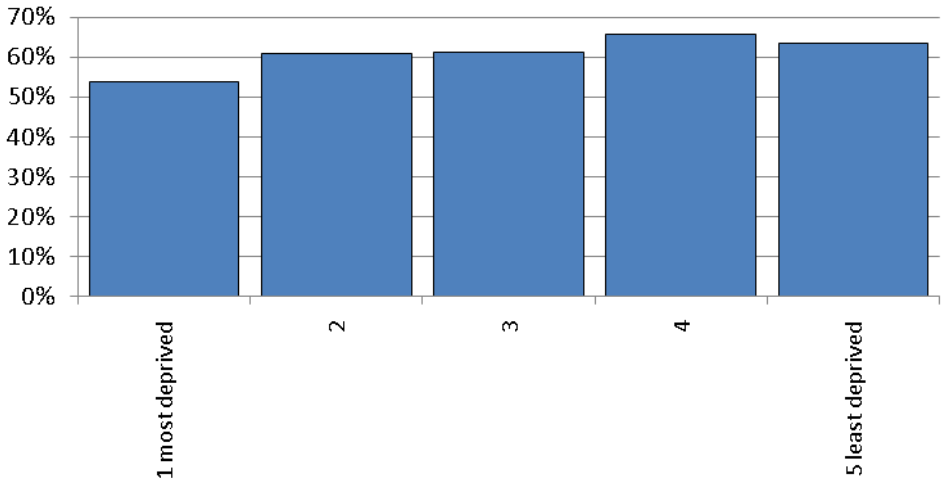


Figure 22: Proportion of people consuming five or more portions per day, by deprivation of area of residence



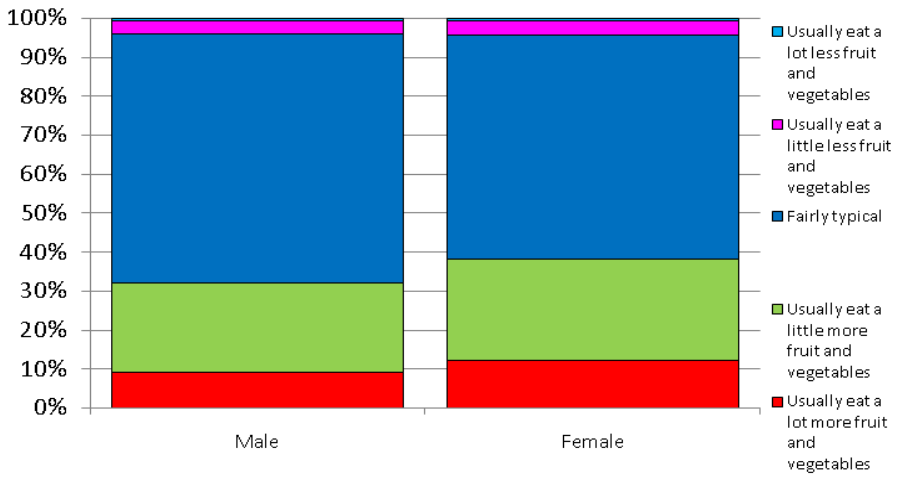
6.27 Results throughout the five Local Authority areas of Somerset showed little variation. Taunton Deane had the highest proportion achieving the Five-a-Day target (65%) and Sedgemoor the lowest (58%). The Health Survey for England 2008[3] data shows that Somerset figures are well above the national average of 28%. However, there were some minor differences in methodology between these two data sets; for example the national data set was gathered using face to face interviews rather than via a questionnaire and as such these figures may not compare exactly.

Table 6: Proportion of people eating five or more portions of fruit and vegetables a day, by Local Authority area

Portions of fruit and vegetables consumed per day	Mendip	Sedgemoor	South Somerset	Taunton Deane	West Somerset	Somerset	England 2008
	%	%	%	%	%	%	%
5+	62.4	57.7	60.4	65.5	62.3	61.4	28.0

6.28 Participants were also asked whether or not the previous day had been a fairly typical day of their normal fruit and vegetable consumption. The majority (61%) reported that the previous day's consumption had been typical.

Figure 23: Fruit and vegetables: typical consumption, by gender



Cooking Methods

6.29 They way in which people cook their food can have a significant influence on the fat and nutritional content of what they are eating. Participants were asked to identify how many times per week they used different cooking methods.

6.30 Boiling was the cooking method used by the most people, with 85% using it during the previous week. 11% used this method every day. The least popular method was poaching with only 22% using it at some stage. Microwaving was used by 5% every day and steaming was used by 4% every day , showing that whilst it was generally not very popular, those who did use these methods were likely to do so fairly regularly. The most common instance of a method being used once a week was roasting, at 51%.

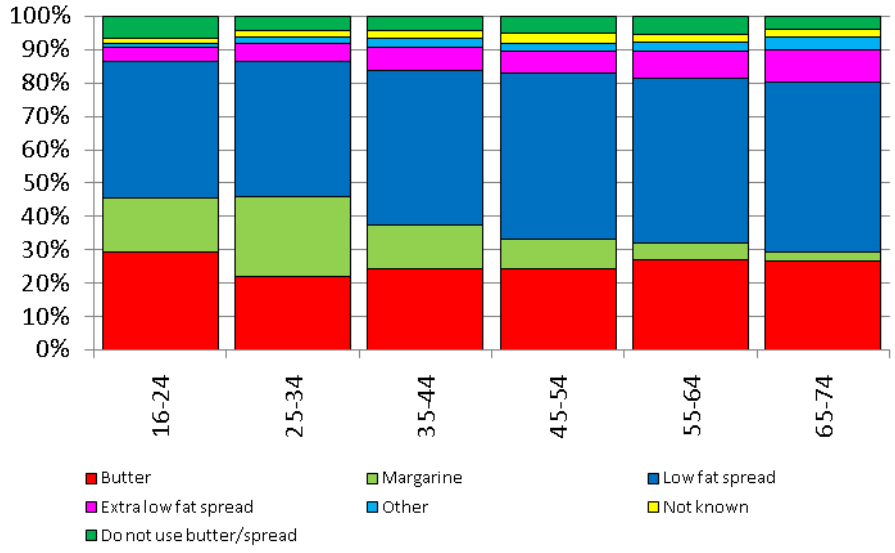
Table 7: Methods of cooking used

No. of times per week	Boiling	Roasting	Grilling	Baking	Micro-waving	Frying	Steaming	Slow Cooking	Poaching
	%	%	%	%	%	%	%	%	%
Never	15	22	35	44	47	52	59	70	78
1	12	51	25	24	15	28	12	21	16
2-6	61	26	39	30	33	19	26	9	5
7+	11	0	1	2	5	0	4	0	0

Butter/Spread

6.31 Participants were asked about the butters or spreads they used most often. Where the participant selected "other" and entered the name of the product, these were categorised as high-fat (spread >62% fat), low-fat (>41% but not more than 62%) or extra-low fat (<42%)[9]. Almost half (47%) of the participants used low fat spread. 26% used butter and 5% did not use any butter or spread.

Figure 24: Type of butter/spread used, by age group



6.32 There were no significant differences in types of spread used between men and women or by social gradient. However there was a trend for older people to be more likely to use low fat spread (with over 60% using a low fat or extra low fat spread in the oldest age group). This might be linked to increasing awareness and prevalence of specific health problems with age, such as high cholesterol and high blood pressure. Figures 25 and 26 show

comparisons between the type of butter/spread used and these two specific health problems. Those who had these conditions, or suspected that they might have, were in both cases more likely to use the low fat or extra low fat spreads.

Figure 25: Type of butter/spread used, by whether participant had high blood pressure

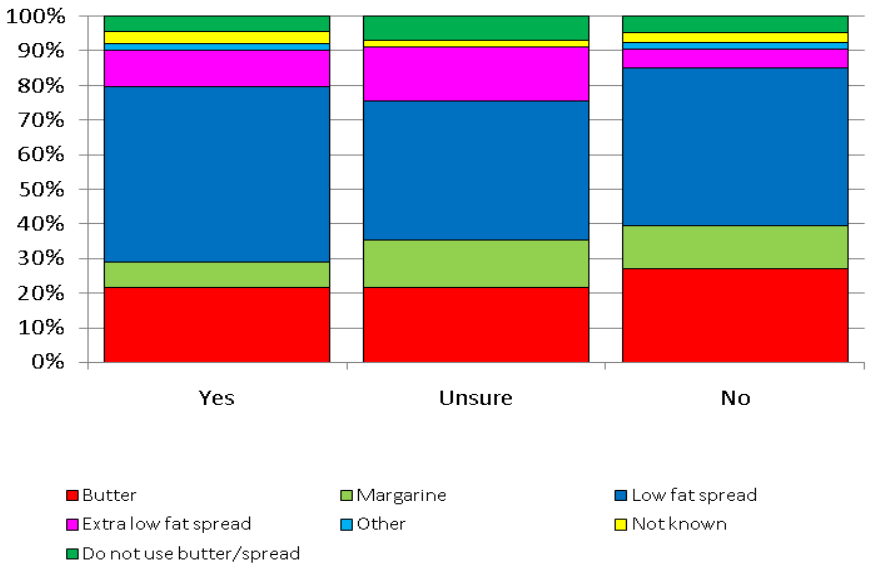
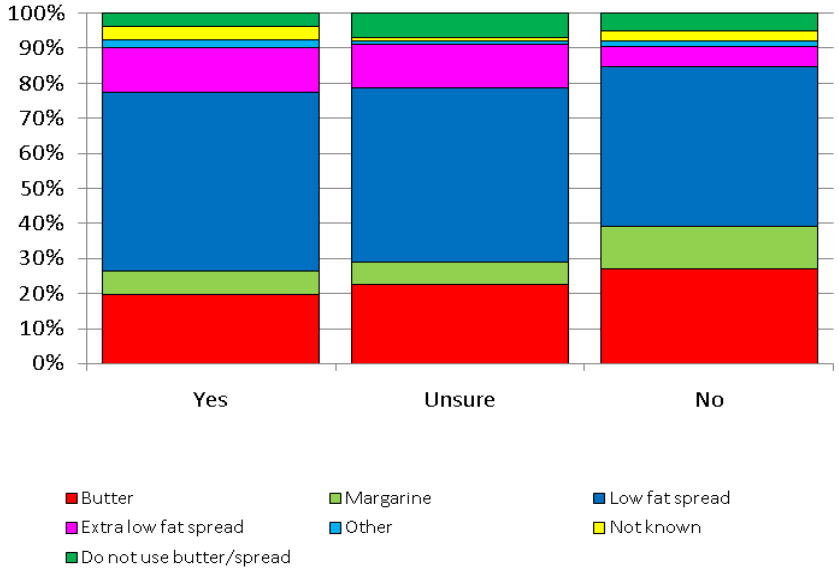
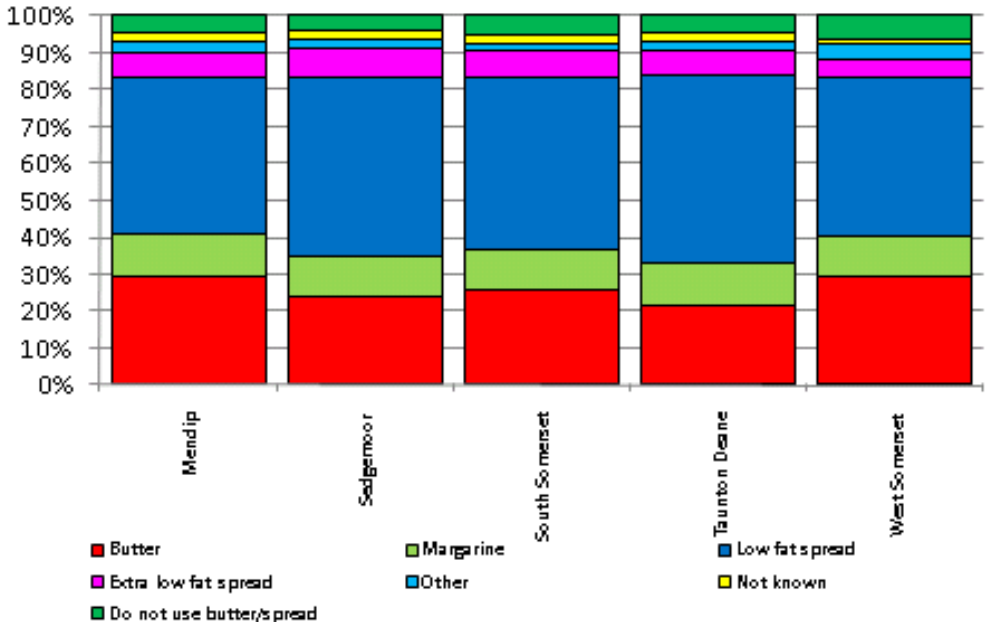


Figure 26: Type of butter/spread used, by whether participant had high cholesterol



6.33 The proportion of people using low fat or extra low fat spreads did not differ significantly between the Local Authority areas, ranging from 48% in West Somerset to 58% in Taunton Deane.

Figure 27: Type of butter/spread used, by Local Authority area



Milk

6.34 Participants were asked what type of milk they used most often. Semi-skimmed milk was by far the most popular type of milk and was used by 68% of participants. The next most popular was skimmed milk at 15%. 3% did not use milk at all.

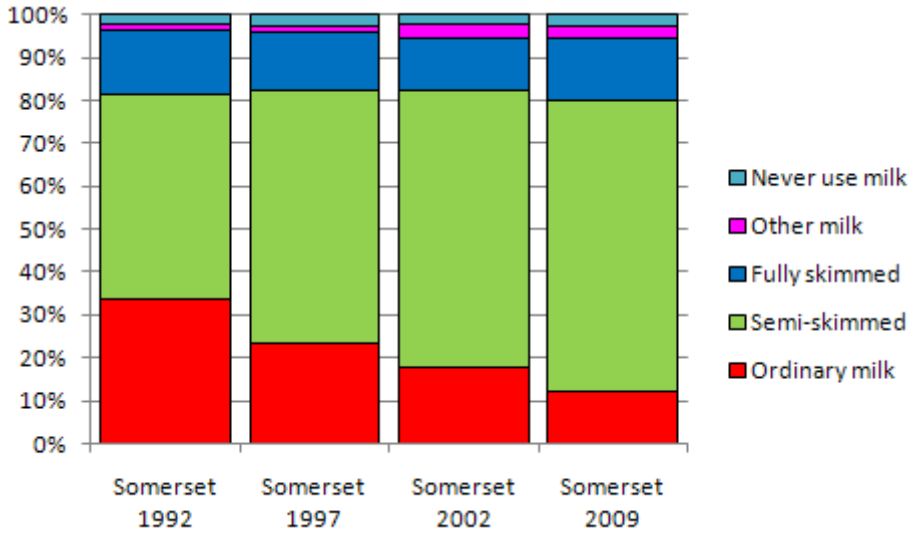
Table 8: Type of milk used, by gender

Milk used	Male %	Female %	Total %
Full fat milk	14.4	9.5	11.9
Semi-skimmed milk	70.1	65.7	67.9
Skimmed milk	11.5	18.0	14.8
Soya milk	1.4	3.4	2.4
Other milk (for example, evaporated or condensed)	0.2	0.6	0.4
I do not use milk	2.4	2.7	2.6

6.35 More women than men used skimmed milk and soya milk and more men than women used full fat milk and semi-skimmed milk. Soya milk and skimmed milk was more popular with the older age groups. There was very little difference in the type of milk chosen across the social gradient and by Local Authority area.

6.36 When comparing these results with previous lifestyle surveys, a clear trend can be seen, showing increasing usage of semi-skimmed milk and a reduction in use of whole/ordinary milk.

Figure 28: Trends in milk consumption 1992 – 2009



"Eating Out"

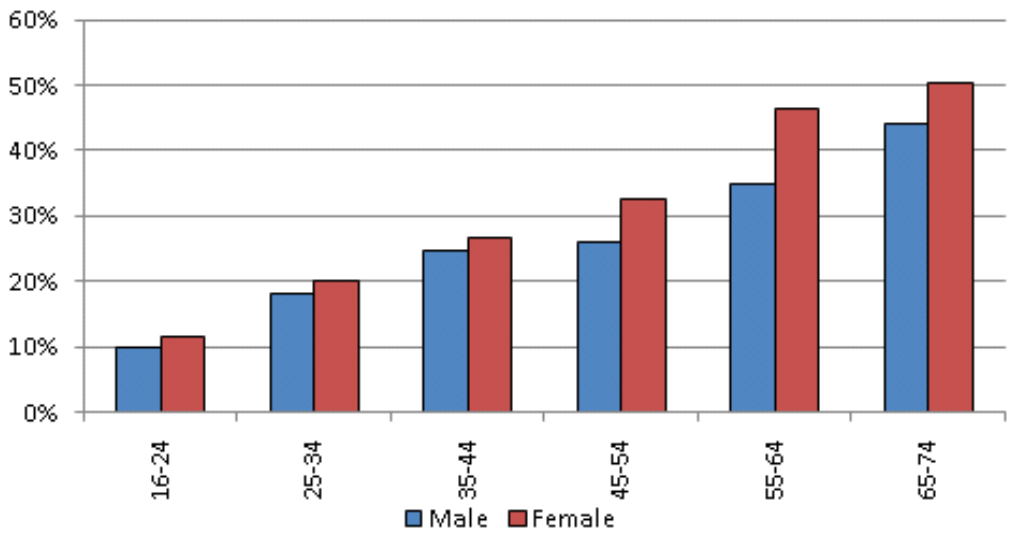
6.37 There has been an increasing trend nationally for more meals to be eaten that have not been cooked at home. Participants were asked "How many times in a week do you eat the following foods?" Takeaways were eaten most during the week and fast food the least.

Table 9: Frequency of meals eaten/bought outside of the home

Number of times a week	Takeaway	Pub	Sandwiches	Restaurant	Café	Fast food
	%	%	%	%	%	%
Never	61	77	78	81	84	86
1	36	21	12	16	7	12
2-6	3	2	9	2	8	2
7+	0.5	0.5	0.3	0.3	0.5	0.4

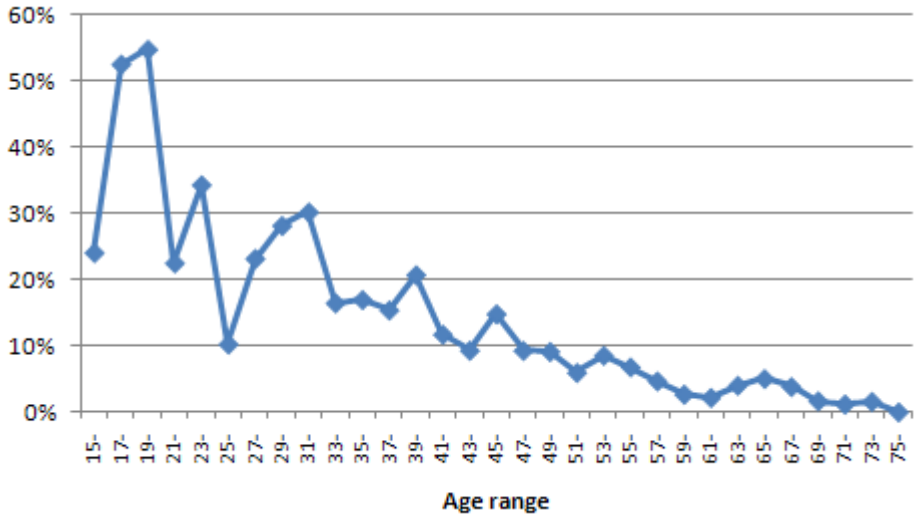
6.38 The proportion reporting they had not eaten the foods listed increases with age and in every age group it is more likely in women than men.

Figure 29: Proportion of people who said they never ate any of the foods, by age group and gender



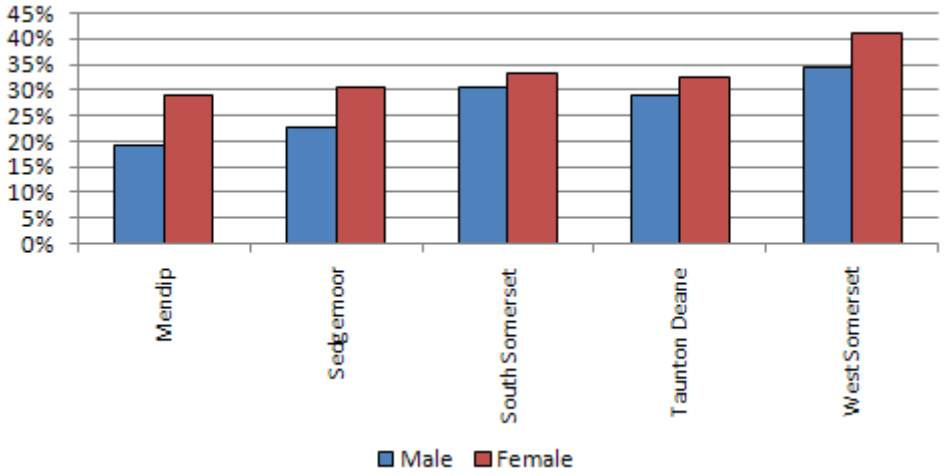
6.39 Age is clearly a factor in what people eat. For example, Figure 30 looks at the proportion of people, by age group, who reported eating fast food. Fast food was clearly eaten more by younger people.

Figure 30: Proportion of people who said that they had eaten fast food in a typical week



6.40 The proportion of people who reported not eating the foods listed is similar in all deprivation groups. However differences can be seen between Local Authority areas, ranging from 19% of men and 29% of women reporting they did not eat these foods in Mendip, to 34% of men and 41% of women in West Somerset. Again, in every group it is more women who are less likely to eat these types of food than men.

Figure 31: Proportion of people who said they never ate any of the foods, by Local Authority area and gender



Food Labelling

6.41 Participants were asked if they had noticed "traffic light" food labelling. If they had, they were further asked if they had found it useful in making their choice. 42% of people had noticed the labelling and two thirds of these people had found it useful. 13% more women than men had noticed the labelling and 9% more women than men found it useful once they had noticed it. This gender difference continues across all ages. For women in particular, there seems to be a decrease in noticing the labelling with increasing age. However, for those who have noticed the labelling, its usefulness appears to increase with age.

Figure 32: Proportion of people noticing labelling, by age group and gender

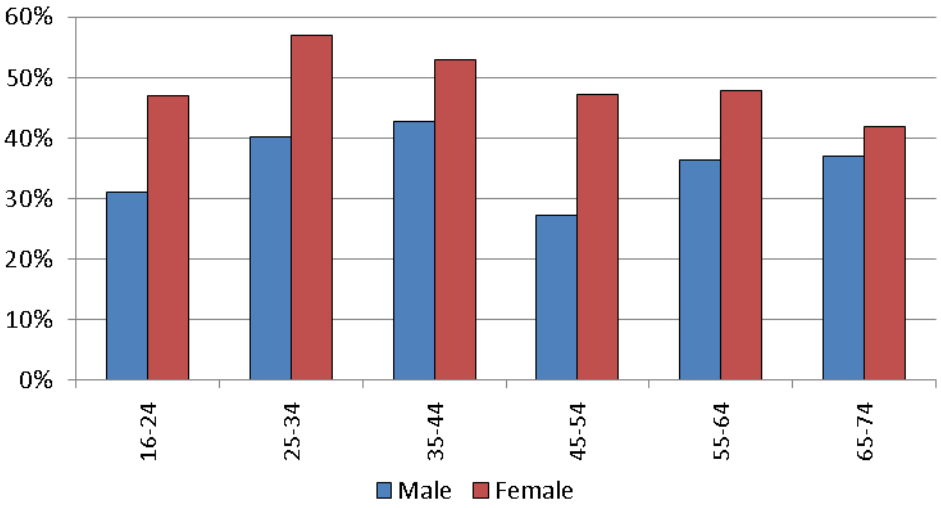
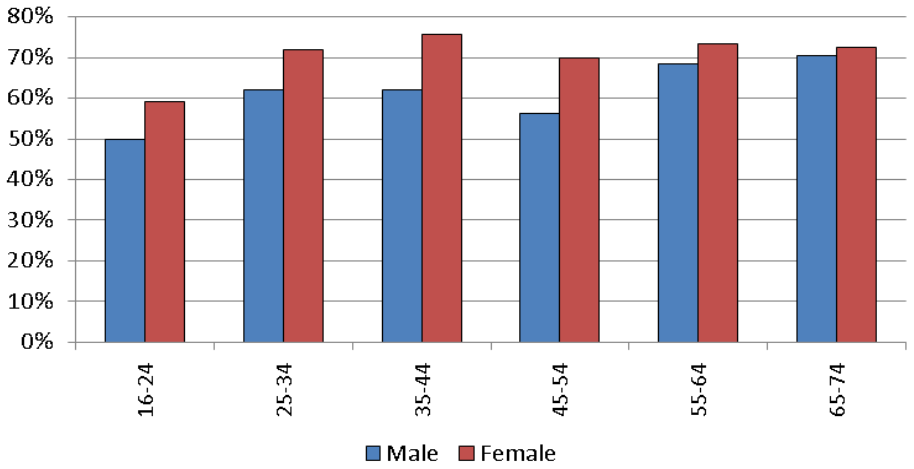


Figure 33: Proportion of people finding labelling useful, by age group and gender



6.42 There were no differences across the social gradient or Local Authority areas in people noticing or finding the labelling useful.

Healthy Weight

6.43 Nationally, levels of obesity have been rising rapidly over the past 30 years. If the current trends continue at the same rate, it is estimated that by 2020 one third of adults, one third of girls and one fifth of boys will be obese. Overweight and obesity are conditions whereby weight gain (which is predominantly fat) has reached the point of endangering the health of an individual. Overweight and obesity can have serious health consequences for children and adults.

6.44 Rising obesity levels have been brought about by behavioural and environmental changes, resulting in the consumption of high calorific foods and a more sedentary way of life.

6.45 The most common measurement of obesity is the Body Mass Index (BMI). It is defined as a person's weight in kilograms divided by the square of their height in metres (kg/m^2). Table 10 shows the classification of overweight and obesity using BMI according to the World Health Organisation[10].

Table 10: World Health Organisation BMI definitions

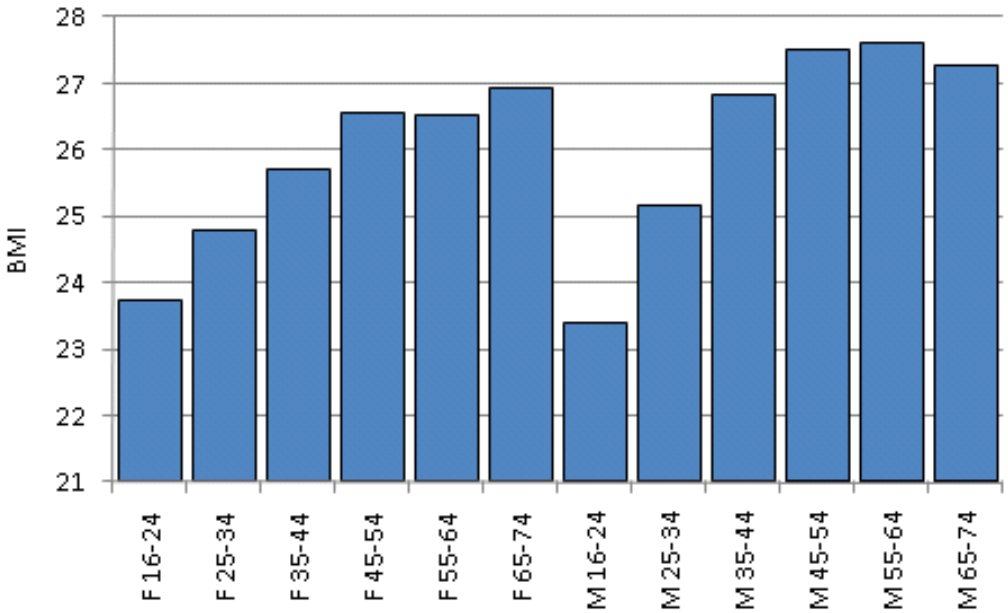
BMI score	Category Definition
18.4 or lower	Underweight
18.5 – 24.9	Normal weight
25.0 – 29.9	Overweight
30.0 – 39.9	Obese
40 or above	Severe (morbid) obesity

6.46 The 2009 Lifestyle Survey asked people to report their height and weight so that BMI levels could be calculated.

6.47 The mean height of a man was 1.78m and for a woman it was 1.64m. There was a slight fall in the average height with age. The mean weight of a man was 85.2kg and for a woman it was 70.0kg. The results show a trend towards greater average weight with increasing age up to the age of 64.

6.48 Overall, the mean BMI recorded was 26.4 with the mean BMI for men being 26.9 and for women 26.0. Like weight, there is a trend towards higher BMI with age.

Figure 34: Average BMI, by age group



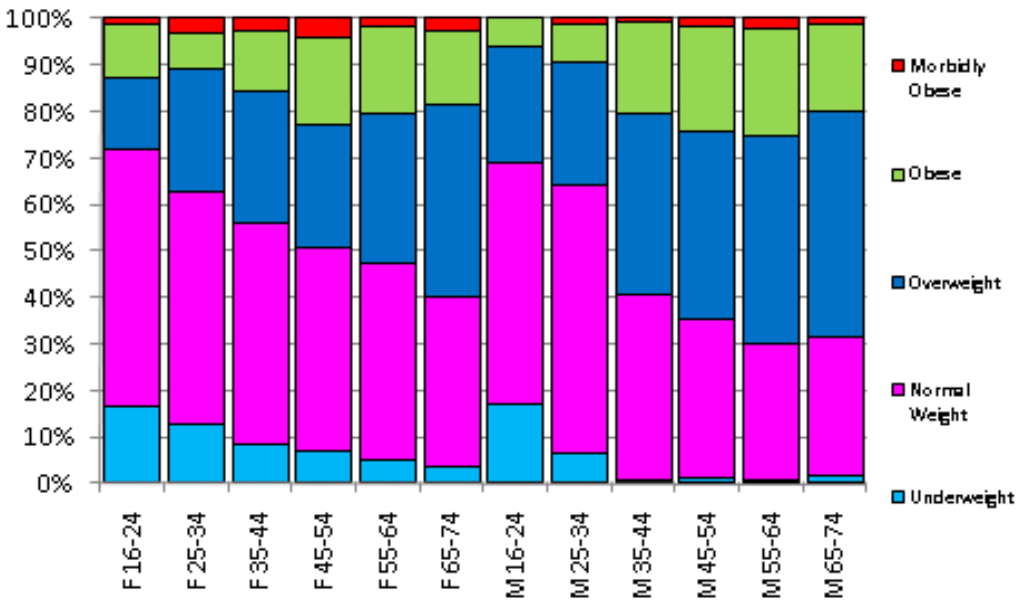
6.49 42% of participants were classified as being “normal weight”, while 6% were underweight. In total, more than half (52%) were classed as being overweight or obese.

Table 11: BMI category, by gender

BMI category	Male	Female	Total
	%	%	%
Underweight	4.3	8.4	6.4
Normal Weight	39.3	45.4	42.4
Overweight	38.0	28.7	33.3
Obese	17.1	15.0	16.0
Morbidly Obese	1.3	2.5	1.9

6.50 Figure 35 shows the BMI categories with respect to age and gender. In line with national trends, underweight appears to be more prevalent in the younger age groups for both males and females and overweight and obesity increases with increasing age.

Figure 35: BMI category, by age and gender

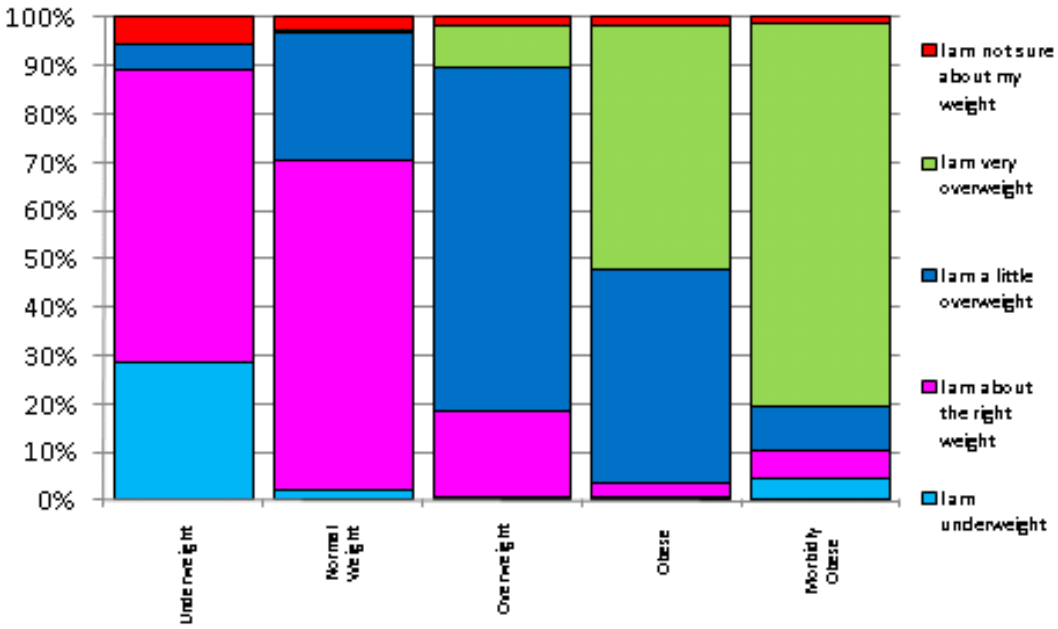


6.51 Participants were asked to describe their weight and the following options were given: I am underweight, I am about the right weight, I am a little overweight, I am very overweight and I am not sure about my weight. The results seen in Figure 36 were gained by cross-referencing the results of this question with a participant's BMI category.

6.52 As shown in Figure 36, 61% in the underweight category considered themselves "about the right weight" with 5% considering themselves overweight. For those who were within the normal weight category, 27% considered themselves "a little overweight".

6.53 At the opposite end of the scale, 40% of those in the obese and morbidly obese categories considered themselves "a little overweight", a further 3% identified themselves as "about the right weight" and 1% considered themselves "underweight".

Figure 36: BMI category, by perception of weight



6.54 Comparison between Local Authority areas shows West Somerset had the highest proportion of those in the overweight and obese categories at 53%. The lowest proportion was in the residents of Mendip at 50%. Whilst there was little variation between Local Authority areas, there were considerable differences between the overall 2009 Lifestyle Survey data and the national data which comes from The Health Survey for England 2008[3]. The 2009 Lifestyle Survey found the proportion of those in the underweight category was more than 3.5 times greater than The Health Survey for England 2008[3]. In addition, the local survey showed 8% fewer fell into the obese and morbidly obese categories. This could be as a result of using self-reported heights and weights in the Lifestyle Surveys (as opposed to nurse measured heights and weights in the Health Survey for England 2008[3]) with people tending to under estimate their weight. The rates in Local Authority areas were all substantially below the national prevalence of overweight and obesity[Σ].

6.55 The results of the national survey indicate 63% of the general population being either overweight or obese, while the 2009 Lifestyle Survey gives a figure of 52% for Somerset.

[Σ] National BMI is based on nurse measured heights and weights. There is some evidence to suggest that BMI based on self reported heights and weights produces an underestimate –so comparison between Somerset and England should be treated cautiously.

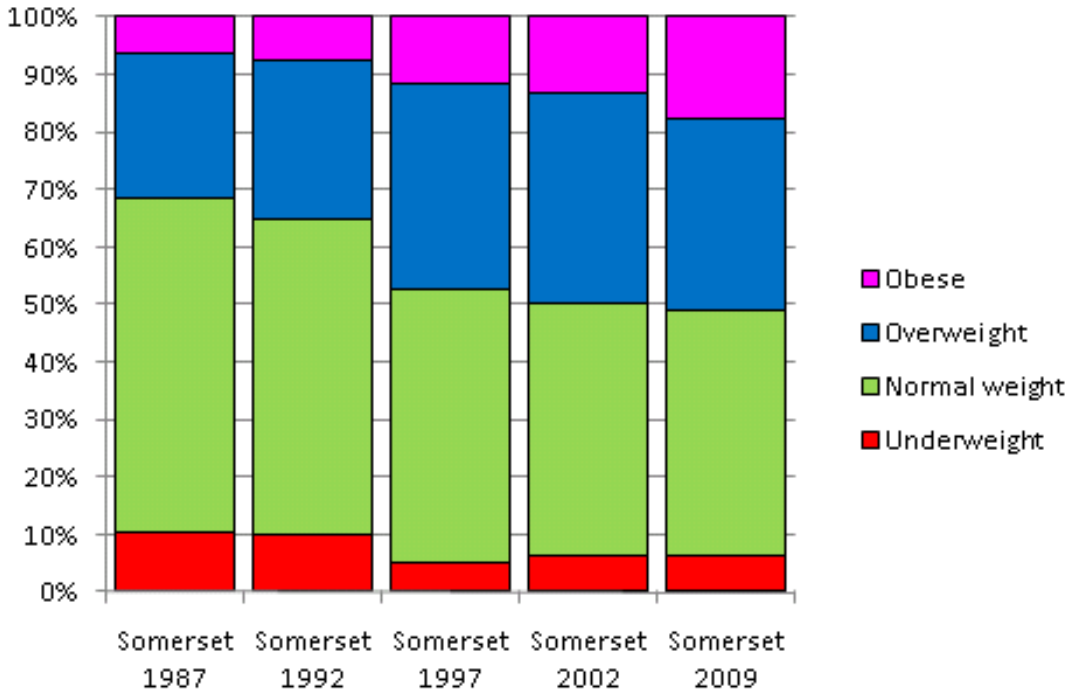
Table 12: BMI category, by Local Authority area and England

BMI category	Mendip	Sedgemoor	South Somerset	Taunton Deane	West Somerset	Somerset	England 2008
	%	%	%	%	%	%	%
Underweight	7.3	6.3	5.6	5.7	9.6	6.4	1.7
Normal Weight	42.3	42.3	43.8	42.0	37.5	42.4	35.7
Overweight	34.3	34.7	32.1	33.0	33.2	33.3	37.0
Obese	13.2	15.3	17.0	17.4	18.0	16.0	23.5
Morbidly Obese	3.0	1.5	1.4	1.9	1.7	1.9	2.1

6.56 "Morbidly obese" is a term used for people who have a BMI of 40 or more. This survey found that 5.4% of the participants had a BMI of 35 or over and 1.9% of participants were found to have a BMI of 40 or more. If this figure is applied to the adult population of Somerset, it is estimated that approximately 7,000 individuals in Somerset are morbidly obese.

6.57 Comparisons with previous lifestyle surveys mirror the national trend in rising obesity levels. Figure 37 shows overweight levels in Somerset have increased from 25.2% in 1987 to 33.3% in 2009. Similarly the proportion of people who are obese has increased from 6.4% to 17.9% respectively.

Figure 37: BMI in Somerset 1987 – 2009



7 RESULTS - SMOKING

Summary of Results

- 18% of participants were current smokers and 35% had at some stage smoked but no longer did so. The remainder had never smoked. There were fewer current smokers than there were nationally
- about 9% more males than females reported being, or having been, a smoker. Older people were less likely to be current smokers and there was an association with social gradient with more people in the most deprived areas reporting being a current smoker
- the most popular form of tobacco was hand-rolled cigarettes (58%). Manufactured cigarettes were second most popular at 49%
- when asked how smokers felt about smoking and their health 30% reported being a contented smoker. 29% of people were planning to stop and 7% were in the process of stopping
- about 80% of current smokers had tried giving up at some stage, with 7% having tried more than five times. 8% more males than females had never tried giving up
- the most popular form of smoking cessation support was support from a health professional at 27%, followed by support from friends and relatives which 20% of those who had tried to give up smoking had received. However, about 60% said that they did not receive any support in their attempt to give up smoking

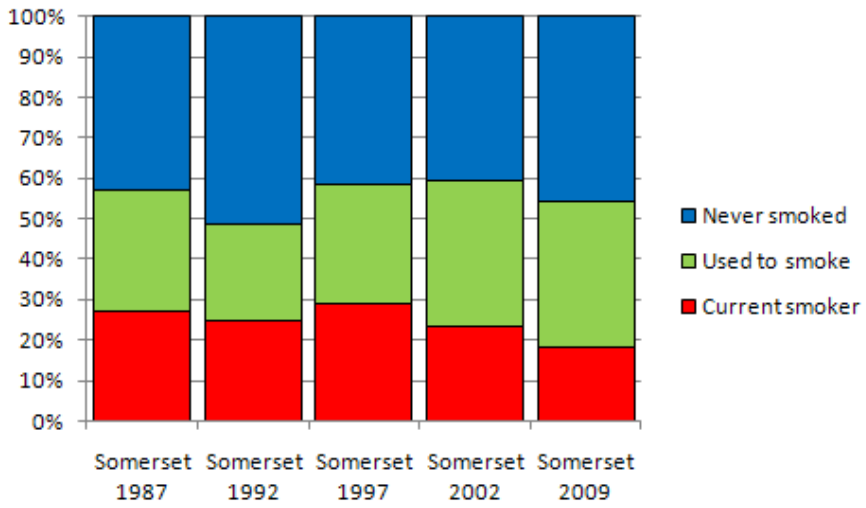
7.1 Helping people to stop smoking remains the single most effective method of improving health. Smoking prevalence is highest in more deprived areas. Services supporting people to stop smoking have the opportunity to improve the health of many individuals and make a significant impact on health inequalities. Once stopped for a year, the risk of heart attack is half that of a smoker, although it requires being quit for 15 years before the risk reduces to the level of someone who has never smoked.

7.2 Somerset is estimated to have 820 deaths per year from circumstances relating to smoking[11]. That is 165.8 deaths per 100,000 population compared to the national death rate from smoking of 210.2 deaths per 100,000 population. These figures suggest that smoking has less impact in Somerset than for the country overall. However, with around 68,000 smokers the impact is still considerable and needs to be addressed.

7.3 The impact of secondhand smoke on health, particularly on vulnerable people such as young children, is now well established. The smokefree legislation has led to clean air in workplaces and public venues, but many children are still exposed to smoke in private spaces such as cars and homes. The Royal College of Physicians has recently estimated that each year these cases generate over 300,000 UK GP consultations and about 9,500 hospital admissions, costing the NHS about £23.3 million[12].

7.4 Participants were asked whether they had ever smoked. 54% stated that they had been, or currently were, a smoker. 18% of participants fell into current smoker category and 35% were ex-smokers; for example, they had smoked but had since given up completely. The remainder had never smoked at all. When compared with previous lifestyle surveys, a decrease in people reporting to be current smokers can be seen from 2002 onwards. The National Stop Smoking Service and associated NHS targets were introduced in 1999 which may help explain this downwards trend.

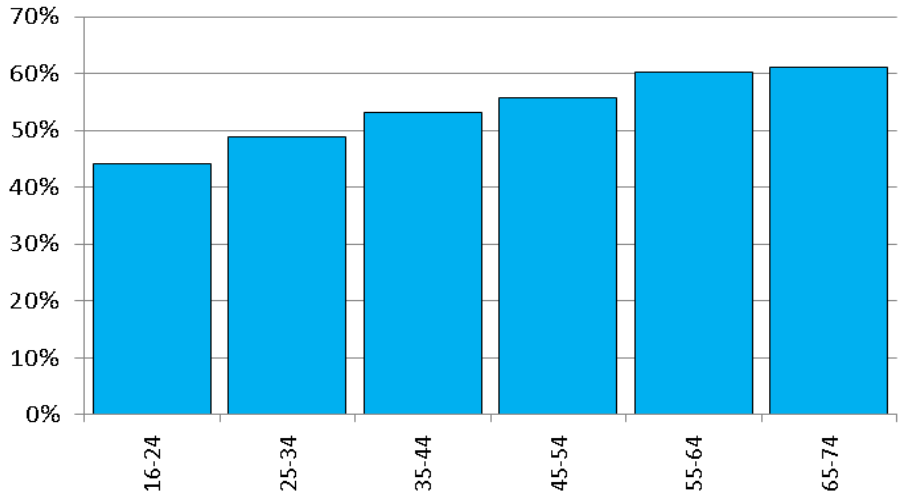
Figure 38: Trends in reported smoking status 1987 - 2009



7.5 About 9% more males than females reported being, or having been, a smoker. The difference between males and females has reduced since the 2002 Lifestyle Survey.

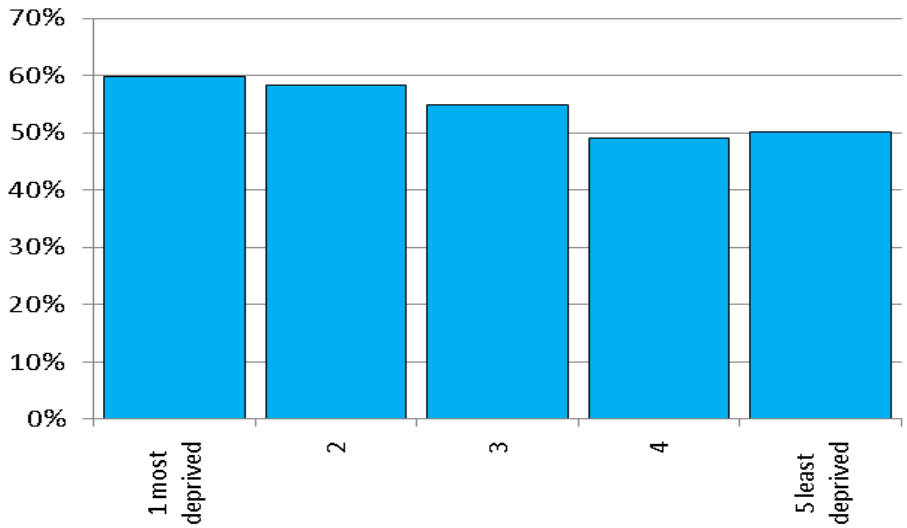
7.6 Figure 39 shows that prevalence of smokers or ex-smokers ("ever smokers") increases with age, with 44% in the youngest age group and 61% in the oldest age group.

Figure 39: Proportion of people who said that they had ever smoked, by age group



7.7 Differences within the social gradient were also found with a trend of increasing prevalence of "ever smokers" as deprivation increases. The proportion of people who had ever smoked was similar across the Local Authority areas of Somerset, with the exception of West Somerset where the proportion of past and current smokers was slightly higher.

Figure 40: Proportion of people who said that they had ever smoked, by deprivation of area of residence



7.8 The proportion of current smokers decreased with increasing age and decreasing deprivation. The proportion who used to smoke was fairly similar for all deprivation groups, but it increased with increasing age. Ex-smokers are more likely to live longer than a current smoker and this may account for the greater proportion of ex-smokers in the higher age categories. Also, over time, a smoker would possibly have had more opportunity to give up smoking.

Figure 41: Current smoking status, by age group

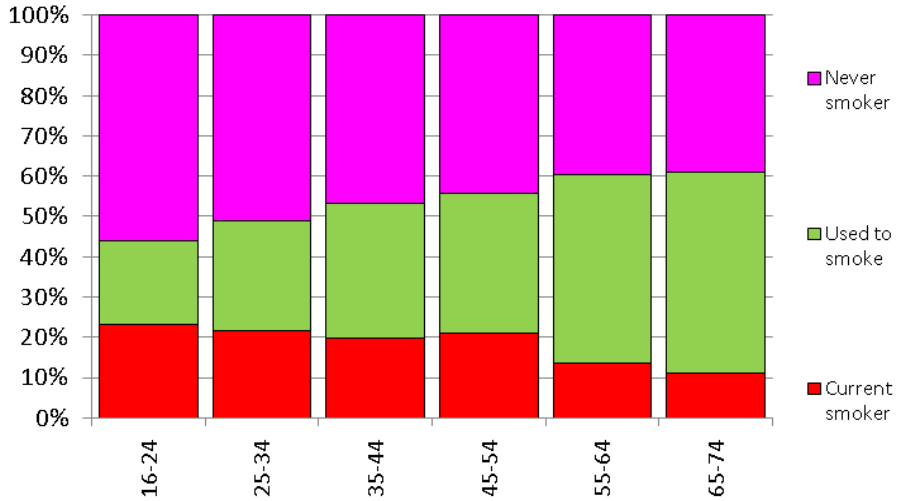
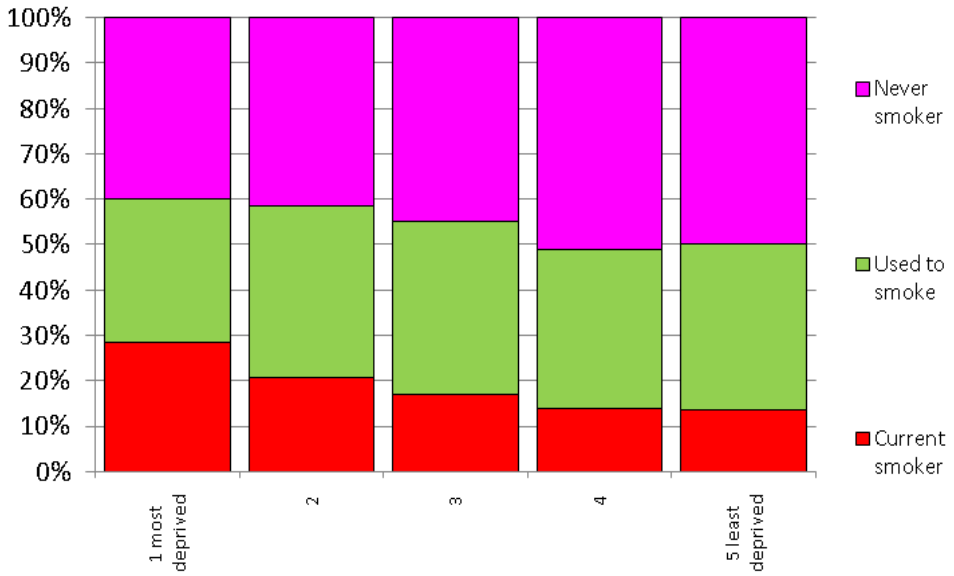


Figure 42: Current smoking status, by deprivation of area of residence



7.9 Hardly any variation was found between the Local Authority areas in Somerset. The highest proportion of current smokers was in South Somerset at 19%. The lowest was in Mendip at 17%. 41% of those in West Somerset had smoked but had given up – the largest proportion in this category. All Local Authority areas had a higher number who had given up than the national average. Taunton Deane and Mendip had the highest proportion of "never" smokers (47%), slightly lower than the national average. All of the five Local Authority areas in Somerset had fewer current smokers than the national average of 22%.

Table 13: Current smoking status, by Local Authority area

Smoking category	Mendip	Sedgemoor	South Somerset	Taunton Deane	West Somerset	Somerset	England 2008
	%	%	%	%	%	%	%
Current smoker*	16.9	18.9	19.3	17.4	18.4	18.3	22.2
Used to smoke	36.4	35.0	35.4	35.7	41.2	36.0	24.8**
Never smoked	46.7	46.0	45.2	46.9	40.4	45.7	53.6**

*National data only includes cigarettes, but the Somerset data included also cigars and pipes.
** Data is for England 2008[13]

7.10 The results of the following sections include only those who answered yes to "Have you ever smoked at all (including manufactured cigarettes, hand-rolled cigarettes, pipes and cigars)?". Those who have never smoked have been excluded.

7.11 Contrary to the 2002 Lifestyle Survey, the most popular form of tobacco overall was hand-rolled cigarettes with 58% of current smokers using them. This is much higher than the 2002 figure of 26%. However, the question was asked in a slightly different way so the figures may not be directly comparable. This was closely followed by manufactured cigarettes at 49%. There were very few cigar and pipe smokers and they were mostly men. Women were more likely to use manufactured cigarettes than hand-rolled cigarettes.

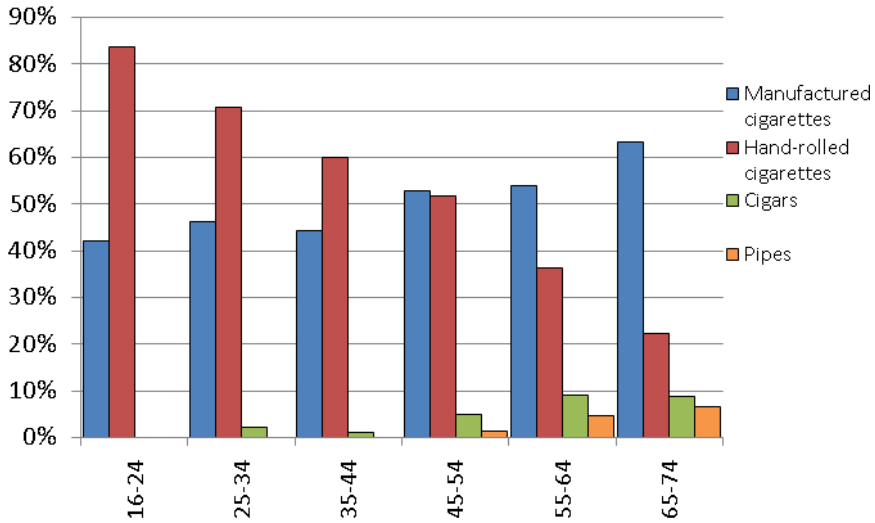
Table 14: What people smoke, by gender

What people smoke*	Male	Female	Total
	%	%	%
Manufactured cigarettes	40.0	60.8	49.0
Hand-rolled cigarettes	63.1	50.2	57.5
Cigars	6.4	0.3	3.8
Pipes	2.8	0.0	1.6

*People could choose more than one product

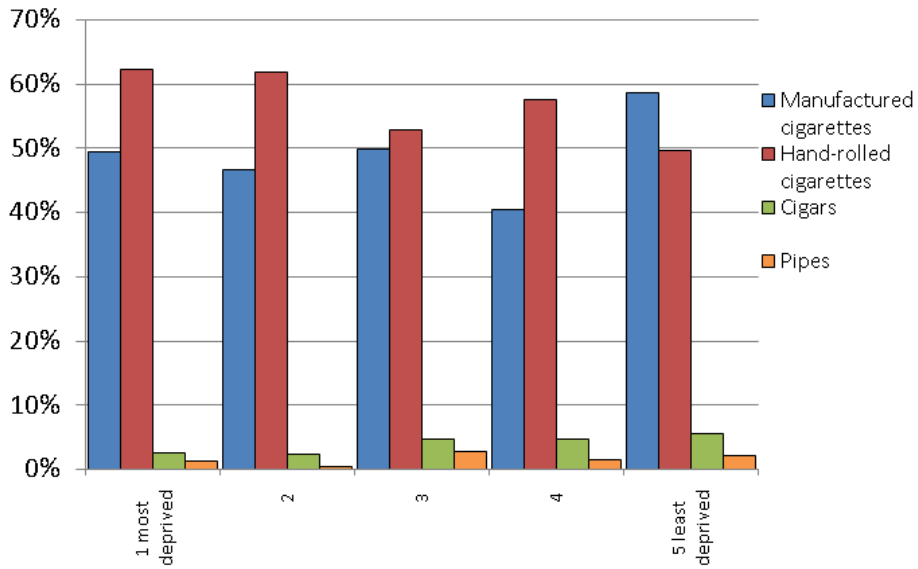
7.12 The use of hand-rolled cigarettes decreased with age and there was a corresponding increase in the use of manufactured cigarettes. Cigar and pipe smoking was largely confined to the older age groups.

Figure 43: What people smoke, by age group



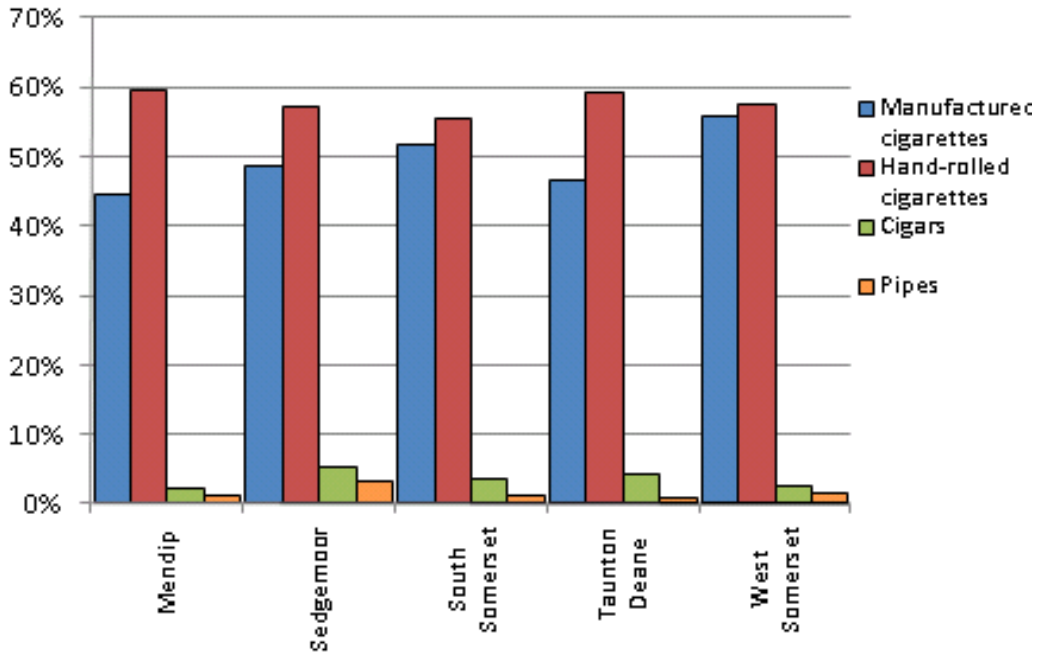
7.13 There is a suggestion that hand-rolled cigarettes are less used in the less deprived areas and cigars and pipes slightly more used.

Figure 44: What people smoke, by deprivation of area of residence



7.14 There are big differences in the use of manufactured and hand-rolled cigarettes in Mendip and Taunton Deane and less so in the other areas.

Figure 45: What people smoke, by Local Authority area



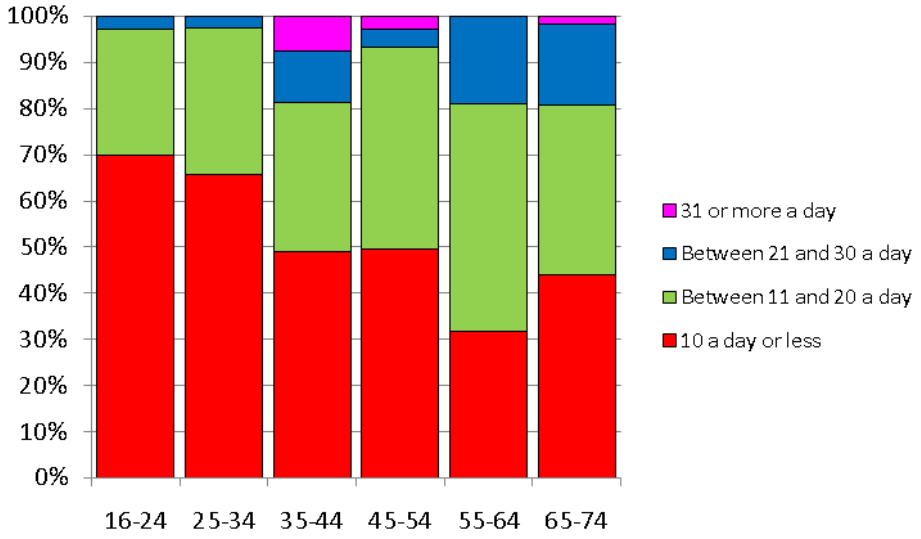
7.15 53% of those who smoke manufactured cigarettes smoke 10 a day or less. Only 10% smoked over 20 a day. Women were more likely to fall into the 10 a day or less category by a little over 10% and so men were the heavier smokers.

Table 15: Number of manufactured cigarettes smoked per day, by gender

Number of manufactured cigarettes per day	Male %	Female %	Total %
10 a day or less	49.1	53.8	53.2
Between 11 and 20 a day	36.4	38.3	36.6
Between 21 and 30 a day	10.1	7.6	8.1
31 or more a day	4.5	0.4	2.1

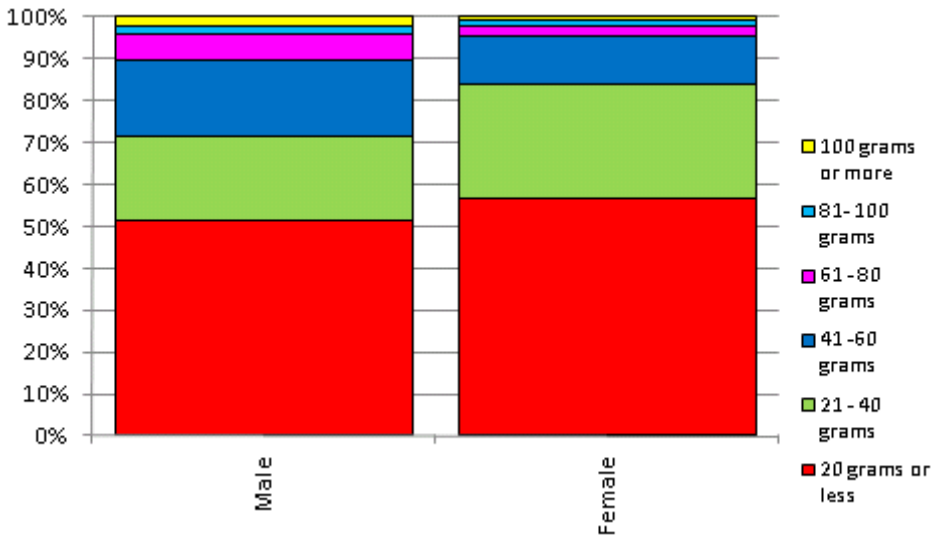
7.16 The heaviest smokers of manufactured cigarettes were in the 35-44 years age group and in general, the proportion of those smoking in the lowest category decreased with age. Very little difference was found for people across the social gradient. However smokers of manufactured cigarettes in Taunton Deane and West Somerset were more likely to be smoking less than those in the other three areas.

Figure 46: Number of manufactured cigarettes smoked per day, by age group



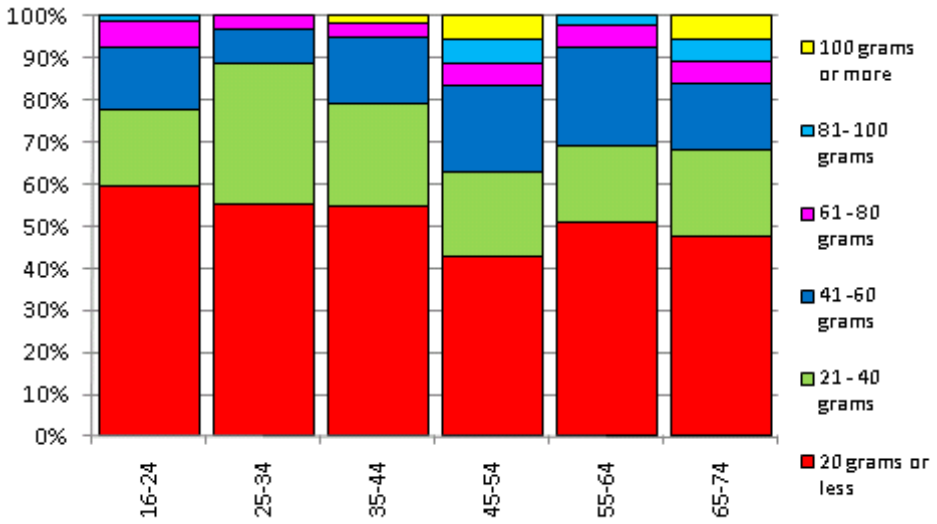
7.17 Of those people who reported smoking hand-rolled cigarettes, 55% smoke 20 grams a day or less. 8% reported smoking over 60 grams a day. As shown in Figure 47, women smoked less than men.

Figure 47: Amount of hand-rolled cigarettes smoked per day, by gender



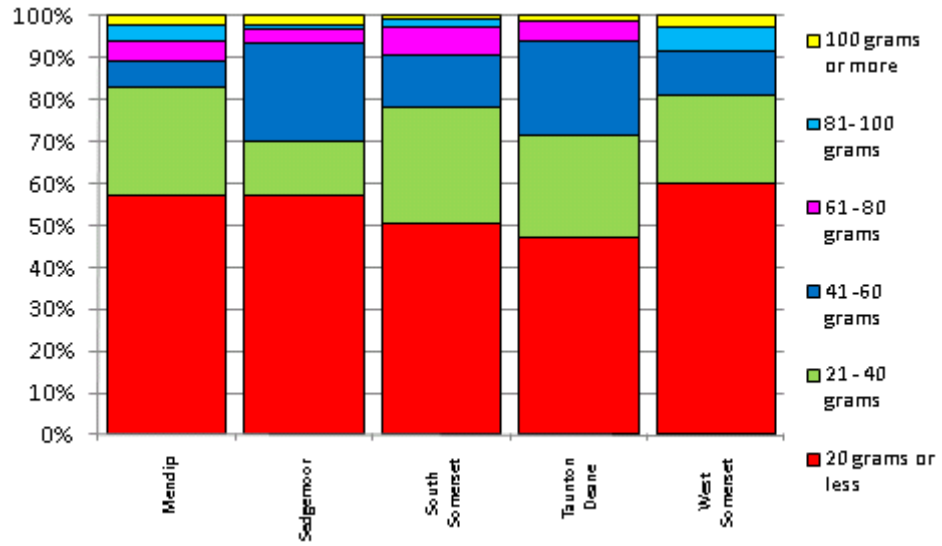
7.18 The heavier smokers were in the older age groups. In general the proportion of those smoking in the lowest category decreased and the proportion in the highest category increased with age. The heaviest smokers of hand-rolled cigarettes lived in the areas of higher social need.

Figure 48: Amount of hand-rolled cigarettes smoked per day, by age group



7.19 Variation in smoking hand-rolled cigarettes was found across the Local Authority areas of Somerset, with a 10% difference in those in the lowest category between Taunton Deane at 47% and West Somerset at 60%.

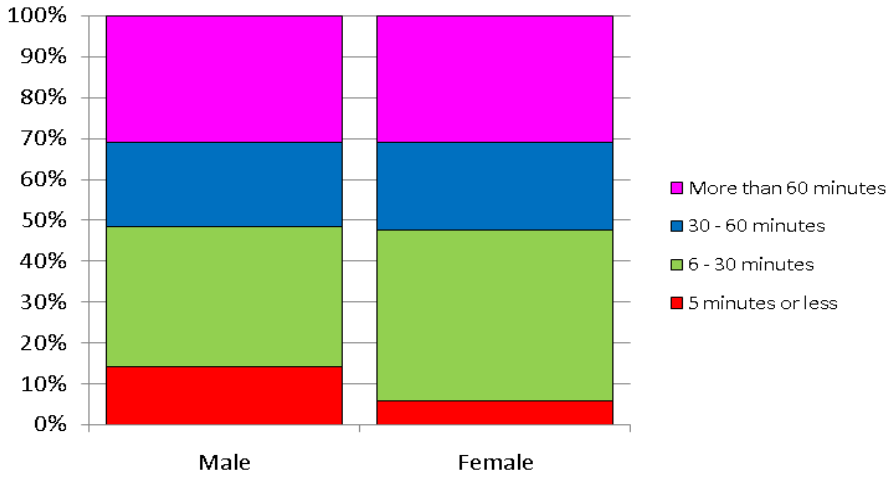
Figure 49: Amount of hand-rolled cigarettes smoked per day, by Local Authority area



7.20 Participants were asked to record the approximate time of their first cigarette/tobacco of the day as this provides a proxy measure to the level of addiction. Of the available options listed, about half the smokers had their first cigarette of the day within half an hour of waking. Men were more likely to smoke within five minutes of waking than women, but the proportion within the first half an hour was about the same. People in the 45-54 year age group and those who live in an area of highest social need were the most likely to have their first cigarette in the shortest time, which

repeats the finding from the 2002 Lifestyle Survey. There were no significant differences between Local Authority areas, with the exception of West Somerset having very few people who said they had their first smoke within five minutes of waking.

Figure 50: Time of first cigarette/tobacco, by gender



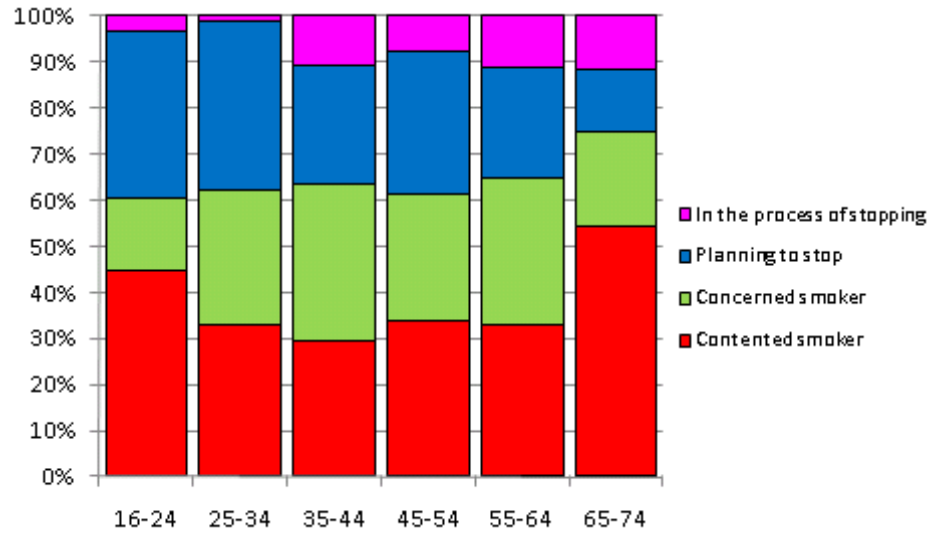
7.21 To further investigate the smoking habits of the population, participants were asked “How do you feel about smoking and your health?”. 36% of people reported being a “contented smoker”. This was followed by “planning to stop” at 29%. Interestingly the number of those who were “planning to stop” (29%) was four times that of those who were in the process of stopping” (7%). 10% more males than females described themselves as “contented smokers” suggesting male attitudes towards smoking are often different to those of women.

Table 16: Attitude to smoking, by gender

Attitude to smoking	Male %	Female %	Total %
Contented smoker	40.2	31.7	36.5
Concerned smoker	25.7	28.6	27.0
Planning to Stop	26.9	32.2	29.2
In the process of stopping	7.2	7.5	7.3

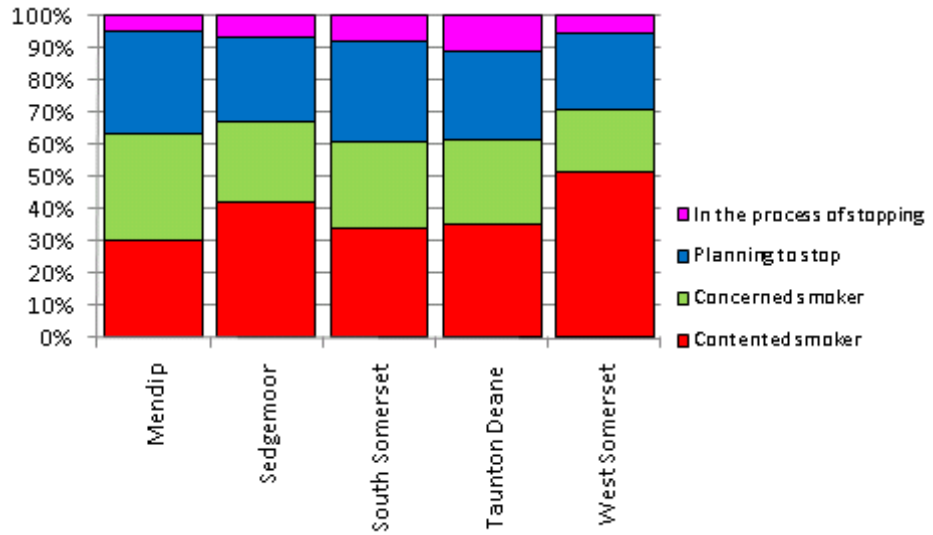
7.22 The proportion of those who were “concerned smokers” and “planning to stop” decreased over the age categories. As age increased participants were increasingly more likely to fall into either the “contented smoker” or “stopping” categories; for example, the numbers of those who smoked and were concerned about their health and therefore gave up, increased over time as might be expected. Of those in the 65-74 age group, around 55% were contented smokers.

Figure 51: Attitude to smoking, by age group



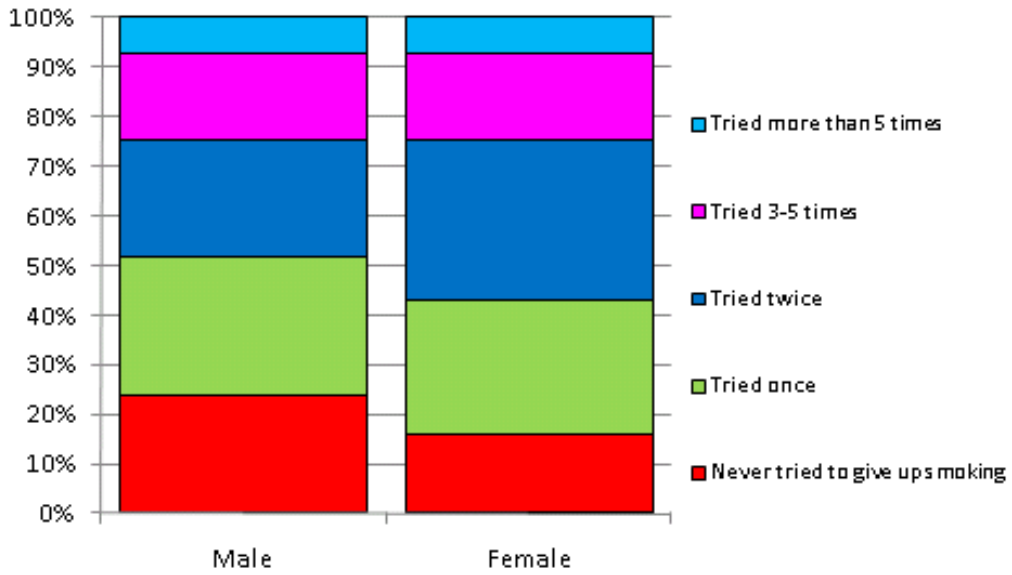
7.23 Deprivation did not appear to have a large effect on a participant's attitude towards smoking and their health. West Somerset had the highest proportion of "contented smokers" at 52% and the lowest was in Mendip at 30%.

Figure 52: Attitude to smoking, by Local Authority area



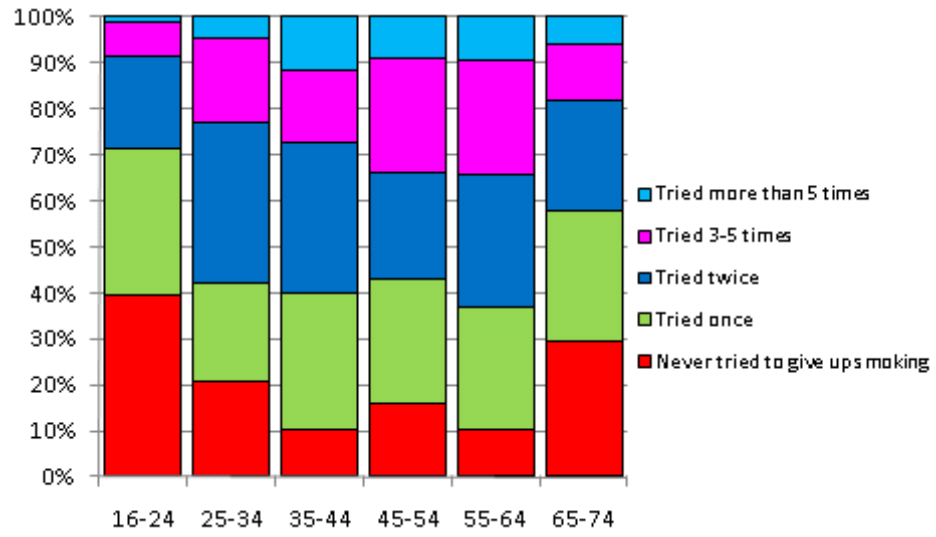
7.24 "Current smokers" were asked: "Have you ever tried giving up smoking in the past?" About 80% of them had tried giving up at some stage, with 7% having tried more than five times. 8% more males than females had never tried giving up. This is in line with the findings above, showing males generally have less concern about the health risks of smoking.

Figure 53: Attempts to give up smoking, by gender



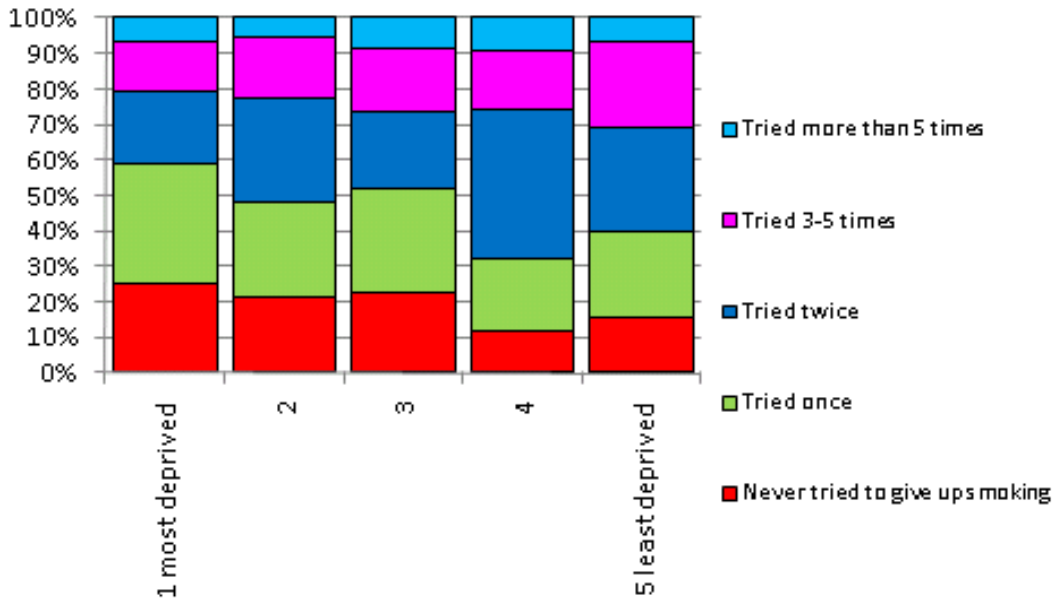
7.25 As would be expected, the youngest age category had the highest proportion of people to have never tried to give up smoking. The second highest group was the aged 65-74. This was also the age group with highest contentment with smoking. West Somerset was highest of all the Local Authority areas for the proportion of people who have never tried to give up.

Figure 54: Attempts to give up smoking, by age group



7.26 Those in the most deprived areas show least evidence of having tried to give up at all or have only tried once.

Figure 55: Attempts to give up smoking, by deprivation of residence



7.27 Current and ex-smokers who had tried to give up at least once were asked "When you tried to stop, did you get support from any of the following?" Respondents were able to select more than one method of support.

7.28 The most popular form of smoking cessation support was support from a health professional at 27%, followed by support from friends and relatives, which 20% of those who had tried to give up smoking had received. However, about 60% said that they did not receive any support in their attempt to give up smoking. 5% more men than women said they received no support and women were more likely to use self-help materials than men.

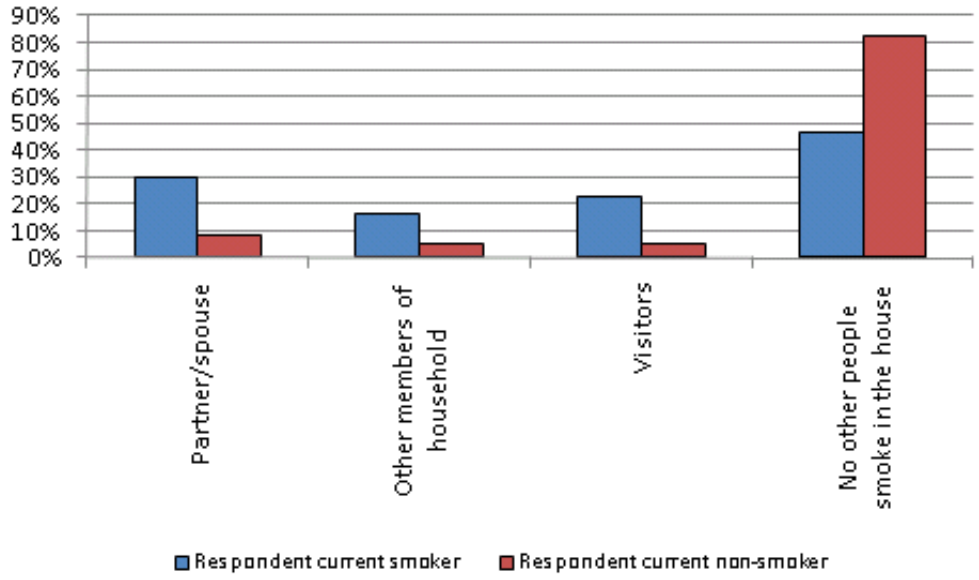
Table 17: Methods used to support to stop smoking, by gender

Support to stop smoking	Male %	Female %	Total %
Health professional	25.7	28.1	26.8
Friends/relatives	18.3	22.3	20.2
Self-help books/leaflets	6.7	11.4	8.8
Websites/forums	2.7	2.5	2.6
Telephone helpline	0.4	0.9	0.6
No support	62.9	57.9	60.6

7.29 All participants were asked about the smoking habits of other people in their homes. If the respondent was a current smoker then in 30% of cases they had a spouse/partner who also smoked and in general, the more likely it

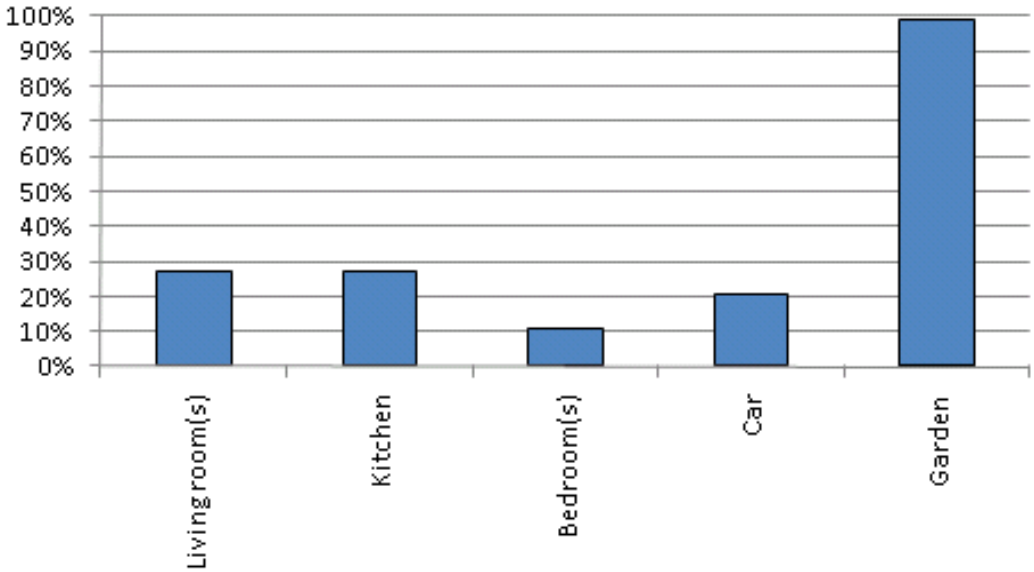
was that other people in their home also smoked. If the respondent was a non-smoker then 82% of them did not share their home with any smokers.

Figure 56: Other smokers in their home who smoke, by smoking status of respondent



7.30 In almost all households that allowed smoking, it was permitted in the garden, but only 11% of these households allowed smoking in the bedroom.

Figure 57: Where smoking happens in the household



7.31 A child was considered “exposed to smoke” if the respondent was a current smoker, or if their spouse, others or visitors smoked. Of the 911 children under 8 with known exposure status, 271 (29.7%) were actually exposed to tobacco smoke.

8 RESULTS – ALCOHOL USE

Summary of Results

- the majority (52%) of participants said that they drank alcohol once a week or more. Just under 9% reported never drinking at all
- the most popular alcoholic drink was wine with 43% of participants saying they had drunk it in the last seven days. The next most popular were ordinary strength beer/cider both at 24% and spirits at 20%
- the average number of units consumed weekly by those who had drunk alcohol was 12.5. However, when those who said they never drank alcohol were excluded the average number of units consumed became 13.7
- 26% of people overall were drinking at unsafe weekly levels, (31% of males and 21% of females)
- 56% of males and 39% of females were drinking unsafe daily levels of alcohol
- more women than men would like to cut down on their alcohol consumption and more of those who drink unsafe weekly levels would like to cut down. This could reflect an increased awareness of weekly advised safety limits compared to daily ones

8.1 Many people enjoy drinking alcohol - it is often part of our social and family life and plays an important role in the economy of the South West. However, an increasing number of people are regularly drinking above the recommended daily alcohol limits of 2–3 units of alcohol for women and 3-4 units for men. Drinking more than the recommended limit increases the risk of developing a number of health problems, including high blood pressure, liver disease and several types of cancer.

8.2 It is easy to sometimes drink too much and for drinking to sometimes get out of control. The misuse of alcohol, especially amongst young people, is a growing problem.

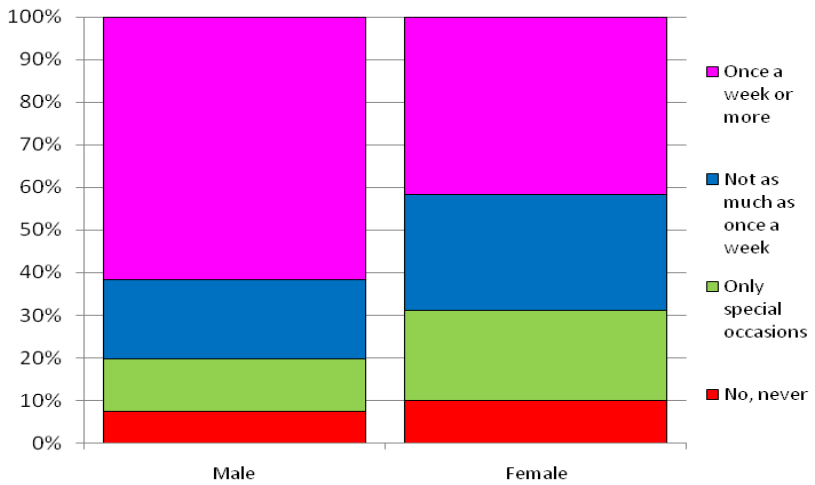
8.3 Alcohol is estimated to be responsible for about 33,000 deaths each year in the UK. Around a third (31%) of men and one in five (20%) women are regularly drinking more than the recommended limits. Alcohol-related admissions to hospital have increased dramatically in recent years – for example, in the South West admissions increased by more than 50% between 2001 and 2005. Admissions for 18 – 24 year olds related to alcohol increased by 140% between 1998 and 2004. In Somerset in 2008 over 8,000 admissions to hospital were linked to alcohol use. About half of

all violent crimes and a high proportion of domestic violence incidents are linked to alcohol.

8.4 Participants were asked whether or not they ever drank alcohol and then on what days they had drunk different alcoholic drinks. From this information, their weekly consumption of alcohol in units was calculated and compared to accepted safe levels.

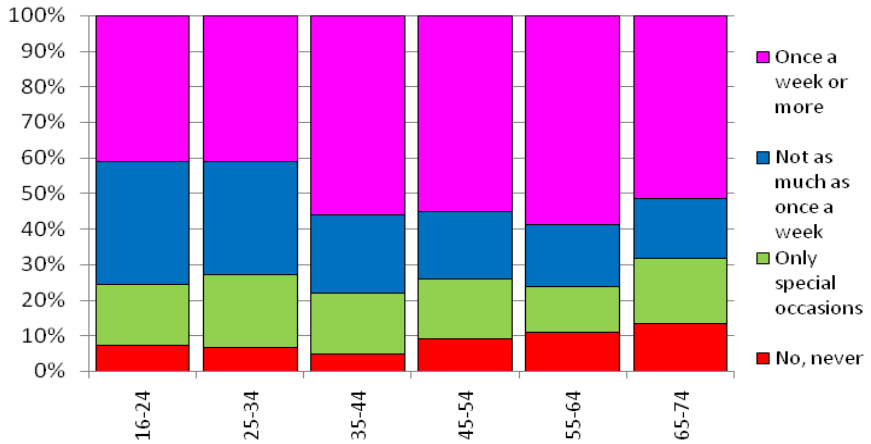
8.5 The most frequent response was once a week or more with approximately 52% answering this way. In this category there was a large difference between male and female responses, indicating a higher frequency of regular consumption of alcohol among men. Just under 9% said that they never drank at all.

Figure 58: Proportion of people who ever drink alcohol, by gender



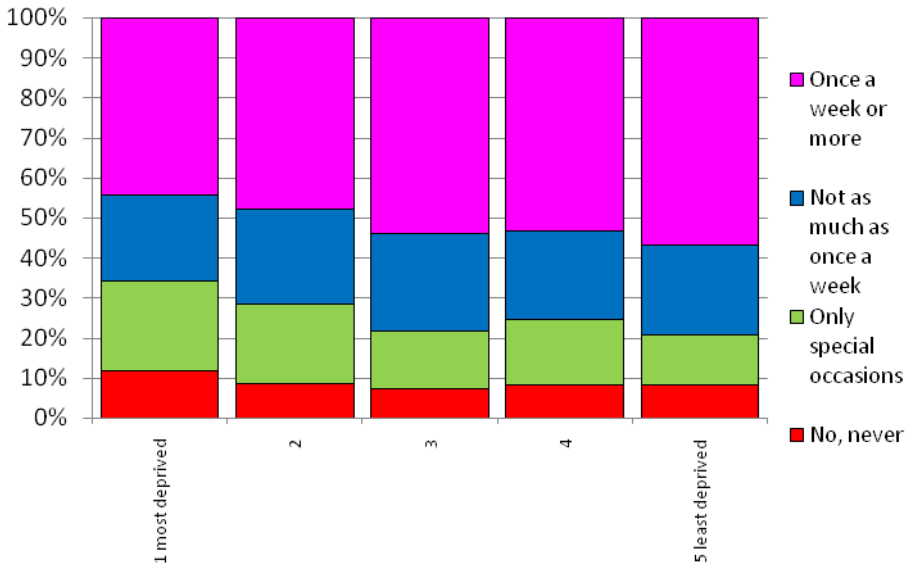
8.6 The proportion of people reporting never drinking increased slightly with age. However frequency of drinking also increased with age.

Figure 59: Proportion of people who ever drink alcohol, by age group



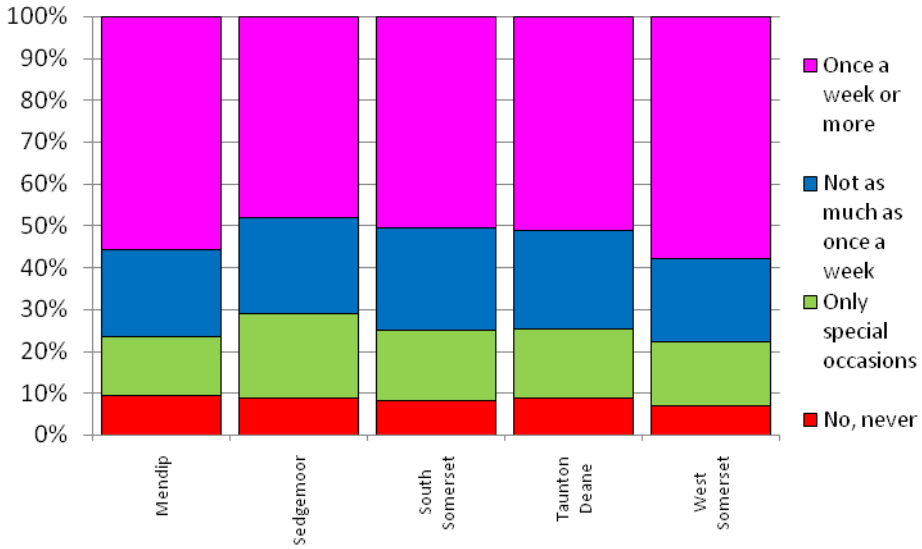
8.7 Prevalence of drinking decreased slightly with increasing deprivation. Many other indicators show increased prevalence of risk-taking behaviour with increasing deprivation and this is one of the few in which the trend is reversed.

Figure 60: Proportion of people who ever drink alcohol, by deprivation of area of residence



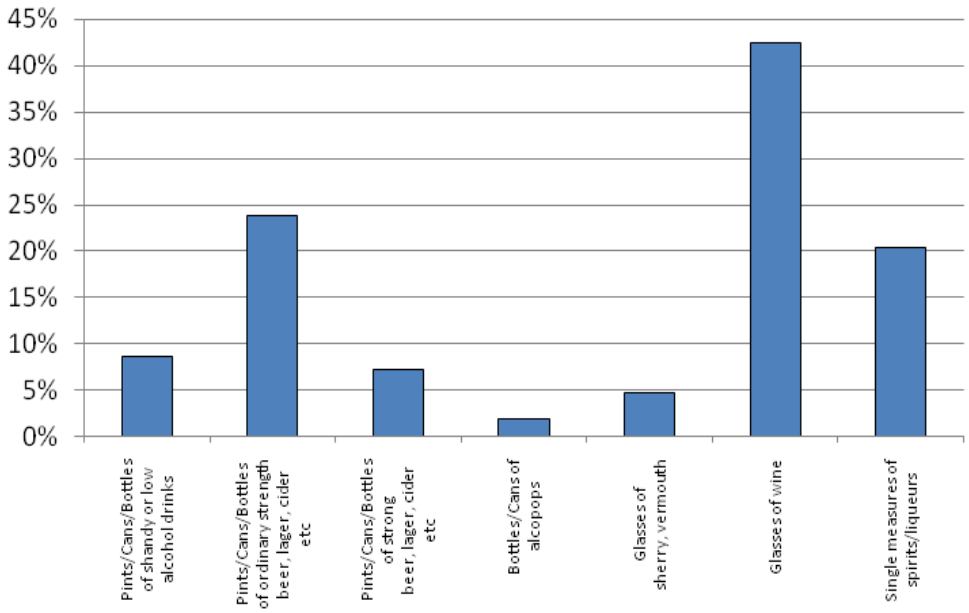
8.8 Prevalence of drinking was similar in all Local Authority areas, with Mendip and West Somerset having slightly higher proportions reporting drinking once a week or more than the other three Local Authority areas.

Figure 61: Proportion of people who ever drink alcohol, by Local Authority area



8.9 The most popular alcoholic drink was found to be wine with 43% of participants saying that they had drunk it in the previous seven days. The next most popular was ordinary strength beer/cider at 24% and spirits at 20%. The least popular drink were alcopops at 2%. The more popular drinks are also the more heavily drunk.

Figure 62: Proportion of people who had drunk different types of alcoholic drinks



8.10 The drinks consumed over the previous seven days were converted to units of alcohol according to the scale below:

Table 18: Units of Alcohol

Alcoholic drink	Units
Pints/Cans/Bottles of shandy or low alcohol drinks	1.1
Pints/Cans/Bottles of ordinary strength beer, lager, cider etc	2.3
Pints/Cans/Bottles of strong beer, lager, cider etc	3
Bottles/Cans of alcopops	1.4
Glasses of sherry, vermouth	1
Glasses of wine	2.5
Single measures of spirits/liqueurs	1

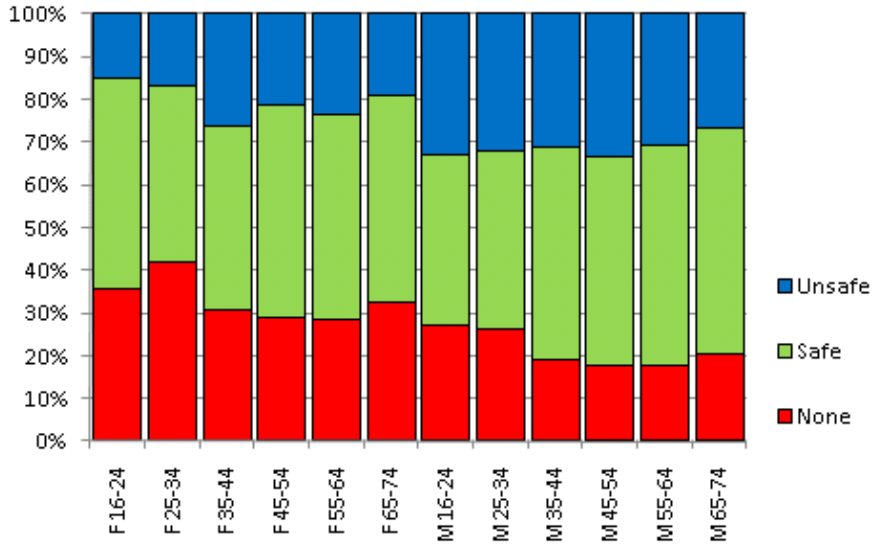
8.11 The average number of alcoholic units consumed by participants in the previous week was 12.5, compared to the national average of 12.8 units[13]. However, when those who said they never drank alcohol were excluded the average number of units consumed in Somerset was 13.7.

8.12 For the purposes of further analysis the results of the unit calculations were categorised with respect to “safe” drinking levels, defined as no more than 21 units per week for a man and 14 units for a woman.

8.13 Overall 26% (31% of males and 21% of females) fell into the unsafe drinking levels category. In contrast, 32% of females and 21% of males had not drunk alcohol at all. The 2002 Lifestyle Survey showed 28.7% of participants consumed unsafe drinking levels (based on the 2009 definition of unsafe levels). Therefore there has been a slight fall.

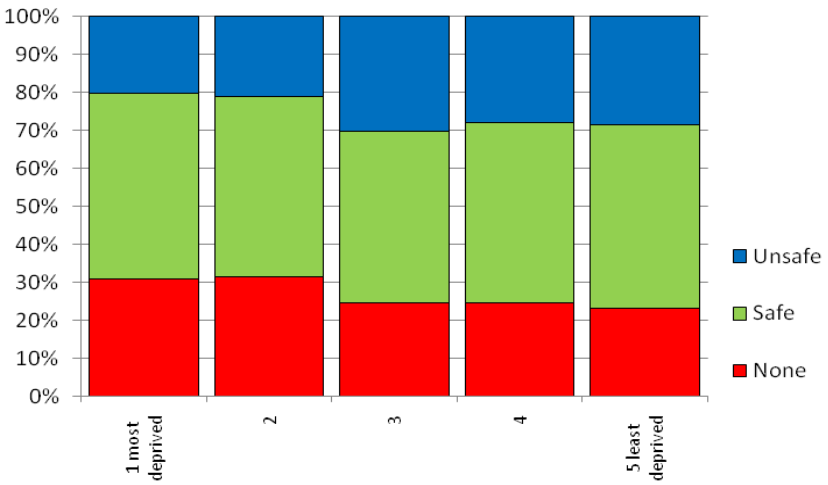
8.14 Age group comparisons show a slight decrease of unsafe drinkers in males with increasing age. There is a slight tendency for there to be fewer people drinking in the younger age groups

Figure 63: Weekly safety of drinking, by age group and gender



8.15 In line with the units of alcohol consumed, as deprivation increased, the higher the proportion that did not drink and the lower the proportion of unsafe drinking.

Figure 64: Weekly safety of drinking, by deprivation of area of residence



National and Local Authority Comparisons

8.16 There is little difference in the safe drinking levels between the Local Authority areas. However larger differences were found in comparison to the national data[13] set which shows a greater proportion of non-drinkers than found in this survey. The data also suggests a greater proportion of people in Somerset drink unsafe levels of alcohol compared to national figures.

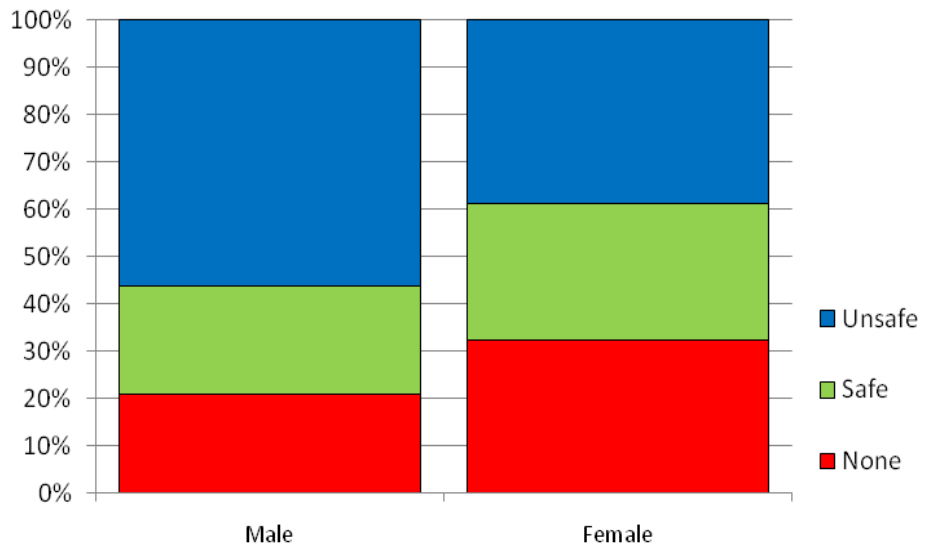
Table 19: Weekly safety of drinking, by Local Authority area

Weekly Drinking category	Mendip	Sedgemoor	South Somerset	Taunton Deane	West Somerset	Somerset	England 2008
	%	%	%	%	%	%	%
None	22.3	30.4	27.1	26.9	25.1	26.7	34.5
Safe	48.9	44.1	47.4	49.9	44.6	47.3	
Unsafe	28.8	25.5	25.6	23.1	30.3	26.0	14.5*

*Figure for England 2008[13]

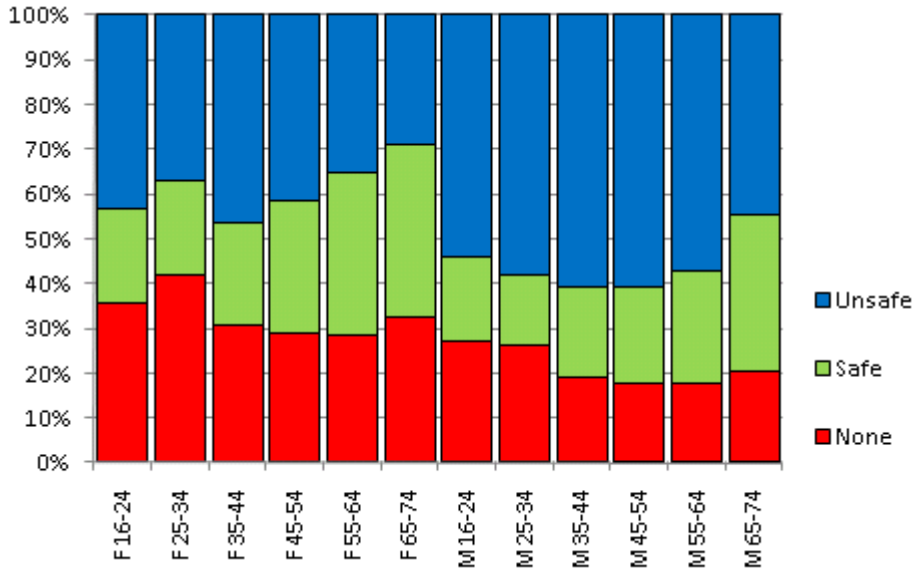
8.17 The unit calculations were also categorised with respect to daily consumption -safe drinking levels defined as “no day with more than four units for men and three units for women.” 56% of males fell into the unsafe category; for instance, had consumed more than four units on at least one day in the previous week, compared to 39% of females, who in turn had consumed more than three units.

Figure 65: Daily safety of drinking, by gender



8.18 Age group comparisons show a decrease of unsafe daily drinking after the age of 44, particularly for females. Again, as deprivation increases, the higher the proportion that did not drink and the lower the proportion of unsafe drinking, suggesting that alcohol has an inverse relationship with deprivation.

Figure 66: Daily safety of drinking, by age group and gender



8.19 Rates of unsafe daily drinking ranged from 44% in Sedgemoor to 52% in Mendip. However, again the largest differences were in comparisons to the national data set which found fewer unsafe drinkers compared to the 2009 Lifestyle Survey.

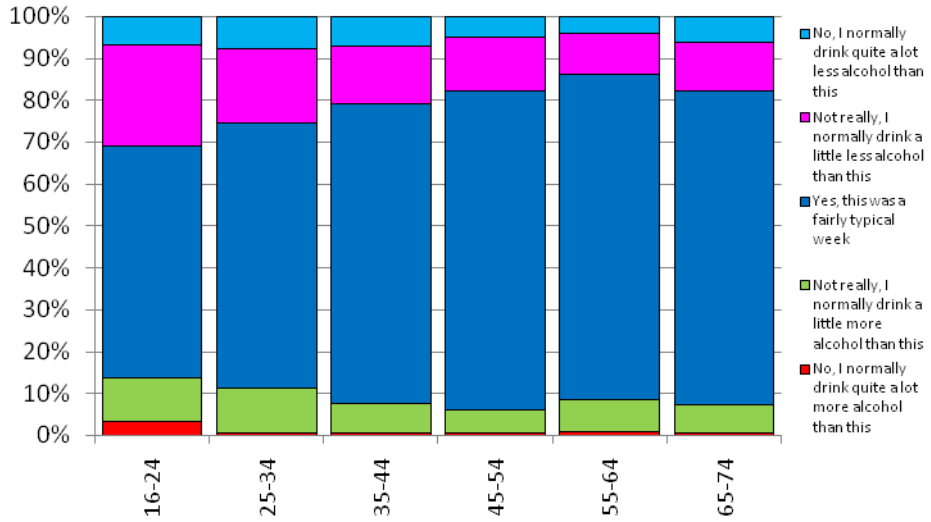
Table 20: Daily safety of drinking, by Local Authority area

Daily Drinking category	Mendip	Sedgemoor	South Somerset	Taunton Deane	West Somerset	Somerset	England 2008
	%	%	%	%	%	%	%
None	22.3	30.4	27.1	26.9	25.1	26.7	34.5
Safe	25.3	26.0	24.5	27.1	27.8	25.7	27.6
Unsafe	52.4	43.5	48.4	45.9	47.1	47.5	37.9

8.20 A comparison of weekly and daily unsafe drinking shows that about half of those who drink unsafe amounts on a daily basis also drink unsafe amounts on a weekly basis. Almost all of those who drink unsafe amounts on a weekly basis are likely to drink unsafe amounts on a daily basis.

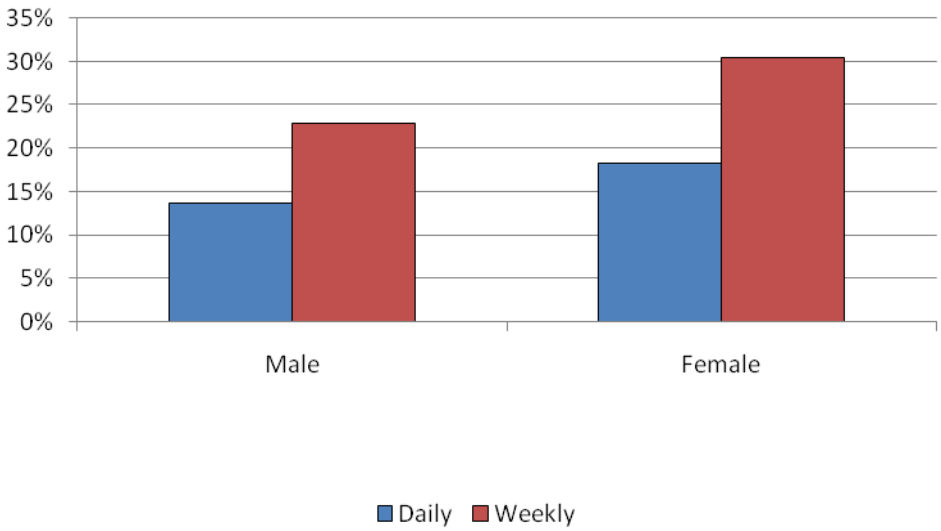
8.21 To further investigate drinking habits, participants were asked whether the last week was fairly typical of what they usually drink in a week. The majority (70%) said that the previous week's drinking had been typical. As age group increased a higher proportion stated that it had been a typical week.

Figure 67: Alcohol: typical consumption, by age group



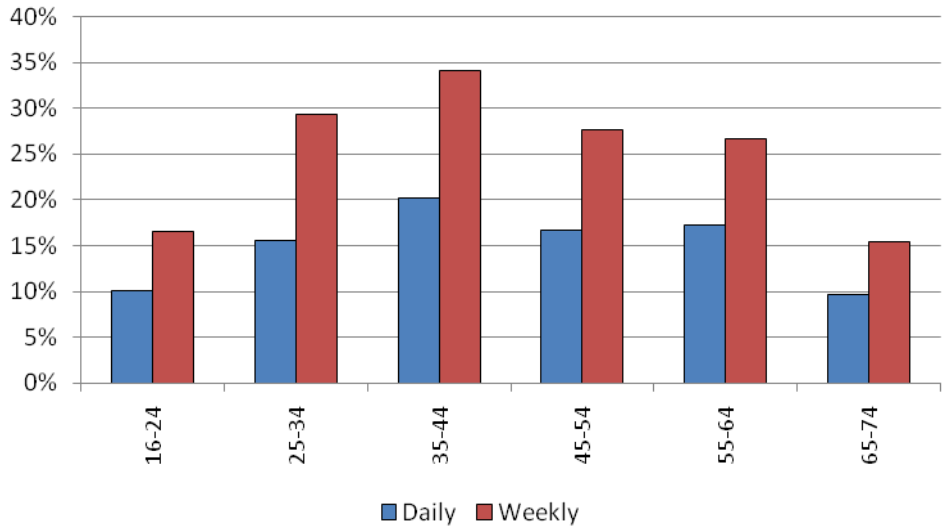
8.22 Participants were asked how content they were with their current levels of alcohol consumption. The results indicate that more women than men would like to cut down on their alcohol consumption and more of those who drink unsafe weekly levels would like to cut down. This could reflect an increased awareness of weekly advised safety limits compared to daily ones.

Figure 68: Proportion of people who drink unsafely who would like to cut down, by gender



8.23 People in the mid-age bands are more concerned about their drinking levels and would like to cut down. By Local Authority area, the proportion of people drinking unsafely who would like to cut down ranges from 23% in South Somerset to 29% in West Somerset and Mendip (weekly) and from 14% in South Somerset to 18% in West Somerset (daily).

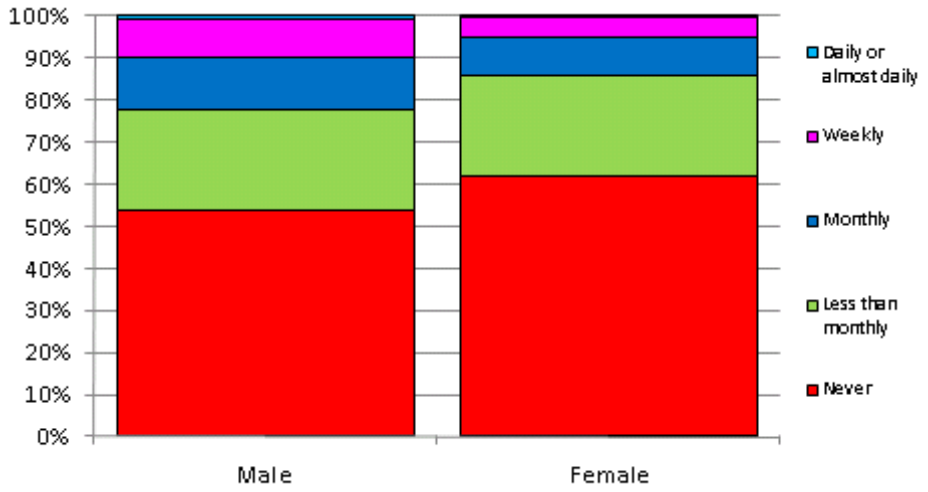
Figure 69: Proportion of people who drink unsafely who would like to cut down, by age group



8.24 Participants were then asked how often they drank eight or more drinks (for men) or six or more drinks (for women) (referred to below as "binge drinking"). If they responded monthly, weekly or daily or almost daily, an additional question was asked, the Fast Alcohol Screening Test (FAST)[14], which is a rapid test to establish if drinking levels are at hazardous or harmful levels. This brief intervention tool was originally developed at the University of Sydney as part of a World Health Organisation collaborative study. A FAST score of three or more was taken as an indicator of harmful/hazardous drinking.

8.25 More women than men report never binge drinking and of those who say they binge drink, more men have a high FAST score (22%) than women (15%). Overall it was estimated that about 3% of the total Somerset population aged 16-74 had hazardous or harmful drinking levels.

Figure 70: Proportion of people who binge drink, by gender



8.26 A strong association was found between binge drinking and age. The proportion who never binge drink increases with age and the proportion who weekly or daily binge drink decreases with age. However, with the exception of those aged 25-34, the proportion of binge drinkers with a high FAST score is similar in all age groups, perhaps suggesting a greater awareness of the effects of alcohol with increasing age.

Figure 71: Proportion of people who binge drink, by age group

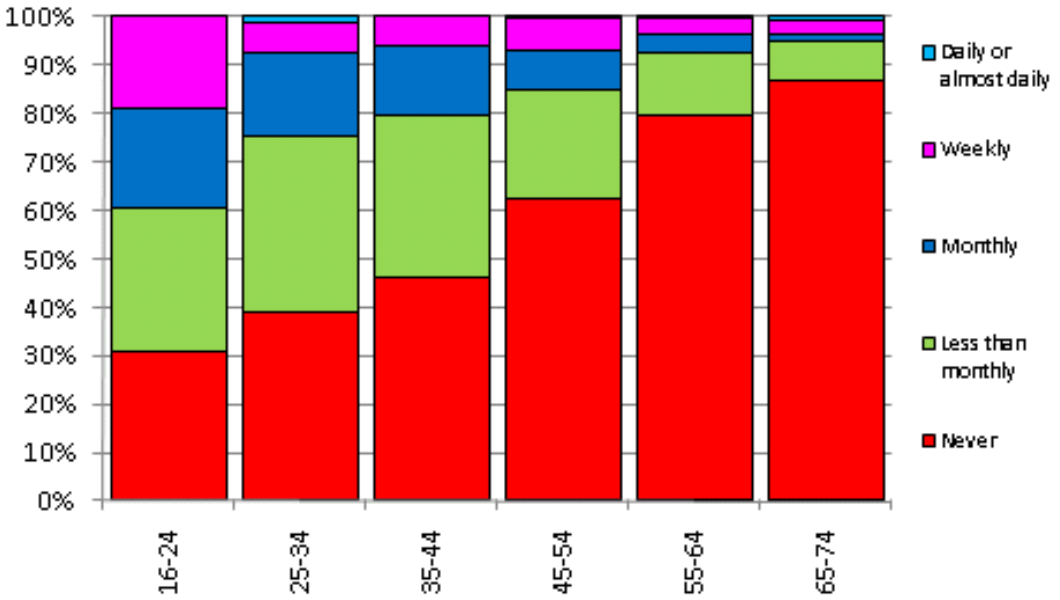
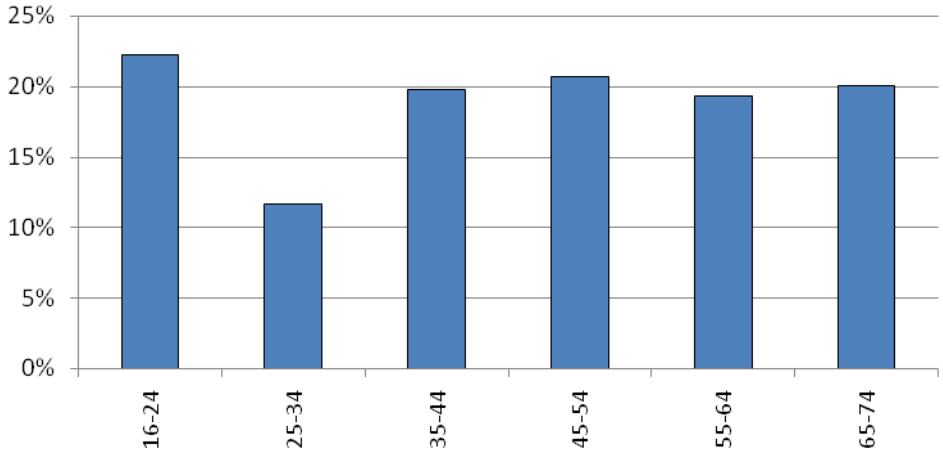


Figure 72: Proportion of people who binge drink who score three or more on FAST score, by age group



8.27 Similar levels of binge drinking and binge drinking with a high FAST score were found across the social gradient. However differences were found between Local Authority areas. The proportion of those who say they never binge drink varied from 54% in Sedgemoor to 64% in West Somerset. The proportion of binge drinkers who have a high FAST score was lowest in Sedgemoor (12%) and highest in South Somerset (24%).

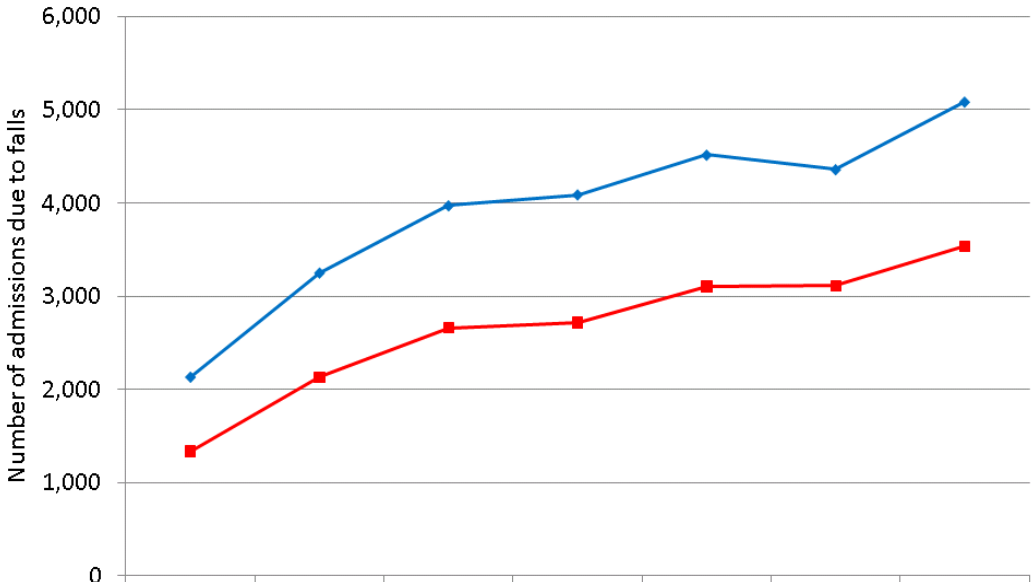
9 RESULTS – PREVENTING ACCIDENTS

Summary of Results

- 90.2% of participants said that they had a working smoke alarm in their home
- of those with toddlers and an open fire, 41% had a fireguard that was secured to the fireplace and 38% had a fireguard that was loose. 20% did not have any kind of fireguard. In addition 31% of participants with a toddler and stairs in their home had no stair gate fitted
- overall 20% of participants had fallen in the last 12 months and of these 4.2% had visited their general practitioner or went to a hospital as a result
- 13% of respondents were on four or more medications per day. A surprising amount (20%) said that they could not rise from a chair of knee-height without using their arms

9.1 Falls are a major cause of disability and the leading cause of mortality due to injury in people aged over 75. A fall represents the most frequent and serious type of injury for anyone over the age of 65 years. However, as seen in Figure 73, the number of hospital admissions due to a fall is increasing for people of all ages.

Figure 73: Admissions due to falls in Somerset 2003 - 2010



	2003/4	2004/5	2005/6	2006/7	2007/8	2008/9	2009/10
65+	1337	2129	2661	2717	3103	3110	3534
All ages	2134	3251	3972	4089	4515	4359	5084

Smoke Alarms

9.2 Participants were asked whether they had a working smoke alarm in their homes. 90.2% of participants said they did have a working smoke alarm, 6% said they did not have one and a further 4% said that while they did have an alarm, it was not working. The proportion of people who reported having a working smoke alarm in the home has risen since the 2002 Lifestyle Survey where 85.2% reported having a working smoke alarm. Responses to this section were not affected by gender, Local Authority, age or deprivation.

Protecting Toddlers

9.3 The following question relates to those who had toddlers in the house and whether or not they had a fireguard. The results of this question only include those who said they had a toddler and an open fire (4% of the respondents).

9.4 Of those with toddlers and an open fire, 41% had a fireguard that was secured to the fireplace and 38% had a fireguard that was loose. 20% did not have any kind of fireguard.

9.5 To investigate toddler safety awareness participants were asked “If you have a toddler in your house, do you have a stair gate fitted?” Only participants with toddlers and stairs were included (8.5% of the respondents). 31% of participants with a toddler and stairs in their home had no stair gate fitted. There was no difference observed between genders or deprivation.

Falls

9.6 Participants were asked whether they had fallen over in their home, garden or public place in the past six months and whether or not any treatment had been sought. Overall 20% had fallen in the last 12 months and of these 4% had fallen and had needed to see their GP or go to a hospital.

Table 21: Falls, by gender

Fall in the last 12 months	Male %	Female %	Total %
No	82.9	77.2	80.0
Yes, but no GP or hospital	13.7	17.9	15.8
Yes, and GP or hospital	3.5	4.9	4.2

9.7 Slightly more women than men had fallen and had sought GP or hospital treatment. The oldest age groups fell and sought professional help the most (just over 5% of respondents) but in general falls seem relatively unrelated to age within the age groups included in the survey. No association was found between falls and deprivation of the Local Authority area of residence.

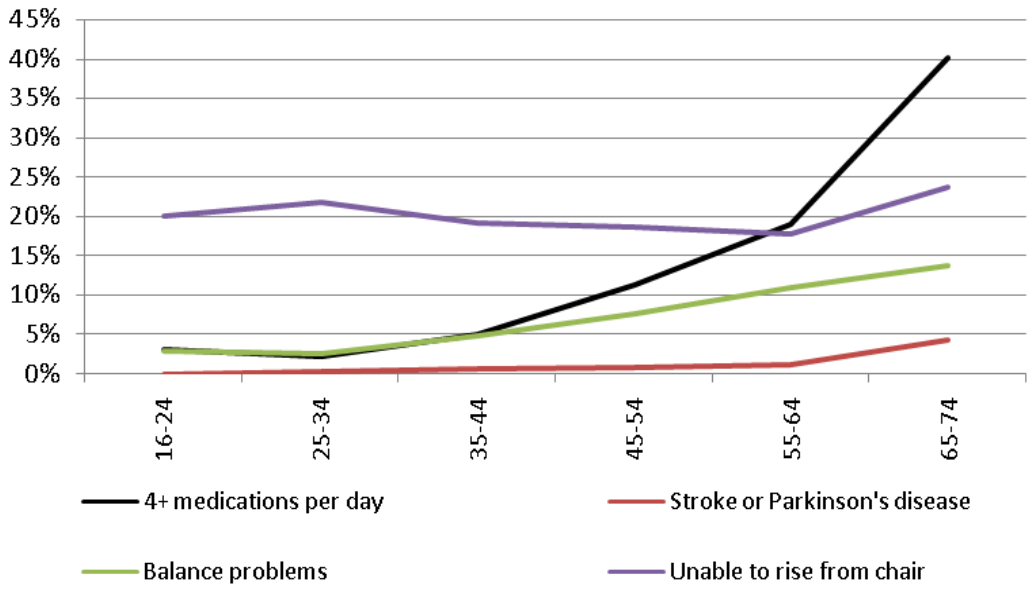
9.8 Participants (whether or not they had fallen in the past 12 months) were then asked about risk factors for falls. 13% of respondents were on four or more medications per day. A surprising number (20%) said that they could not rise from a chair of knee height without using their arms, although this may have been a result of misunderstanding the question.

Table 22: Risk factors for falls, by gender

Risk factor for falls	Male %	Female %	Total %
4+ medications per day	13.5	13.1	13.3
Stroke or Parkinson's disease	1.4	0.9	1.1
Balance problems	5.8	8.6	7.2
Unable to rise from chair without using your arms	19.4	20.5	19.9

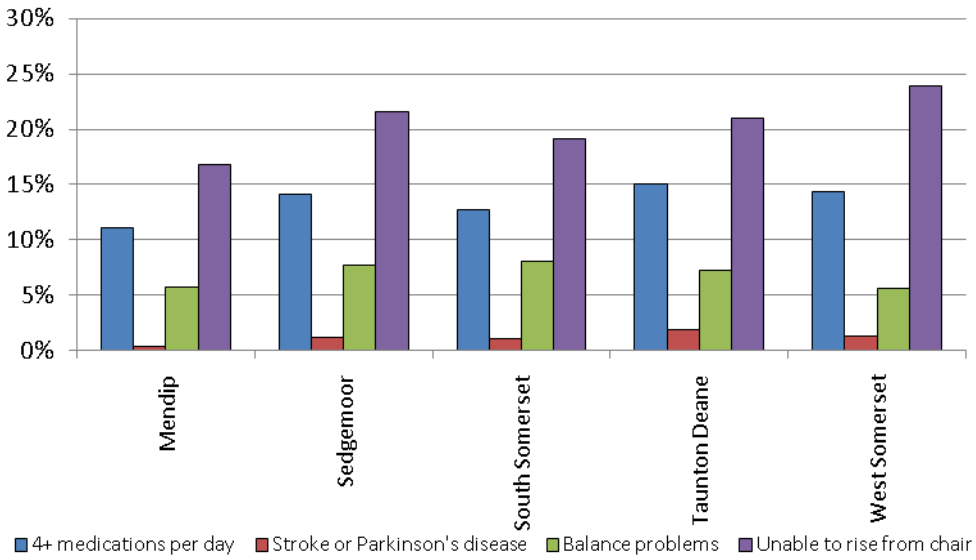
9.9 The prevalence of using four or more medications per day rose with age to 40% in the oldest age group. Balance problems and stroke or Parkinson's also increased with age to 4% and 14% respectively. The inability to rise from a chair remained reasonably constant over these age groups – a fifth of those aged 16-24 said that they could not perform this activity.

Figure 74: Risk factors for falls, by age group



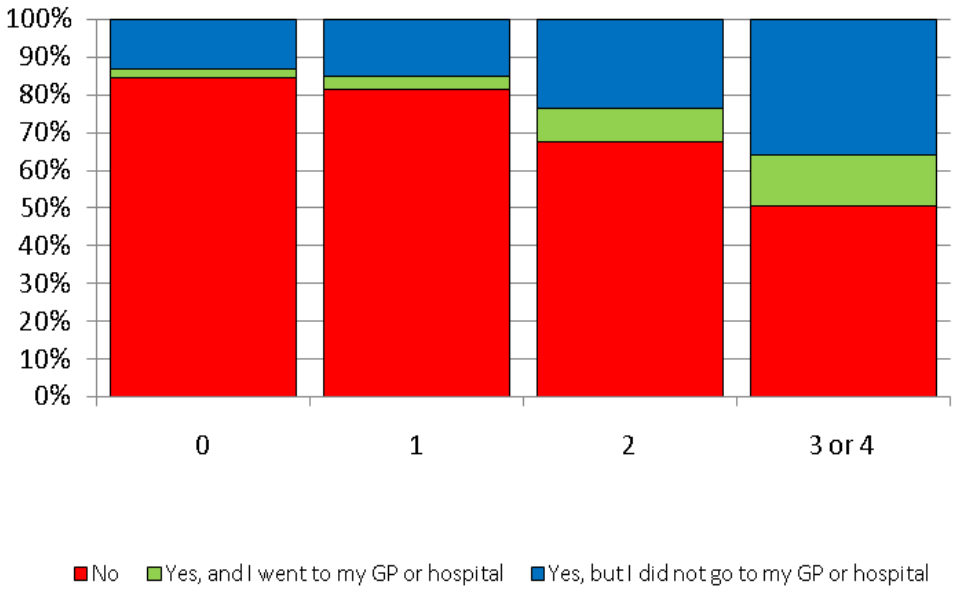
9.10 The general trend was for all risk factors to decrease with decreasing deprivation. Across the Local Authority areas, Mendip had the lowest proportions for all of the risk factors.

Figure 75: Risk factors for falls, by Local Authority area



9.11 To explore whether these conditions were indeed factors that affected risk, the number of risk factors experienced was compared with whether or not the respondent had fallen in the last six months. As expected, as the number of risk factors increased, the proportion of people who had fallen increased from 16% to 50%. The severity of the fall (as measured by seeking professional help) also increased from 17% to 28%.

Figure 76: Falls, by number of risk factors



10 RESULTS - SAFE IN THE SUN

Summary of Results

- the most popular measure of sun safety was to use sunglasses; about half the respondents said they wore them. Almost half used sunscreen, but almost twice as many women as men would use it. Approximately a third stated they would cover up, a third would stay inside and a fifth would wear a hat

- approximately 30% of women had tried using sunbeds but only about 2% still use them

- 23% agreed a tan was healthy (this was 28% of those who expressed an opinion). 18% did not know whether a tan was healthy or not. Interestingly, 67% said that a tan was attractive (three quarters of those who expressed an opinion) although 57% thought that a tan was less fashionable then it used to be

10.1 Rates of skin cancer have risen by over 20% during the last five years with incidence and mortality in Somerset being higher than the national average. The most significant risk factor for skin cancer is exposure to the sun. Exposure during childhood is particularly important in determining risk although other factors also play a role. These include:

- use of sunbeds
- family history of skin cancer
- being fair-skinned
- burning easily
- having a large number of freckles and/or moles
- being an outdoor worker

10.2 Fortunately skin cancer can be prevented. Prevention strategies need to focus on public education about the health hazards of sun exposure, providing adequate shade within the wider environment, safety campaigns around sunbed usage and emphasising the importance of early detection and reporting of lesions.

10.3 Participants were asked whether they used protective measures against harmful exposure to the sun. The most popular measure was to use sunglasses; about half the respondents said they wore them. Almost half used sunscreen, but almost twice as many women as men would use it. Approximately a third stated they would cover up, a third would stay inside

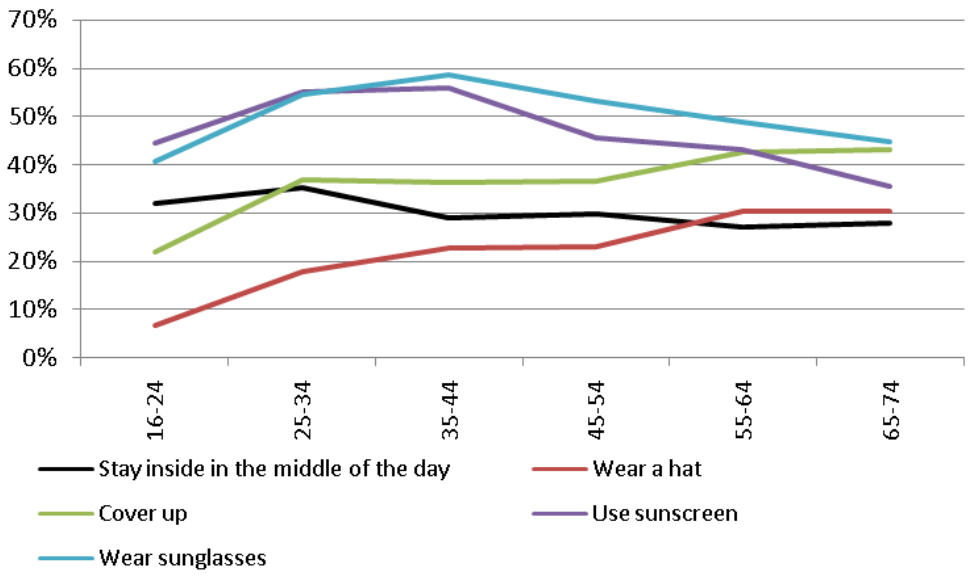
and a fifth would wear a hat. Most of the measures were more popular with women than men, but men were slightly more likely to wear a hat.

Table 23: Protective measures taken, by gender

Preventive measure	Male %	Female %	Total %
Stay inside in the middle of the day	26.4	33.5	30.0
Wear a hat	26.3	18.4	22.3
Cover up	37.7	34.9	36.3
Use sunscreen	32.0	61.3	46.9
Wear sunglasses	42.5	58.6	50.6

10.4 Covering up with clothes or a hat increased in popularity with age, whereas the use of sunscreen and sunglasses appeared to decline in the older age groups. There were no obvious marked trends in usage across the social gradient or across Local Authority areas in the county.

Figure 77: Protective measures taken, by age group



10.5 Participants were also asked whether they used sunbeds or tanning booths. Most people had never used a sunbed or tanning booth. Approximately 30% of women had tried them, but only about 2% still use them; five in every thousand use them once a week or more.

10.6 Participants were asked to consider a range of sun exposure related statements and say whether they agreed or disagreed with them. 23% agreed a tan was healthy (this was 28% of those who expressed an opinion). 18% did not know whether a tan was healthy or not. Interestingly, 67% said that a tan was attractive (three quarters of those who expressed an opinion) although 57% thought that a tan was less fashionable then it used to be.

10.7 There did appear to be some gaps in knowledge about sun safety, as 55% agreed that sun exposure during childhood could be related to skin cancer in adults, but a further 39% did not know. Half the people who responded thought that a sunscreen with an SPF of 30 was twice as protective as one with an SPF of 15. About a third did not know.

Table 24: Agreement with sun exposure related statements

Statement	Agree %	Disagree %	Don't Know %	% Agreed of those who expressed an opinion
A tan is healthy	22.6	59.4	17.9	27.6%
A tan is attractive	67.3	22.7	10.1	74.8%
A tan is less fashionable than it used to be	56.7	23.7	19.6	70.5%
There is little chance that I will get skin cancer	17.3	49.0	33.6	26.1%
it is safe to get sunburnt once or twice a year	4.5	86.2	9.3	4.9%
You can get sunburnt on cloudy days	80.2	11.6	8.2	87.4%
Tanning beds are safer than the sun	1.0	84.7	14.3	1.1%
Getting a suntan is a safe way to protect skin from sun damage	3.2	86.5	10.2	3.6%
Sun exposure during childhood is related to skin cancer in adulthood	55.3	6.0	38.7	90.2%
A sunscreen with an SPF of 30 provides twice the protection of a sunscreen with an SPF of 15	50.3	15.0	34.7	77.0%

Potential Signs of Skin Cancer

10.8 Participants were then asked to identify which of a list of symptoms could be potential signs of skin cancer. For all but "A sore that doesn't heal" a large majority of people expressed an opinion and in each case more than 90% of those who expressed an opinion said that the description was a potential sign of skin cancer. However 39% did not know if "A sore that doesn't heal" could indicate potential skin cancer. Again, the results would suggest there seems to be some uncertainty around some of the signs of skin cancer.

Table 25: Identification of potential signs of skin cancer

Potential sign of skin cancer	Yes %	No %	Don't Know %	% Yes of those who expressed an opinion
A sore that doesn't heal	45.3	15.9	38.7	74.0%
A change in the appearance of a mole	95.1	0.5	4.3	99.5%

Potential sign of skin cancer	Yes %	No %	Don't Know %	% Yes of those who expressed an opinion
A freckle that has changed in shape or size	77.4	6.6	16.0	92.2%
A mole or sore that itches or hurts	82.6	2.8	14.6	96.7%
A mole that bleeds	78.5	3.4	18.1	95.9%

11 RESULTS - MENTAL HEALTH

Summary of Results

- 17.5% of participants scored four or more on the General Health Questionnaire-12 (GHQ-12); a higher proportion of females than males reached this score. This was especially pronounced in the 16-24 year age category where almost twice as many females than males scored four or more, (27.4% compared to 15.5%)
- 53% of those who stated that they had a mental health problem had scored four or more on the GHQ-12, compared to only 16% who stated that they did not have a problem
- the proportion of people reporting some lack of social support on the Social Support Scale was 23% while the proportion of those reporting a severe lack of social support was about the same, at 22%
- the proportion of those reporting any isolation was 42%. Males and females reported similar levels of any isolation, but there was a suggestion that more females experienced more intense isolation
- there was a decrease in perceived social isolation with age. Those aged over 55 reported being very connected more than twice as often as those aged less than 25

11.1 Mental health is the emotional wellbeing and resilience which enables us to enjoy life and to live it to its fullest. Mental health is about how we think, feel and behave. It enables us to make the most of opportunities, learn how to make the best decisions, to survive pain, disappointment and sadness and to be able to contribute to society. It is a positive sense of wellbeing and an underlying belief in our own and others' dignity and worth.

11.2 Mental health is affected by a wide range of factors which can protect from, or increase, the risk of mental illness. These include "lifestyle factors" such as taking sufficient physical activity, keeping alcohol consumption within sensible daily limits and eating a healthy diet with plenty of fruit and vegetables. Other factors such as employment, education and access to strong social networks also promote good mental health and wellbeing.

Psychiatric Morbidity

11.3 As with previous years, the 2009 Lifestyle Survey included the General Health Questionnaire (GHQ-12). This is a measure of psychiatric morbidity and a GHQ-12 score of four or more is used to identify respondents with a possible psychiatric disorder. The answers from this question were scored using the method recommended in the General Health Questionnaire User's Guide[15] where the two positive answers (first two) received a score

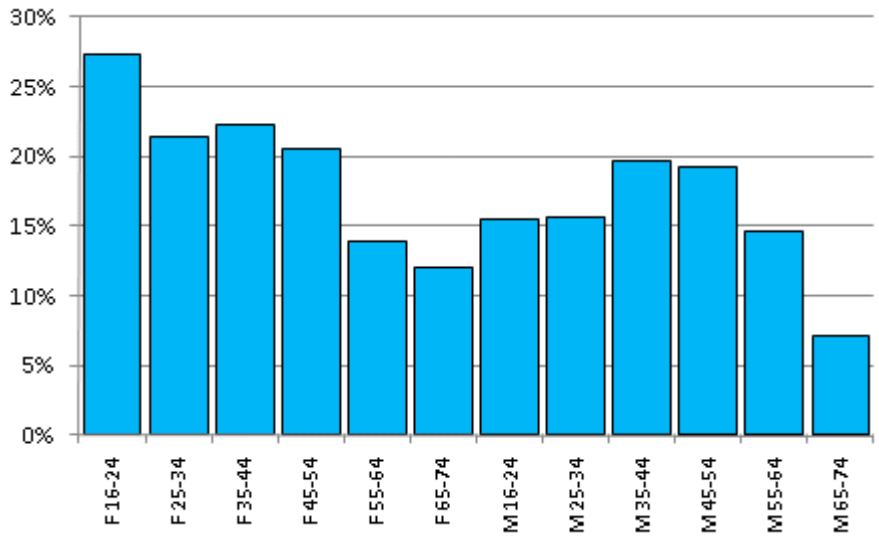
of zero, and the two negative answers (last two) received a score of one. For example, “better than usual” or “same as usual” scored zero, “less than usual” or “much less than usual” scored one.

11.4 In 2002, if respondents had left any part of the question blank, their response to the whole question was excluded, so this approach was taken for the initial scoring to enable comparison with previous data. In addition, where respondents had left one or more questions blank, a calculation was made from the answers they had given to see if the unanswered question(s) could affect their overall score. Their data was included if the score was unaffected by any missing answers. This enabled an additional 81 records to be included.

11.5 In total 17.5% of participants scored four or above on the GHQ-12. As shown in Figure 78, there was a higher proportion of females attaining this score than males. This was especially pronounced in the 16-24 year age category where almost twice as many females than males scored four or more (27.4% compared to 15.5%). These findings were similar to those in the 2002 Lifestyle Survey.

11.6 For women, Figure 78 shows a trend for a decreasing proportion of them with a score of four or more as they get older; however this trend is not evident for men. There was little difference recorded in the answers returned from each Local Authority area, with Sedgemoor showing the highest level (19.6%) and Taunton Deane the lowest (15.7%).

Figure 78: Prevalence of GHQ-12 score of four or more, by age and gender group

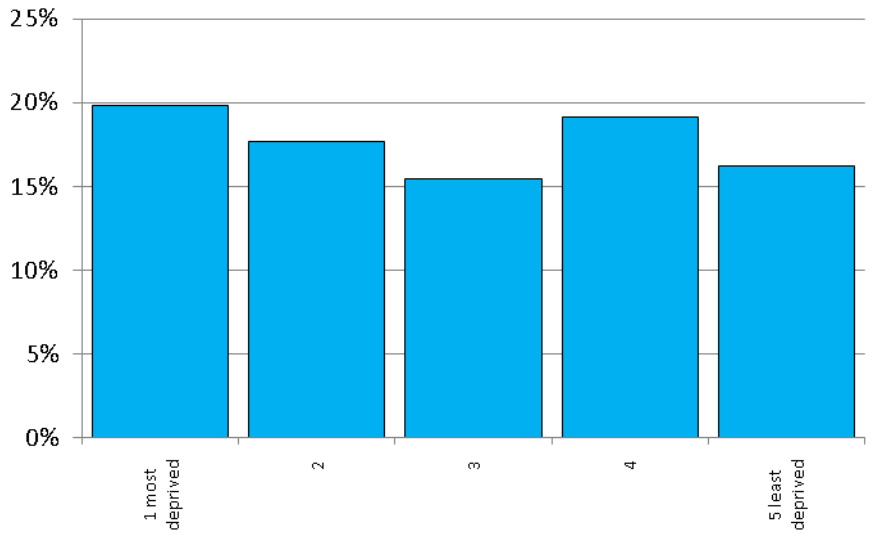


11.7 There was little difference recorded in the answers returned from each Local Authority area.

11.8 Those who scored four or more in the GHQ-12 were cross-referenced with those who stated that they had a mental health problem in the disabilities

section. 53% of those who stated that they had a mental health problem had scored four or more on the GHQ-12, compared to only 16% who stated that they did not have a problem. It is clear that those with a mental health problem were much more likely to score four or more. This result is very similar to the result in the 2002 Lifestyle Survey.

Figure 79: Prevalence of GHQ-12 score of four or more, by deprivation of area of residence



11.9 There were many people who stated that that they did not suffer from a mental health problem yet still scored four or more on the GHQ-12. This might be due to definition, as some would be unwilling to classify a condition such as depression as a disability due to on-going stigmas relating to mental health problems. A fifth of the people in the most deprived areas scored four or more on the GHQ-12 questions, but there is not a clear trend with deprivation.

11.10 Sedgemoor had the highest proportion of those scoring four or more, at 19.6%. The lowest proportion was in the residents of Taunton Deane at 15.7%. There was a considerable difference between the overall 2009 Lifestyle Survey data and the national data which comes from The Health Survey for England 2008. This might reflect the different time periods covered as the Lifestyle Survey was carried out during an economic recession. However in the 2002 Lifestyle Survey, Somerset also had a higher prevalence of GHQ-12 score than England.

Table 26: Prevalence of GHQ-12 score of four or more by Local Authority area and England

GHQ-12 score	Mendip	Sedgemoor	South Somerset	Taunton Deane	West Somerset	Somerset	England 2008
	%	%	%	%	%	%	%
0-3	81.4	80.4	83.1	84.3	84.0	82.5	87.3
4+	18.6	19.6	16.9	15.7	16.0	17.5	12.7

11.11 The "support from family and friends" question asked informants about the amount of support and encouragement they receive from family and friends. The scale is based on seven questions about physical and emotional aspects of social support. From these, a single scale was derived by assigning a score of between one (lack of support) and three (no lack of support) for each of the questions. Informants with the maximum score of 21 were classified as having no lack of social support, those with a score of 18 to 20 were classified as having some lack of social support and those with a score under 18 as having a severe lack of social support.

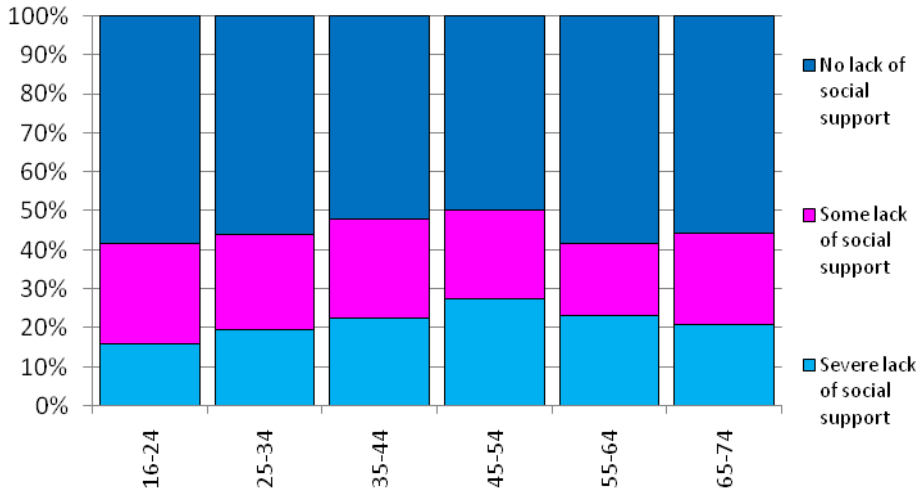
11.12 The proportion of those reporting some lack of social support was 23% while the proportion of those reporting a severe lack of social support was similar, at 22%.

Table 27: Support from family and friends, by gender

Gender	Severe lack of social support	Some lack of social support	No lack of social support
	%	%	%
Male	22.5	25.2	52.3
Female	21.5	21.1	57.4
Total	22.0	23.1	54.9

11.13 Lack of social support appears to be highest in the middle age bands. Between 40% and 50% of all age groups reported some lack or a severe lack. No significant associations were found between perceived lack of social support and deprivation.

Figure 80: Prevalence of perceived social support, by age group



11.14 The Friendship Scale[16] was developed in order to provide a short, user-friendly scale measuring felt social isolation. The overall score excluded the question "others felt they had to help me" and from the other questions a single scale was derived by assigning a score of between zero (most isolated) and four (most connected) for each of the questions. Scores were grouped into five categories ranging from "very isolated" to "very connected". Data was excluded where participants did not answer one or more parts of the question.

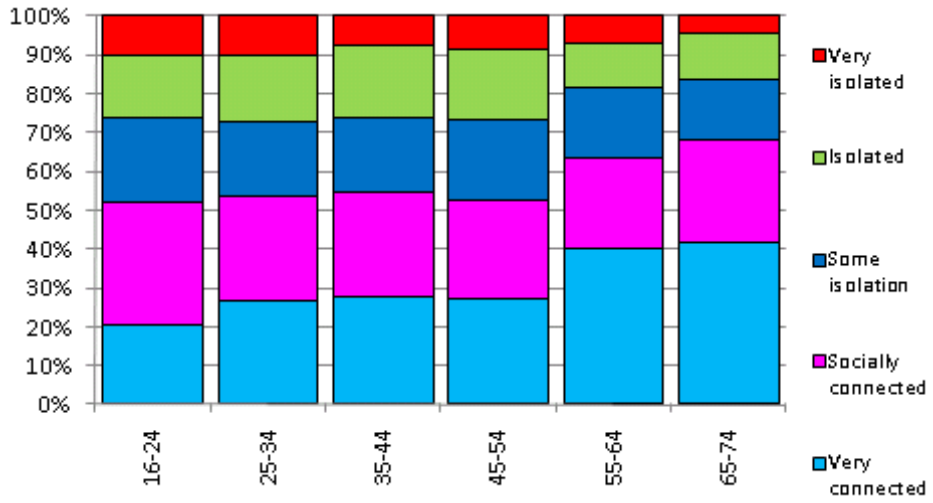
11.15 The proportion of those reporting any isolation was 42%. Males and females reported similar levels of any isolation, but there was a suggestion that more females experienced more intense isolation.

Table 28: Isolation, by gender

Gender	Very connected	Socially connected	Some isolation	Isolated	Very isolated
	%	%	%	%	%
Male	30.0	27.8	19.2	16.3	6.7
Female	31.6	25.3	19.0	15.0	9.0
Total	30.0	27.8	19.2	16.3	6.7

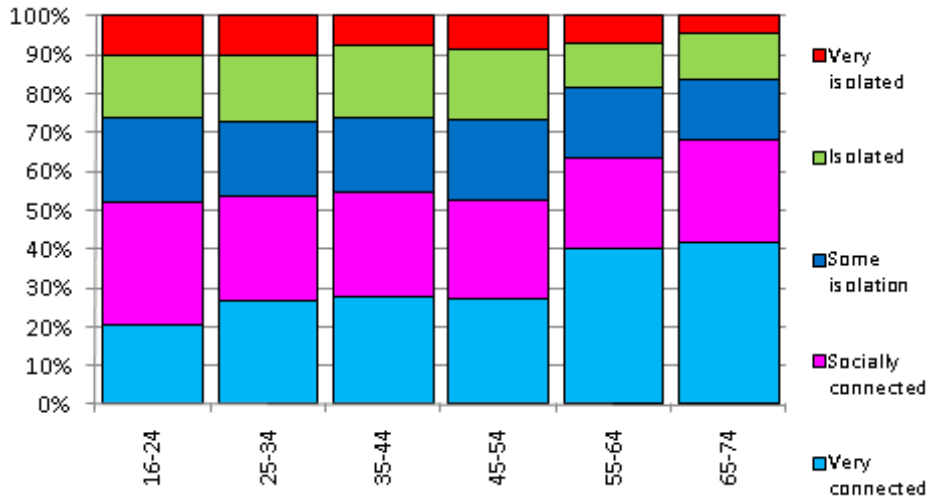
11.16 There was a decrease in perceived social isolation with age. Those aged over 55 reported being very connected more than twice as often as those aged less than 25.

Figure 81: Prevalence of perceived social isolation, by age group



11.17 There was no apparent trend of increasing social isolation with increasing deprivation. However, despite West Somerset being the most geographically isolated area, the proportion of "very connected" was the highest and the proportion of "very isolated" the lowest.

Figure 82: Prevalence of perceived social isolation, by Local Authority area



12 CONCLUSIONS

12.1 The 2009 Lifestyle Survey aimed to investigate the lifestyle behaviours of adults aged 16 to 74 years in Somerset. The information gained from this survey will be used to inform work in the county to support and encourage people to take responsibility for their own health through the lifestyles choices they make.

12.2 The survey has shown some interesting results and some clear trends can be seen in certain aspects of lifestyle behaviour, when comparing the data with previous lifestyle surveys.

12.3 Marked behaviour changes can be seen for certain aspects of lifestyle, in particular dietary changes. There has been a downward trend in people adding salt to their food both during cooking and at the table and a downward trend in the use of full fat milk. Both these behaviour changes are really positive steps forward for reducing risk of high blood pressure, CHD, stroke and many other conditions.

12.4 Whilst individual lifestyle choices present one part of the picture in reducing risk of lifestyle-related disease, further work needs to take place at a national and local policy level to make healthier choices easier for people. National policy to encourage food producers and retailers to reduce salt content in food and present clear food labelling is a key part of reducing overall salt intake.

12.5 Whilst there have been some positive changes in dietary behaviour, levels of overweight and obesity continue to rise in the county. Overweight and obesity are a consequence of low levels of physical activity and high calorific diets. The results of the 2009 Lifestyle Survey have shown that levels of overweight and obesity in Somerset continue to increase. Whilst the proportion of people who are of normal weight has not changed significantly, the proportion of people in the obese category has increased, suggesting that overweight people have continued to put on weight and have moved into the obese category.

12.6 These findings present a strong argument to focus work associated with dietary change towards addressing the high calorific diets, largely brought about by foods high in fats and sugars and excessive portion sizes.

12.7 Participation in physical activity in the county has remained relatively constant, in line with national surveys. A quarter of people reported doing no regular physical activity at all. Efforts should focus on encouraging those who do no regular activity to do something, as this is considered to be the area which holds the most significant public health gain.

12.8 Whilst behaviour change and support at an individual level can continue to make significant changes to individual lives, large scale societal change will be required to tackle what has been termed as the “obesinogenic

environment" in which we live. This public health issue represents a challenge for national policy that has yet to be tackled.

12.9 A reduction in the number of current smokers in Somerset represents another clear trend in behaviour change seen in the past 20 years. This lifestyle area provides a good example of local support for behaviour change working alongside national policy and action to improve population health. Whilst there is still considerable work that can be done with people who are current smokers and wish to stop, supporting people to stop smoking will ultimately get more difficult as the proportion of smokers decreases and the more contented smokers remain. Work should begin to focus more on preventing young people from starting smoking and continuing to try and protect children and young people from the effects of secondhand smoke.

12.10 This survey found an alarming proportion of people (26% overall) who were drinking at unsafe weekly levels, (31% of males and 21% of females). Furthermore, 56% of males and 39% of females also reported drinking unsafe daily levels of alcohol. These levels were significantly higher than those estimated for Somerset from national surveys. Levels for males were particularly high. This is an area of public health concern that requires greater focus in the future.

12.11 This survey found high rates of preventative measures against accidents were used around the home - for example, smoke detectors. This possibly reflects changes to building regulations over the past decade. The inclusion of the falls section was a new addition to the survey and provided some useful information about people's level of multiple risk. 13% of people reported taking multiple medications, commonly recognised as a risk factor for falling. This high proportion possibly reflects increasing reliance and availability of medication and advances in science, meaning that people are now living longer with more chronic long-term conditions.

12.12 The safe in the sun section was also a new addition to the lifestyle survey. The findings from this survey show that whilst there is some awareness of sun protection and use of preventative measures, this is not widespread. There are gaps in people's knowledge around sun awareness and skin cancer. It is recommended that there is increased activity in raising awareness of the effects of the sun and early signs of skin cancer.

12.13 The mental health section of the survey provided some interesting results with 17% of people scoring highly on the General Health Questionnaire (GHQ-12). There was a high correlation with people who reported a mental health problem as would be expected. However 16% of people who reported no mental health problem scored high on the scale, suggesting that people are perhaps not recognising signs and symptoms of mental stressors. A high score on this scale was particularly seen in women in the younger age brackets.

12.14 One further important finding is in the area of social isolation. Females particularly reported high social isolation and particularly younger women. Interestingly, social isolation decreased with age suggesting that older people are more connected with their communities than was expected. This was particularly true in West Somerset where people seemed to experience a significant degree of connection with their community.

12.15 In summary, the results of the 2009 Lifestyle Survey provide useful insights into the changing behaviours of the Somerset population. Whilst the survey used self reported data which can be less accurate than actual measurements, the trends over time that can be drawn from previous Lifestyle Surveys provides useful information on the direction of travel. It is recommended that the Lifestyle Survey continues to be undertaken every five years to build up further knowledge on the changing behaviours of the Somerset population.

12.16 From these findings there are a number of areas of work which require continued or increased focus. These include:

- physical activity
- high calorific diets
- prevention of smoking in children and young people
- alcohol
- awareness of polypharmacy as a risk factor for falling
- knowledge of the effects of the sun and sun protection measures
- mental health, particularly for younger women

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Somerset Health and Wellbeing Partnership

Working together for a healthier Somerset

NHS Somerset

P200001

SOMERSET LIFESTYLE SURVEY 2009

This questionnaire should be answered by the person to whom it was addressed. Please feel free to discuss the questionnaire with other members of your household or friends (and of course, they may fill in the questionnaire on your behalf), but make sure all the answers relate to you.

Please take care to follow any instructions given beside any questions which apply to you.

Please remove the covering letter and return only the questionnaire to us in the FREEPOST envelope we have provided.

Thank you.

Please use BLACK or BLUE ink to complete this survey. Please write clearly.

Where asked to select any boxes, please complete them like this: ☒

If you make a mistake, please completely fill in the box you have chosen, then make the correct selection.

When asked to write in amounts, single numbers can be written in either the left or right hand boxes (there is no need to add in a zero before a single number), for example:

4	

	8

Double figures must be entered as one figure in each box, as in the example below:

2	0

Este folheto está disponível em Português por telefone **01935 385030**

Ta broszura jest dostępna w języku polskim, poprzez kontakt telefoniczny **01935 385030**

Эта листовка доступная в русском языке, по телефону **01935 385030**

为这个通报在广东电话 **01935 385030**

Please turn over

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P200001

FOOD

Q1 Are you following any of these specific diets?
Please select ONE only.

- ☐ Slimming / weight reducing diet
- ☐ Vegetarian / vegan diet
- ☐ Other medical diet
- ☐ Other specific diet
- ☐ No specific diet

Q2 How much salt do you normally use?

(a) Is salt generally used in cooking the foods you eat?
Please select ONE only.

- ☐ Yes
- ☐ No
- ☐ Don't know

(b) Do you add salt to your meals at the table?
Please select ONE only.

- ☐ No
- ☐ When the food is not salty enough
- ☐ Almost always before tasting

Q3 How many portions of the fruit listed below did you eat yesterday?
Please write the amount in figures in the boxes provided below.

- ☐☐ Fresh fruit
- ☐☐ Tinned fruit
- ☐☐ Frozen fruit
- ☐☐ Dried fruit (but not in cakes / puddings)
- ☐☐ Fruit juice
- ☐☐ How many of these portions were citrus fruit? (for example, satsumas, oranges, clementines)

A portion is equivalent to ONE heaped handful of fruit (or ONE small glass of juice)

Q4 How many portions of the vegetables listed below did you eat yesterday?
Do NOT count potatoes. Please write the amount in figures in the boxes provided below.

☐☐	Fresh vegetables (including salad vegetables, mushrooms)
☐☐	Baked beans
☐☐	Frozen vegetables
☐☐	Tinned vegetables
☐☐	Dried vegetables (including lentils, but NOT potatoes)
☐☐	Vegetable juice (for example, V8, carrot juice)
☐☐	How many of the above portions were leafy vegetables? (for example, broccoli, cabbage or salad vegetables)

A portion is equivalent to ONE heaped handful of vegetables (or ONE small glass of juice)

Q5 Would you say that yesterday was fairly typical of the fruit and vegetables that you usually eat?
Please select ONE only.

- ☐ No, I usually eat quite a lot more fruit and vegetables than this
- ☐ Not really, I usually eat a little more fruit and vegetables than this
- ☐ Yes, yesterday was a fairly typical day
- ☐ Not really, I usually eat a little less fruit and vegetables than this
- ☐ No, I usually eat a lot less fruit and vegetables than this

Q6 How many times a week do you use the following cooking methods?
Please write the amount in figures in the boxes provided below.

☐☐ Boiling	☐☐ Frying	☐☐ Roasting
☐☐ Grilling	Poaching	Microwaving
☐☐ Steaming	Slow cooking	Baking

If you do not cook, please select this box:

☐ I do not cook

Q7 What type of butter or spread do you use most often?
Please select ONE only.

☐ Butter	☐ Low-fat spread	☐ Other
☐ Margarine	☐ Extra-low fat spread	☐ I do not use butter / spread

If you selected "Other", please give details:

Please turn over

Q8 What kind of milk do you use most often?
Please select ONE only.

- ☐ Full-fat milk
- ☐ Semi-skimmed milk
- ☐ Skimmed milk
- ☐ Soya milk
- ☐ Other milk (for example, evaporated or condensed)
- ☐ I do not use milk

Q9 How many times in a typical week do you eat the following foods?
Please estimate for a normal week and write the amount in figures in the boxes provided below.

- ☐☐ Shop bought pre-packed sandwiches
- ☐☐ Fast food outlet (for example, McDonalds, Burger King, KFC)
- ☐☐ Takeaway food (for example, Chinese, Indian, Thai, pizza, fish & chips, kebab)
- ☐☐ Cafe or canteen meals (for example, workplace)
- ☐☐ Restaurant meals
- ☐☐ Pub meals

If you do not eat any of these foods, please select this box:

☐

Q10 Some manufacturers are now putting information about the amount of salt, fat and sugar contained in foods, by using red, orange and green on the front of packaging to identify levels. Have you noticed this?
Please select ONE only.

- ☐ Yes
- ☐ No

(a) If you selected "Yes", did it help in making your choice?
Please select ONE only.

- ☐ Yes
- ☐ No

Please turn over

PHYSICAL ACTIVITY

Q11 Physical Activity

Please think carefully about your physical activity at home, at work and during free time over the last four weeks.

During an average week (a full seven days) how many times a week do you usually do the following activities for more than 15 minutes?

Please write your answers in the boxes provided below.

Number of times per week

Strenuous activity:
Sport / exercise / hard manual labour

For example: jogging, running, squash, vigorous swimming, football, hockey, heavy lifting and carrying, shovelling and pushing heavy objects

Number of times per week

Moderate activity:
Physical recreation / leisure activities / manual work

For example: fast walking, tennis, easy cycling, disco dancing, easy swimming, lifting and carrying medium weight objects, working with a pneumatic drill, hammering and sawing

Number of times per week

Mild activity:
Physical hobbies / light recreation

For example: easy walking, bowling, golf, scrubbing floors and walls, stocking shelves and chopping wood

Please turn over

HOME SAFETY

Q12 Do you have a working smoke alarm in your home?
Please select ONE only.

- ☐ Yes, I have a working smoke alarm
- ☐ I have a smoke alarm but it is not working
- ☐ No, I do not have a smoke alarm

Q13 If you have a child under three years old in your home, do you use a fireguard?
Please select ONE only.

- ☐ I don't have a child under three years old (go to question 15)
- ☐ Yes - the fireguard is secured to the fireplace
- ☐ Yes - the fireguard is not secured to the fireplace
- ☐ I do not have a fireguard
- ☐ I do not have an open fire

Q14 If you have a child under three years old in your home, do you have a stair gate fitted?
Please select ONE only.

- ☐ Yes, I have a stair gate fitted
- ☐ No, I do not have a stair gate fitted
- ☐ I do not have stairs

Q15 Have you fallen over in your home, garden or a public place in the last 12 months?
Please select ONE only.

- ☐ No
- ☐ Yes, and I went to my GP or hospital
- ☐ Yes, but I did not go to my GP or hospital

Please ensure you answer (a), (b), (c) and (d) below, even if you selected "No" above.

		Yes	No
(a)	Do you take four or more different medications per day?	☐	☐
(b)	Do you have a diagnosis of stroke or Parkinson's Disease?	☐	☐
(c)	Do you have any problems with your balance?	☐	☐
(d)	Are you able to rise from a chair of knee-height without using your arms?	☐	☐

Please turn over

SMOKING

Q16 Have you ever smoked at all?
(Including manufactured cigarettes, hand-rolled cigarettes, pipes and cigars)

- ☐ Yes
- ☐ No, never (go to question 23)

Q17 Do you currently smoke?
Please select ONE only.

- ☐ Yes
- ☐ No, but I was a regular smoker in the past (go to question 23)
- ☐ No, I was never a regular smoker (to go question 23)

Q18 Which of the following products do you smoke?
Please select ALL that apply.

- ☐ Manufactured cigarettes (answer part (a) below)
- ☐ Hand-rolled cigarettes (answer part (b) below)
- ☐ Cigars
- ☐ Pipes

(a) Approximately how many manufactured cigarettes do you smoke each day?
Please select ONE only.

- ☐ 10 a day or less
- ☐ Between 11 and 20 a day
- ☐ Between 21 and 30 a day
- ☐ 31 or more a day

(b) Approximately how much tobacco in hand-rolled cigarettes do you smoke in a week?
Please select ONE only.

- ☐ 20 grams a day or less
- ☐ 21 - 40 grams
- ☐ 41 - 60 grams
- ☐ 61 - 80 grams
- ☐ 81 - 100 grams
- ☐ 100 grams or more

Q19 In general, how soon after waking up do you have your first cigarette, pipe or cigar of the day?
Please select ONE only.

- ☐ 5 minutes or less
- ☐ 6 - 30 minutes
- ☐ 30- 60 minutes
- ☐ More than 60 minutes

Please turn over

Q20 How do you feel about smoking and your health?
Please select ONE only.

- ☐ Contented smoker
- ☐ Concerned smoker
- ☐ Planning to stop
- ☐ In the process of stopping

Q21 Have you ever tried to give up smoking?
Please select ONE only.

- ☐ Never (go to question 23)
- ☐ Once
- ☐ Twice
- ☐ 3 - 5 times
- ☐ More than 5 times

Q22 If you have tried to stop, have you received support from any of the following?
Please select ALL that apply.

- ☐ Support from a health professional
- ☐ Support from friends / relatives
- ☐ Support from a telephone helpline
- ☐ Self-help books / leaflets
- ☐ Websites / Forums
- ☐ I did not use support

Q23 Do other people smoke in your home?
Please select ALL that apply.

- ☐ Yes, my spouse / partner
- ☐ Yes, other members of the household
- ☐ Yes, visiting friends and / or relatives
- ☐ No (go to question 24)

(a) Where does smoking take place within your household?
Please select ALL that apply.

- ☐ In living room(s)
- ☐ In bedroom(s)
- ☐ In the garden
- ☐ In the kitchen
- ☐ In the car

Q24 How many children aged eight years old and under live in your house?
Please select ONE only.

- ☐ None
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ More than 4

Please turn over

SUN EXPOSURE

Q25 How often do you do the following:
Please select ONE box on each line.

	Never	Sometimes	Most of the time	Always
Stay inside during the middle of the day (11 am - 3 pm)	☐	☐	☐	☐
Wear a hat to prevent sunburn	☐	☐	☐	☐
Cover up with clothing to prevent sunburn	☐	☐	☐	☐
Use sunscreen	☐	☐	☐	☐
Wear sunglasses	☐	☐	☐	☐

Q26 How often do you use a sunbed or tanning booth?
Please select ONE only.

- ☐ Once a week
- ☐ Once a month
- ☐ Once a year
- ☐ I have used them in the past but no longer do so
- ☐ I have never used a sunbed or tanning booth

Q27 Do you agree or disagree with the following statements?
Please select ONE box only on each line.

	Agree	Disagree	Don't know
A tan is healthy	☐	☐	☐
A tan is attractive	☐	☐	☐
A tan is less fashionable than it used to be	☐	☐	☐
There is little chance I will get skin cancer	☐	☐	☐
It is safe to get sunburnt once or twice a year	☐	☐	☐
You can get sunburnt on cloudy days	☐	☐	☐
Tanning beds are safer than the sun	☐	☐	☐
Getting a suntan is a safe way to protect skin from sun damage	☐	☐	☐
Sun exposure during childhood is related to skin cancer in adulthood	☐	☐	☐
A sunscreen with an SPF of 30 provides twice the protection of a sunscreen with an SPF of 15	☐	☐	☐

Q28 Which of the following do you think are potential signs of skin cancer?
Please select ONE box only on each line.

	Yes	No	Don't know
A sore that doesn't heal	☐	☐	☐
A change in the appearance of a mole	☐	☐	☐
A freckle that has changed in shape or size	☐	☐	☐
A mole or sore that itches or hurts	☐	☐	☐
A mole that bleeds	☐	☐	☐

Please turn over

ALCOHOL

Q29 Do you ever have a drink that contains alcohol?
Please select ONE only.

- ☐ No, never (go to question 34)
- ☐ Only on special occasions (for example, anniversaries, birthdays)
- ☐ More often than just on special occasions but not as much as once a week
- ☐ Once a week or more

Please think carefully about the alcoholic drinks you have consumed over the last seven days.

Q30 Please write in the number of each type of alcoholic drink you have had over the last seven days. Please do not use "halves".

Indicate here if you did not have any alcohol in the past seven days.

☐ No alcohol

If you did not have one particular type of drink, please leave the boxes blank - there is no need to put zero (0) in every box.

Pints / Cans / Bottles of shandy or low alcohol drinks

Mon	Tues	Weds	Thurs	Fri	Sat	Sun

Pints / Cans / Bottles of ordinary strength beer, lager, cider etc (alcohol content below 5%)

Mon	Tues	Weds	Thurs	Fri	Sat	Sun

Pints / Cans / Bottles of strong beer, lager, cider etc (alcohol content above 5%)

Mon	Tues	Weds	Thurs	Fri	Sat	Sun

Bottles / Cans of alcopops (for example, WKD)

Mon	Tues	Weds	Thurs	Fri	Sat	Sun

Glasses of sherry, vermouth (50ml glass)

Mon	Tues	Weds	Thurs	Fri	Sat	Sun

Glasses of wine (175 ml glass)

Mon	Tues	Weds	Thurs	Fri	Sat	Sun

Single measures of spirits / liqueurs (25 ml)

Mon	Tues	Weds	Thurs	Fri	Sat	Sun

Please turn over

Q31 Would you say that last week was fairly typical of the alcohol you usually drink in a week? Please select ONE only.

- ☐ No, I normally drink quite a lot more alcohol than this
- ☐ Not really, I normally drink a little more alcohol than this
- ☐ Yes, this was a fairly typical week
- ☐ Not really, I normally drink a little less alcohol than this
- ☐ No, I normally drink quite a lot less alcohol than this

Q32 How often do you have eight (men) / six (women) or more drinks on one occasion? Please select ONE only.

- ☐ Never (go to question 33)
- ☐ Less than monthly (go to question 33)
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

Only answer parts (a), (b) and (c) below if your answer to Q32 is monthly, weekly, daily or almost daily.

(a) How often in the last 12 months have you not been able to remember what happened when drinking the night before?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

(b) How often in the last 12 months have you failed to do what was expected of you because of drinking?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

(c) Has a relative, friend, doctor or health worker been concerned about your drinking or advised you to cut down?

- ☐ No
- ☐ Yes, but not in the last 12 months
- ☐ Yes, during the last 12 months

Q33 How do you feel about your current level of drinking? Please select ONE only.

- ☐ Content with current level
- ☐ Would like to cut down

Please turn over

P200001

GENERAL HEALTH

We should like to know if you have had any medical complaints, and how your health has been in general, over the past few weeks. Please answer ALL the questions by selecting the answer that applies most closely to you. Remember that we want to know about your present and recent complaints, not problems that you may have experienced in the past. It is important that you try to answer ALL the questions.
Please select ONE box only for each question.

Q34 Have you recently:

(a) been able to concentrate on whatever you are doing?	Better than usual ☐	Same as usual ☐	Less than usual ☐	Much less than usual ☐
(b) lost much sleep over worry?	Not at all ☐	No more than usual ☐	Rather more than usual ☐	Much more than usual ☐
(c) felt that you are playing a useful part in things?	More so than usual ☐	Same as usual ☐	Less useful than usual ☐	Much less than usual ☐
(d) felt capable of making decisions about things?	More so than usual ☐	Same as usual ☐	Less so than usual ☐	Much less capable ☐
(e) felt constantly under strain?	Not at all ☐	No more than usual ☐	Rather more than usual ☐	Much more than usual ☐
(f) felt that you couldn't overcome your difficulties?	Not at all ☐	No more than usual ☐	Rather more than usual ☐	Much more than usual ☐
(g) been able to enjoy your normal day to day activities?	More so than usual ☐	Same as usual ☐	Less so than usual ☐	Much more than usual ☐
(h) been able to face up to your problems?	More so than usual ☐	Same as usual ☐	Less able than usual ☐	Much less able ☐
(i) been feeling unhappy and depressed?	Not at all ☐	No more than usual ☐	Rather more than usual ☐	Much more than usual ☐
(j) been losing confidence in yourself?	Not at all ☐	No more than usual ☐	Rather more than usual ☐	Much more than usual ☐
(k) been thinking of yourself as a worthless person?	Not at all ☐	No more than usual ☐	Rather more than usual ☐	Much more than usual ☐
(l) been feeling reasonably happy, all things considered?	More so than usual ☐	About the same as usual ☐	Less so than usual ☐	Much less than usual ☐

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Please turn over

FAMILY AND FRIENDS

We would now like you to think about your family and friends. By "family" we mean those who live with you, as well as those elsewhere.

Here are some comments people have made about their family and friends. We would like you to say how much each statement is true for you.

Q35 I know people who:
Select the box which most applies to you on each line.

	None of the time	Rarely	Some of the time	Often	All of the time
do things to make me happy	☐	☐	☐	☐	☐
accept me just as I am	☐	☐	☐	☐	☐
make me feel loved	☐	☐	☐	☐	☐
make me feel an important part of their lives	☐	☐	☐	☐	☐
would see that I am taken care of if I needed to be	☐	☐	☐	☐	☐
give me support and encouragement	☐	☐	☐	☐	☐

Q36 In the past few weeks, have any of the following applied to you?
Select the box which most applies to you on each line.

	None of the time	Rarely	Some of the time	Often	All of the time
It has been easy to relate to others	☐	☐	☐	☐	☐
I felt isolated from other people	☐	☐	☐	☐	☐
I had someone to share my feelings with	☐	☐	☐	☐	☐
I found it easy to get in touch with others when I needed to	☐	☐	☐	☐	☐
Others felt they had to help me	☐	☐	☐	☐	☐
When with other people, I felt separate from them	☐	☐	☐	☐	☐
I felt alone and friendless	☐	☐	☐	☐	☐

Please turn over

ABOUT YOURSELF

Q37 Are you male or female?
Please select ONE only.

☐ Male ☐ Female

Q38 How old were you on 1 July 2009?

☐☐ Age in years

Q39 What is your ethnic group?
Choose ONE from (a) to (e), then select the box which shows your ethnic group.

(a) White

☐ English / Welsh / Scottish / Northern Irish / British
☐ Gypsy or Irish Traveller
☐ Irish
☐ Any other white background

If you marked "Any other white background", please give details:

(b) Mixed / multiple ethnic groups

☐ White and Black Caribbean
☐ White and Asian
☐ White and Black African
☐ Any other mixed background

If you marked "Any other mixed background", please give details:

(c) Asian or Asian British

☐ Indian
☐ Pakistani
☐ Any other Asian background
☐ Bangladeshi
☐ Chinese

If you marked "Any other Asian background", please give details:

(d) Black / African / Caribbean / Black British

☐ African
☐ Caribbean
☐ Any other Black / African / Caribbean background

If you marked "Any other Black / African / Caribbean background", please give details:

(e) Other ethnic group

☐ Arab
☐ Any other ethnic background

If you marked "Any other ethnic background", please give details:

Please turn over

FORMAL EDUCATION AND EMPLOYMENT

Q40 What is the highest level of education you have completed?
Please select ONE only.

- ☐ Still in full-time education
- ☐ Primary school
- ☐ Secondary school (or up to age 14, 15 or 16 years)
- ☐ Sixth form/further education (or up to 17 or 18 years)
- ☐ Professional or technical qualification after leaving school (for example, NVQ, BTEC)
- ☐ University / polytechnic degree course or higher
- ☐ Other

If you selected "Other", please give details:

Q41 What is your economic status?
Include any paid work, including casual or temporary work, even if only for one hour.
Please select ALL that apply.
Are you currently:

- ☐ Working as a paid employee
- ☐ On a Government-sponsored training scheme
- ☐ Self-employed or freelance
- ☐ On maternity leave
- ☐ Not in paid employment (previously employed)
- ☐ Not in paid employment (never worked) (go to question 46)
- ☐ Unemployed (previously employed)
- ☐ Unemployed (never worked) (go to question 46)
- ☐ Retired (less than two years ago)
- ☐ Retired (more than two years ago) (go to question 46)

Employment Status / Size of Organisation

The following questions refer to your current main job, or (if you are NOT working) to your last main job.
Please select only ONE box per question.

Q42 Do (did) you work as an employee or are (were) you self-employed?
Please select ONE only.

- ☐ Employee
- ☐ Self-employed with employees
- ☐ Self-employed / freelance without employees (go to question 45)

Please turn over

Q43 Number of employees
Please select ONE only.

For employees: indicate below how many people work (worked) for your employer at the place where you work (worked)

For self-employed: indicate below how many people you employ (employed)

☐ 1 to 24 ☐ 25 or more

Q44 Supervisory Status
Please select ONE only.

Do (did) you supervise any other employees?
A supervisor or foreman is responsible for overseeing the work of other employees on a day-to-day basis

☐ Yes ☐ No

Q45 Occupation

Please select ONE box to show which best describes the sort of work you do, or did.

If you are not working now, please select the box which best describes what you did in your last job.

☐ 1 Modern professional occupations
(such as: teacher, nurse, physiotherapist, social worker, welfare officer, artist, musician, police officer (Sergeant or above), software designer)

☐ 2 Clerical and intermediate occupations
(such as: secretary, personal assistant, clerical worker, office clerk, call centre agent, nursing auxilliary, nursery nurse)

☐ 3 Senior managers or administrators
Usually responsible for planning, organising and co-ordinating work and for finance
(such as: finance manager, chief executive)

☐ 4 Technical and craft occupations
(such as: motor mechanic, fitter, inspector, plumber, printer, tool maker, electrician, gardener, train driver)

☐ 5 Semi-routine and manual occupations
(such as: postal worker, machine operative, security guard, caretaker, farm worker, catering assistant, receptionist, sales assistant)

☐ 6 Routine manual and service occupations
(such as: HGV driver, van driver, cleaner, porter, packer, sewing machinist, messenger, labourer, waiter/waitress, bar staff)

☐ 7 Middle or junior managers
(such as: office managers, retail manager, bank manager, restaurant manager, warehouse manager, publican)

☐ 8 Traditional professional occupations
(such as: accountant, solicitor, medical practitioner, scientist, civil / mechanical engineer)

Please turn over

PERSONAL HEALTH

Q46 What is your height?

Feet ☐ and Inches ☐☐ OR Metres ☐ and Centimetres ☐☐

Q47 What is your weight?

Stones ☐☐ and Pounds ☐☐ OR Kilograms ☐☐☐

Q48 Which of the following do you feel best describes you?
Please select ONE only.

- ☐ I am underweight
- ☐ I am about the right weight
- ☐ I am a little overweight
- ☐ I am very overweight
- ☐ I am not sure about my weight

Q49 Have you had your blood pressure measure in the last five years?
Please select ONE only.

- ☐ Yes
- ☐ No
- ☐ Not sure

Q50 Have you ever been told by a doctor that you have, or have had, any of the following?
Please select ONE box only on each line.

	Yes	No	Not sure
Angina	☐	☐	☐
High cholesterol level	☐	☐	☐
High blood pressure	☐	☐	☐
Diabetes	☐	☐	☐
Stroke	☐	☐	☐
Heart attack (coronary thrombosis, myocardial infarction)	☐	☐	☐

Q51 Do you consider yourself to have any of the following disabilities?
Please select ALL that apply to you.

- ☐ Physical disability
- ☐ Learning disability
- ☐ Visual impairment
- ☐ Hearing impairment
- ☐ Speech impairment
- ☐ Mental health problem
- ☐ No disabilities

Please turn over

Q52 Lastly, if you have any further comments you would like to make, please use the space provided below:

If you are concerned about your health, please contact your GP.

Please return the questionnaire to us in the FREEPOST envelope provided.

Thank you for taking the time to complete the Somerset Lifestyle Survey.