LIFECOURSE TRACKER

Wave 1 Spring 2012: Interim summary report

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1 Overview and main messages

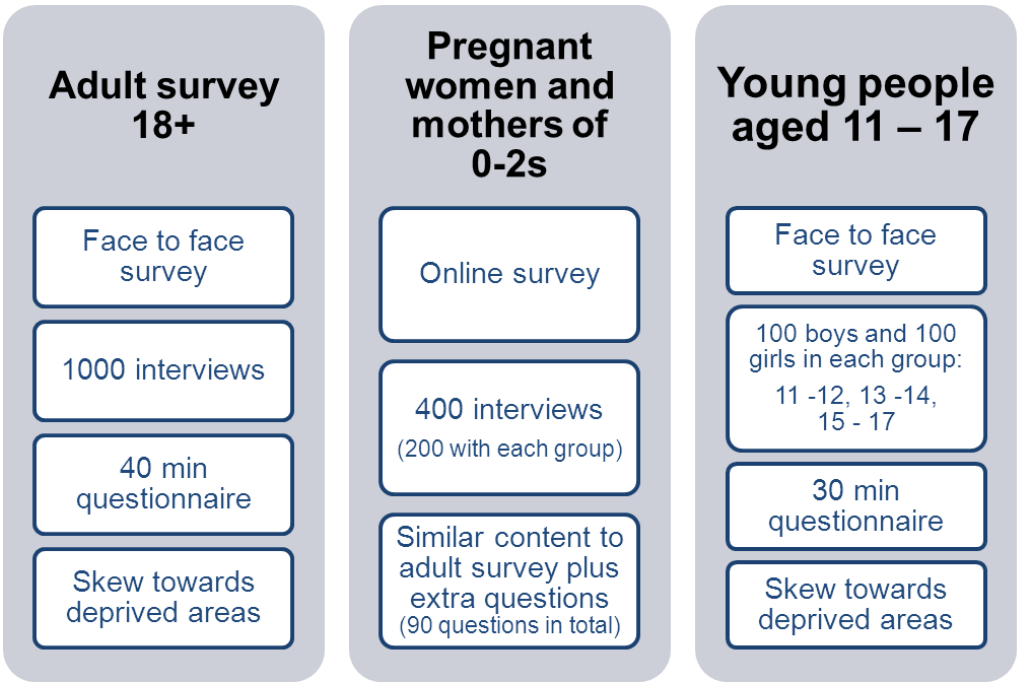
This report is based on the first of a series of bi-annual surveys which aim to feed into the evaluation of the Department of Health (DH) Social Marketing strategy. The surveys will track core health behaviours, their interactions and influences, and how these vary across lifecourses.

The March 2012 survey forms a baseline against which changes over time and seasonal variations can be assessed.

1.1 Summary of research methods

The following figure summarises the methods used to conduct the survey; the survey has been scheduled to run twice a year.

Figure 1. Summary of the Lifecourse tracker research methods



1.2 Overview of findings

Core behavioural indicators were selected for each target group in conjunction with the relevant policy teams to reflect policy priorities. One core indicator was selected to represent each behaviour for longer term tracking but other behavioural characteristics were also measured. For instance, fruit and veg consumption was the core indictor, or proxy, for nutritional behaviour but consumption levels of sugar, fat and fizzy drinks were also measured in the survey.

Behavioural indicators and prevalences are shown in Figure 2.

Figure 2. Summary table of core behavioural indicators (%s highlighted in bold)

	All adults	Pregnant women	Mums of 0-2s	11-17s
Nutrition	23% ate 5 or more portions of fruit/veg yesterday (**77%** did not)	27% ate 5 or more portions of fruit/veg yesterday (**73%** did not)	15% ate 5 or more portions of fruit/veg yesterday (**85%** did not)	28% ate fruit/veg several times a day in a normal week (**72%** did not)
Physical activity	47% did at least 150 active minutes last week (**53%** did not)	n/a	23% did at least 150 active minutes last week (**77%** did not)	32% had been moderately active every day last week (**68%** had not)
Tobacco	**23%** were cigarette smokers	**4%** were cigarette smokers	**16%** were cigarette smokers	**9%** smoke regularly
Alcohol	**16%** were increasing/higher risk drinkers[1]	**9%** had drunk alcohol last week	**32%** had drunk alcohol last week	**23%** drink alcohol at least once a month
Drugs	**7%** had used illegal drugs/legal highs in the past 12 months	**4%** had used illegal drugs/legal highs in the past 12 months	**1%** had used illegal drugs/legal highs in the past 12 months	**8%** had used cannabis, ecstasy or cocaine in the last 12 months
Sexual behaviour	**8%** of under 55s had had unprotected sex with a new/ multiple partners in the past 6 months	n/a	n/a	**14%** had had intercourse

[1] Defined as those who drank more than 21 units (men) / 14 units (women) of alcohol in the last week

1.3 Clustering of unhealthy behaviours

Almost all adults reported at least one negative health behaviour, and over a fifth reported three or more negative health behaviours (out of a possible six). The largest overlap was between nutrition and physical activity although smoking correlated with some behaviours as well.

1.4 Patterns in response

Health behaviours appear to be influenced by lifecourse.

Changes in lifecourse appear to trigger behaviour change:

- Getting older: Prevalence of risk behaviours (e.g. smoking and drug use) increases strongly between ages 15-17, and peaks at age 18-35. Thereafter prevalence tails off quickly. However, the youngest (18-24s) and oldest age groups (75s+) were least likely to be active or eat 5 a day
- Moving in with a partner: Those living with a partner tended to report fewer negative behaviours, even when age is taken into account
- Becoming a parent: Parenthood appears to be a trigger for a range of positive changes to health behaviour, in particular giving up smoking, cutting back on alcohol and improving diet. However, these changes may not always be sustained after becoming a parent.

Social/demographic status and household factors were the most important influences on health.

Those in C2DE[2] households, in deprived areas and with lower levels of education tended to report more negative health behaviours. Household environment was also important, with those living with a smoker, drinker or drug user more likely to report those negative health behaviours themselves.

Mindset and attitudes were less important than social/demographic status or household factors in driving health behaviour.

Norms appear to be a key factor influencing behaviour for all groups.

Those perceiving that healthy lifestyles are the norm for their friends/family tend to report more positive health behaviours. Healthy norms were more prevalent amongst older people (55+s) and ABC1s.

Stopping smoking was acknowledged as the norm by a majority of adults but fewer thought that cutting back alcohol was the norm. Increasing/higher risk drinkers were the least likely

[2] This is a social grade grouping and is based on the occupation of the chief income earner. For more details please see 6.4.2

to think that cutting back alcohol was the norm, and were the most likely to think that daily drinking was acceptable.

A relatively high proportion of 18-24s (47%) thought that most young people of their age take drugs nowadays, and those thinking that drug use is more common were more likely to take drugs themselves.

Norms were particularly influential in driving behaviours for 11-17s: those perceiving risky behaviours to be common amongst their peer group or perceiving those engaging in risky behaviours to be popular or clever were more likely to report risky behaviours themselves.

In addition, pregnant women and mums of 0-2s who felt that breastfeeding was the norm were more likely to intend to try breastfeeding, or to breastfeed exclusively beyond 6 weeks.

Intentions to change.

Intentions to make healthy changes were strongest for activities which involve doing more 'good' things (like eating more fruit/veg or increasing the number of weekly active minutes) as opposed to doing fewer 'bad' things (like stopping smoking or cutting down on drinking). These patterns were evident across all lifecourse groups.

2 Adults aged 18+

2.1 The adult Lifecourse Tracker survey

The adult survey collected data from a nationally representative sample of 1,010 adults aged 18+ in England, with the sample selected using random location sampling. Interviews were conducted in-home face to face using Computer Assisted Personal Interviewing (CAPI); the most sensitive questions were asked using self-completion methods to encourage honesty. Further technical details can be found in the appendices (section 6).

At the same time, additional surveys were conducted amongst young people (11-17) and pregnant women and mums of babies under 24 months. Details of these survey methods are shown later in this report.

2.2 Negative health behaviours amongst adults today

While a range of health behaviours was measured, six core indicators were selected in conjunction with the policy teams.

Indicators represented **negative** health behaviours (Figure 3). These indicators were self-reported, i.e. based on respondents' reports of their own behaviour.

Figure 3. Behavioural indicators

Behaviour	Indicator
Nutrition	Fewer than 5 portions fruit/veg yesterday
Physical activity	Less than 150 active minutes (to a point where breathing faster than usual) last week
Smoking	Currently smokes cigarettes
Alcohol consumption	Increasing/higher risk drinkers: drank more than 21 units (men) / 14 units (women) last week
Drug use	Used illegal drugs/legal highs in the past 12 months
Unprotected sex	Had unprotected sex with new or multiple partners in the past 6 months

The behaviours were analysed in conjunction with many factors, including lifecourse.

Lifecourse was classified based on respondent age, presence of a partner or presence of children. Where 'parents' are referred to in this report these are parents of 0-16 year olds who live in the household.

It should be noted that for some lifecourse groups, such as parents aged 45-54, a larger sample size is required to be more conclusive about their results. Patterns detected at this wave will be monitored at future waves and data will be combined across waves to enable more robust analysis.

There are signficant behavioural challenges to overcome.

Almost all (92%) of adults reported at least one negative health behaviour, and over a fifth (22%) reported 3 or more negative health behaviours (out of a possible 6).

Figure 4. Behavioural challenges

77% ate fewer than 5 portions of fruit/veg yesterday	**53%** did less than 150 active minutes last week
23% were cigarette smokers	**16%** were increasing/higher risk drinkers
7% had used illegal drugs or legal highs in the past 12 months	**8%** of under 55s had had unprotected sex with a new partner/multiple partners in the past 6 months

Base: All respondents (1010)

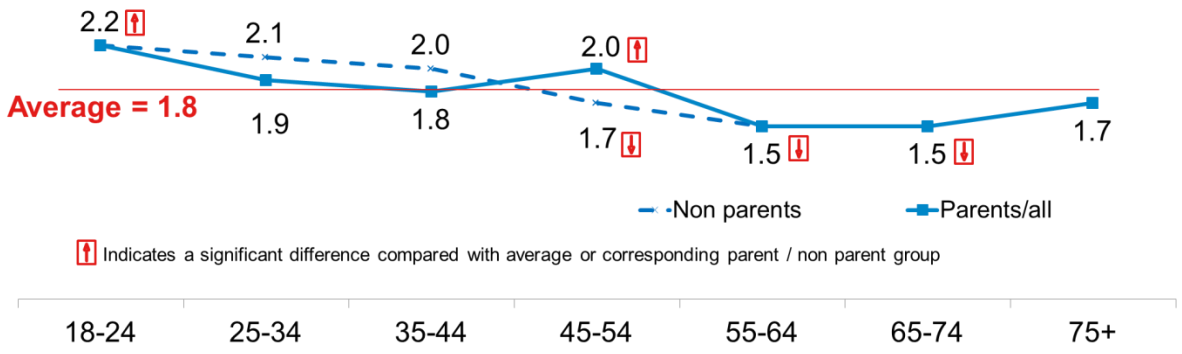
2.3 The impact of lifecourse on behaviour

Health behaviours appear to be influenced by lifecourse. Significant differences were noted between lifecourse groups in prevalence and number of negative health behaviours. Figure 3 shows the mean average number of negative health behaviours reported by the different lifecourse groups.

Changes in lifecourse appear to trigger behaviour change.

- **Getting older.** Older people tended to report fewer negative health behaviours than younger people (although poorer nutrition behaviours and lower levels of activity amongst over 75s increases the number of negative health behaviours reported for this group)
- **Becoming a parent.** Parents tended to report fewer negative behaviours than non parents of a similar age, and the survey of pregnant women and mums of young babies (see Section 4) shows that pregnancy and parenthood are triggers for behaviour change. However, for parents aged 45-54 there appears to be an increase in the number of reported negative health behaviours: though the small base size should be noted (53) and will be monitored at future waves to see if the trend continues
- **Moving in with a partner.** Those living with a partner tended to report fewer negative behaviours, even when age is taken into account.

Figure 5. Mean average number of negative health behaviours reported (out of 6)



Base: All respondents (1010)

The largest overlap between negative health behaviours was between nutrition and physical activity, though smoking was correlated with other risk behaviours, especially amongst C2DEs.

Four in ten (42%) adults reported that they had not eaten 5 portions of fruit/veg yesterday AND had not done 150 active minutes last week. The strongest overlap between these two behaviours was amongst C2DEs (48% v 38% of ABC1s).

In the total adult population (i.e. all adults regardless of lifecourse, social grade etc.), smoking and illegal drug/legal high use were significantly correlated. While a minority of smokers were drug users (20%), over two thirds (69%) of users of illegal drugs/legal highs were smokers. However, the prevalence of both these behaviours is very low: 5% of all adults did both of these things.

Smoking was more likely to be correlated with other negative health behaviours amongst C2DEs, perhaps reflecting the higher smoking prevalence amongst this social group. In particular, smoking was correlated with increasing/higher risk alcohol consumption and not getting 5 portions of fruit/veg a day. These associations were not as strong amongst ABC1s.

Social grade, demographics and household factors were also strongly associated with negative health behaviours.

The Lifecourse Tracker findings echo those of the Marmot Review[3] in indicating that behaviours vary significantly based on social gradient as measured by

- Social grade - C2DEs were more likely to report risk behaviours
- Education - lower levels of education were correlated with risk behaviours
- Locality – those living in more deprived areas[4] tended to report more negative health behaviours
- In addition to wider environmental factors, household environment was also important, as those living with negative influences in the household (e.g. smokers, heavy drinkers, drug users) were more likely to report those negative health behaviours themselves.

[3] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[4] Deprivation: based on Index of Multiple Deprivation (IMD), which measures relative levels of deprivation by location. As well as income deprivation it includes other measures such as housing and education deprivation.

Attitudes were less influential than demographics or situational factors on health behaviours, though some associations with these were still significant.

Specific views on health had more of an influence on behaviours than more general mindset (e.g. self-confidence, anxiety). In particular, not recognising the harms of smoking and alcohol were associated with those behaviours.

There were some associations between mindset and specific behaviours amongst 18-24s, non parents and 55+s (Figure 6). Note that, unless indicated, behaviours correlated at an all adult sample level.

Figure 6. Associations between attitudes/mindset and health behaviours

Attitude	Which negative behaviours correlated with
Health/behaviour related views	
Thinking that healthy lifestyles are not the norm	Physical activity and smoking
Self-positivity (not seeing link between own behaviour and longer term health)	Drugs, for 18-24s Smoking, for 25-54s Nutrition and physical activity, for non parents and 55+s
Health fatalism (thinking if a person is meant to get ill, they will get ill anyway, regardless of whether they lead a healthy lifestyle)	Physical activity and smoking
Feeling that the health risk from smoking is greatly exaggerated	Smoking, for all lifecourse groups
Disagreeing that regularly drinking can slowly damage your body	Alcohol
Mindset	
Feel there is little I can do to change my life	Physical activity and nutrition, for 18-24 year old girls
Anxiety	Smoking and physical activity, for 18-24s
Risk taking	Drug use for 18-24s and non parents
How happy felt yesterday	Physical activity, for 55+s

2.4 Norms, concerns and intentions to change

Norms are a key factor influencing health behaviours.

The perception of a healthy lifestyle as the 'norm' is associated with positive health behaviours. Figure 7 illustrates this.

Figure 7. Impact of positive norms on health behaviour

Amongst those who said that all or most of their friends/family lead a healthy lifestyle nowadays, 52% reported doing at least 150 weekly active minutes (compared with 37% of those who said none/few lead a healthy lifestyle)

95% of those who said that all or most of their friends/family lead a healthy lifestyle nowadays had not used drugs in the past 12 months (compared with 88% of those who said none/few lead a healthy lifestyle)

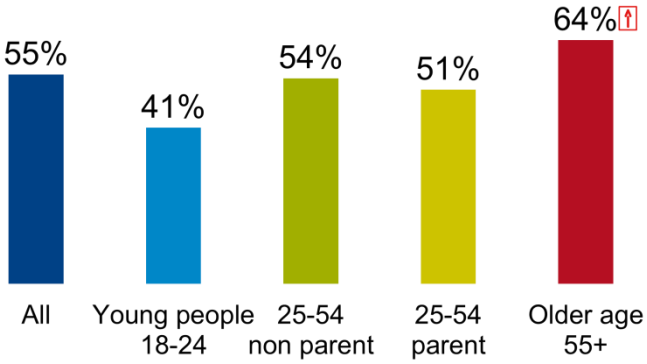
81% of those who said that all or most of their friends/family lead a healthy lifestyle nowadays were non-smokers (compared with 63% of those who said none/few lead a healthy lifestyle)

Base: All respondents (1010)

Older people were more likely to think that leading a healthy lifestyle was the 'norm'.

Just over half of adults said that all or most of their friends and family lead a healthy lifestyle, but older respondents were more likely than younger people to consider leading a healthy lifestyle to be the norm. Two fifths of 18-24s said that all or most of their friends and family lead a healthy lifestyle, compared with almost two thirds of over 55s (Figure 8).

Figure 8. % saying all or most of their friends and family lead a healthy lifestyle nowadays



indicates significant difference compared with young people

Base: All respondents (1010)

Healthy norms were more prevalent amongst ABC1s than C2DEs.

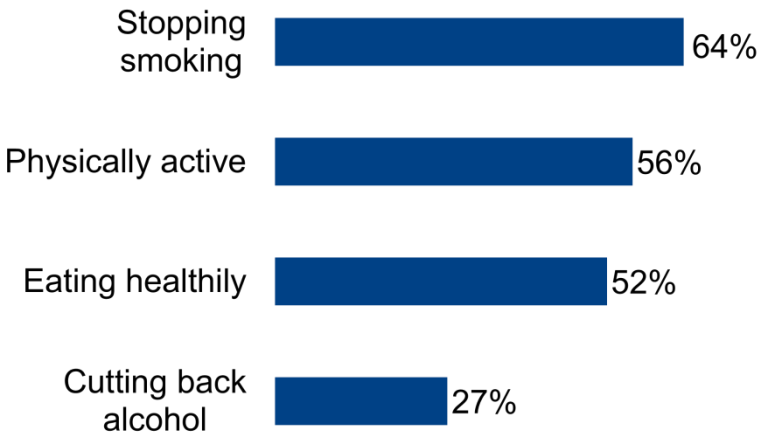
61% of ABC1s said that all or most of their friends and family lead a healthy lifestyle, compared with 48% of C2DEs.

While stopping smoking was acknowledged as the norm by a majority of adults, fewer thought that cutting back on alcohol was the norm.

Two thirds agreed that more people are stopping smoking nowadays, and over half thought that most of the people they know are being physically active and/or eating healthily nowadays (Figure **9**).

However, reducing alcohol consumption was much less likely to be considered common: a quarter agreed that more people are cutting back on alcohol nowadays.

Figure 9. % agreeing that more/most of the people I know are … nowadays



Base: All respondents (1010)

Healthy behaviours were less likely to be the norm for 18-24s.

18-24s were less likely than average to agree that more people are stopping smoking nowadays (39%), eating healthily (27%) or cutting back on alcohol (15%).

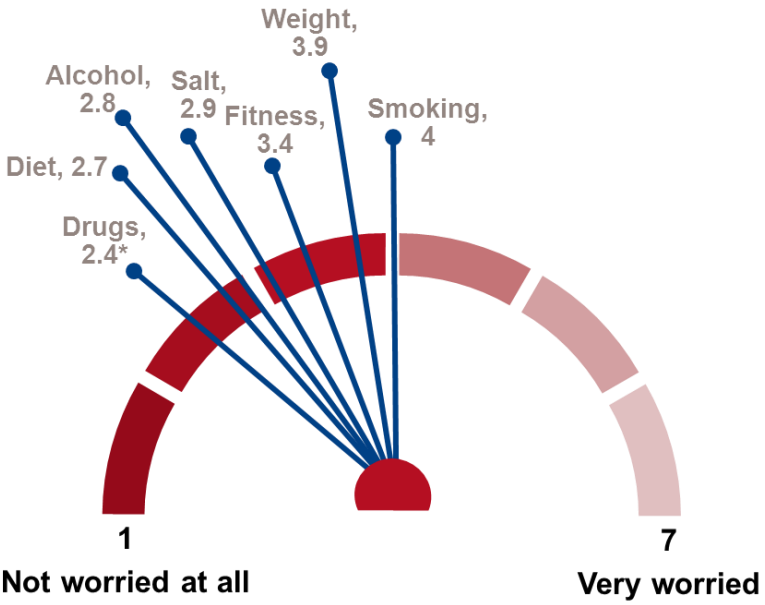
Drug use is perceived to be fairly common amongst 18-24s.

Half (47%) of 18-24s thought that most people of their age take drugs nowadays, but this far outweighs actual drug use with 18% of 18-24s reporting having personally used any illegal drugs/legal highs in the past 12 months.

Smokers were most likely to worry about the impact of smoking on their health, but drug users and heavy drinkers were less likely to worry.

Respondents reporting each negative health behaviour were asked how worried they were about the impact of that behaviour on their health. They answered on a scale of 1 (not worried at all) to 7 (very worried). Figure 10 shows the average worry scores for those reporting each negative behaviour.

Figure 10. Average worry scores amongst those reporting each negative health behaviour



Base varies: those who report each negative behaviour (as defined in Figure 3) / were overweight/obese / generally add salt to their food without tasting it first. *Caution: low base (64)

The average worry score was highest in relation to smoking, though adults who judged themselves to be overweight or obese also gave high average worry scores about their weight. It is interesting to note that average worry scores for behaviours that impact on weight, such as diet or physical activity were lower than for weight, which suggests that the physical manifestation of an unhealthy lifestyle was seen as more concerning than the underlying causes.

Those identified as increasing or higher risk drinkers were less worried about the impact of their alcohol consumption on their health, though increasing/higher risk drinkers do not commonly perceive themselves as heavy drinkers (see section 2.9), and this could go some way to explaining their relative lack of concern. Drug users were the least worried about the impact of their drug use on their health.

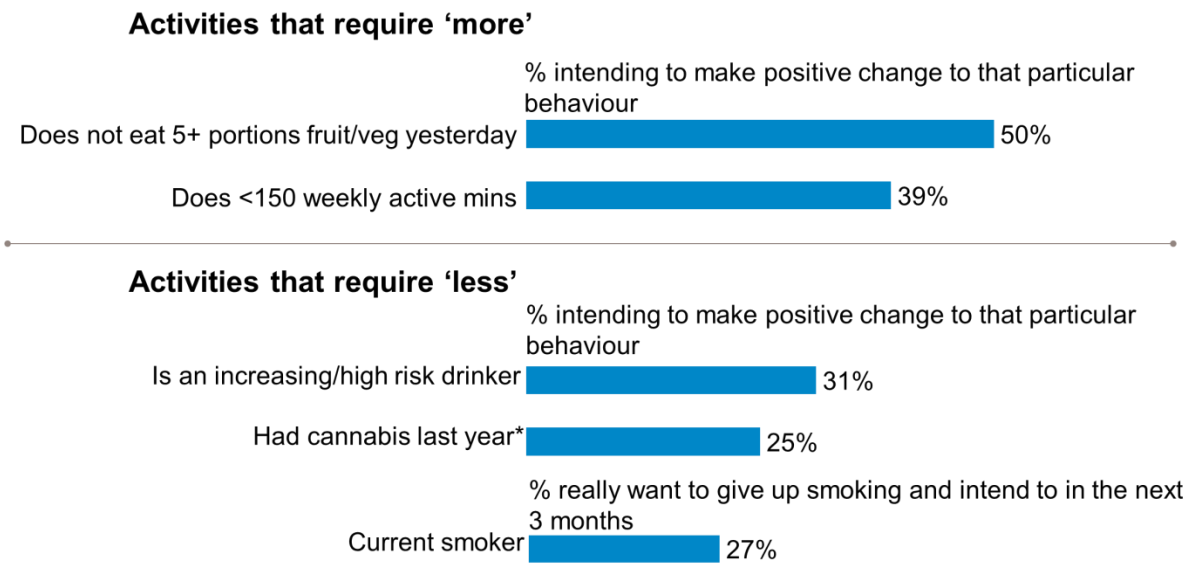
Intentions to make healthy changes were strongest for activities which involve doing more 'good things', as opposed to fewer 'bad things'.

There were indications that adults see doing more good things – such as increasing intake of fruit/veg or increasing physical activity – as a more achievable goal than reducing their engagement in risky behaviours such as smoking, drinking excessively or taking drugs (Figure 11).

Half of adults doing less than 150 active minutes a week said they intended to increase their activity in the next three months, and over a third of those not currently eating 5 a day said they intended to eat more healthily.

Conversely, increasing and high risk drinkers were least likely to say they intend to reduce their consumption (25%) and 27% of smokers intend to quit in the next 3 months.

Figure 11. % intending to make healthy changes in the next 3 months



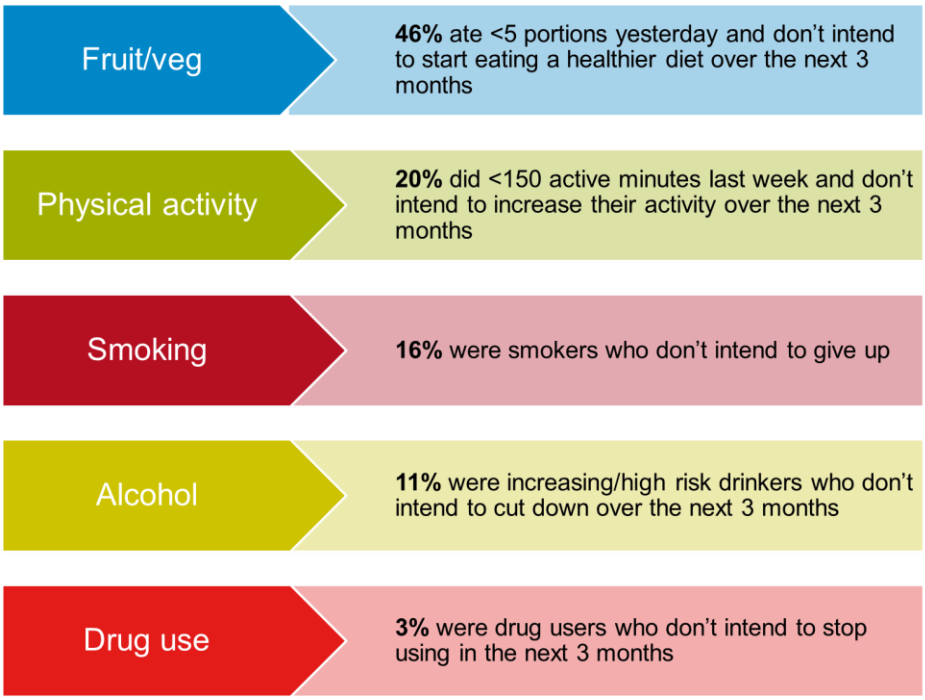
Base varies: all who report each negative behaviour. * Caution: low base (64) Chart shows % giving a score of 5-7 where 1 means they definitely don't intend to make that change, and 7 means they definitely intend to make that change

Almost half of adults didn't eat 5 portions of fruit/veg yesterday and don't intend to eat more healthily.

This represents by far the largest group of negative behavers who don't intend to change. A fifth were not doing 150 weekly active minutes and didn't intend to do more, and a similar proportion were smoking and didn't intend to quit (Figure 12).

In general, these groups were less likely than average to be worried about the impact of their behaviour on their health, which may go some way to explaining their resistance to change.

Figure 12. %s who report negative health behaviours *and* have no intentions to change

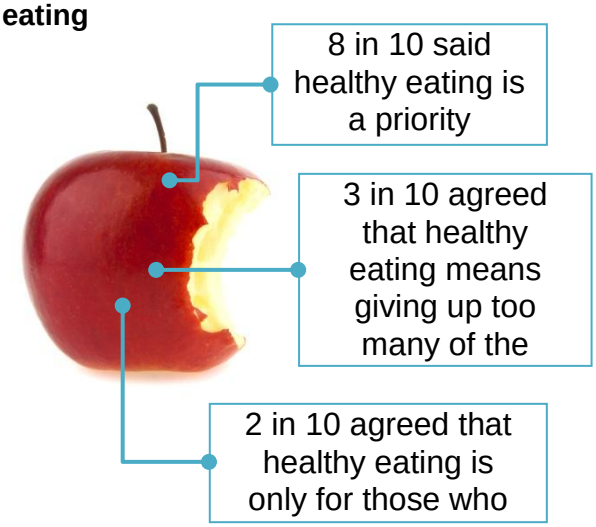


Base: All respondents (1010)

2.5 Nutrition

Eight in ten adults said that healthy eating is a priority nowadays, but almost as many said they had not eaten 5+ portions of fruit or vegetables the day before.

Figure 13. Attitudes towards healthy eating



Men were less likely than women to say that healthy eating is a high priority for them nowadays (76% men, 86% women). Men were also more likely than women to agree that healthy eating means giving up too many of the foods they enjoy (35% men, 27% women).

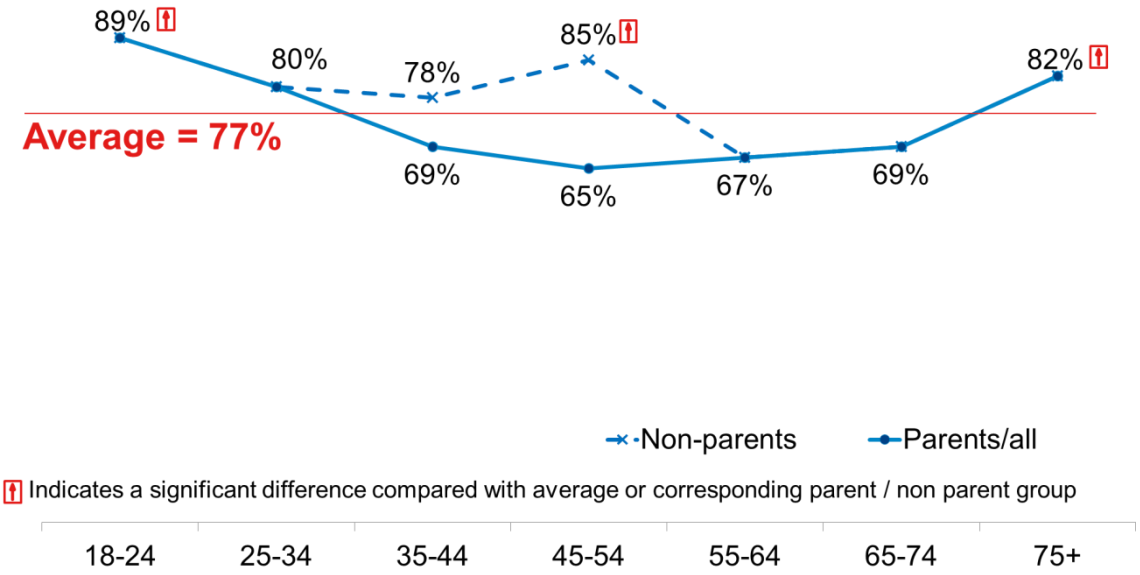
Attitudes towards healthy eating were more negative amongst C2DEs than ABC1s: for example 76% of C2DEs said that healthy eating is a priority nowadays (86% ABC1s).

Base: All respondents (1010)

Lifecourse has an influence on adults' consumption of fruit/veg.

The youngest and oldest age groups were least likely to be eating 5 a day; fruit/veg consumption was higher amongst parents (27% compared with 22% of non parents who had had 5+ portions yesterday).

Figure 14. % who did not eat at least 5 portions of fruit/veg yesterday

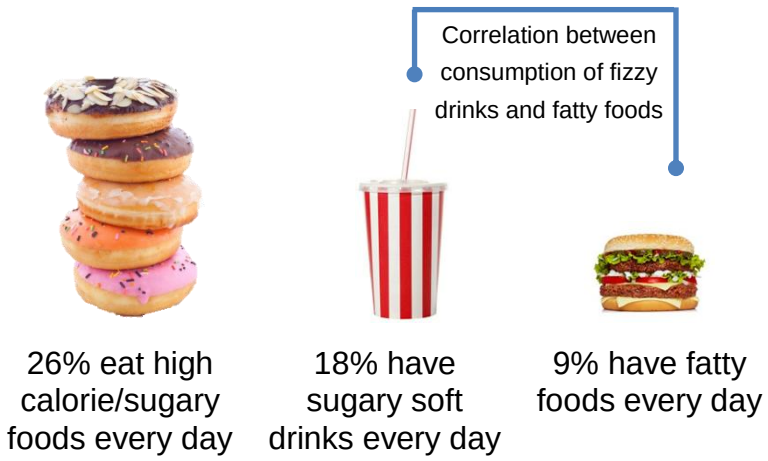


Base: All respondents (1010) (subgroup bases vary)

A quarter ate high calorie/sugary foods daily, and a fifth had sugary soft drinks daily.

Reported levels of daily consumption of high calorie/sugary foods were higher than those of sugary soft drinks and fatty foods (Figure 15).

Figure 15. % eating different types of unhealthy food every day



Base: All respondents (1010)

C2DEs' diets tended to be less healthy than those of ABC1s.

C2DEs were more likely than ABC1s to eat fatty foods and drink sugary soft drinks daily, and less likely to eat fruit/veg daily (Figure 16). However, ABC1s were equally likely to say they eat high calorie/sugary foods daily.

Figure 16. % daily consumption of different food types by subgroup

Daily consumption of:	ABC1s	C2DEs	Parents	Non parents
Fruit/veg	↑ 76%	61%	69%	70%
High calorie/sugary foods	25%	28%	30%	25%
Sugary soft drinks	15%	↑ 23%	22%	17%
Fatty food	6%	↑ 12%	↑ 13%	7%

↑ indicates significant difference (ABC1s vs. C2DES and parents vs. non parents tested)

Base: ABC1s (430), C2DEs (580), parents (336), non parents (674)

Parents tended to eat fatty foods more frequently than non parents.

Parents were more likely to get their 5 a day than non parents (although the proportions who consumed any fruit/veg on a daily basis were similar). However, they were more likely to eat fatty food than non parents and slightly more likely to eat sugary foods or drink sugary soft drinks daily (Figure 16).

C2DEs and smokers were more likely to add salt to food at the table without tasting it first.

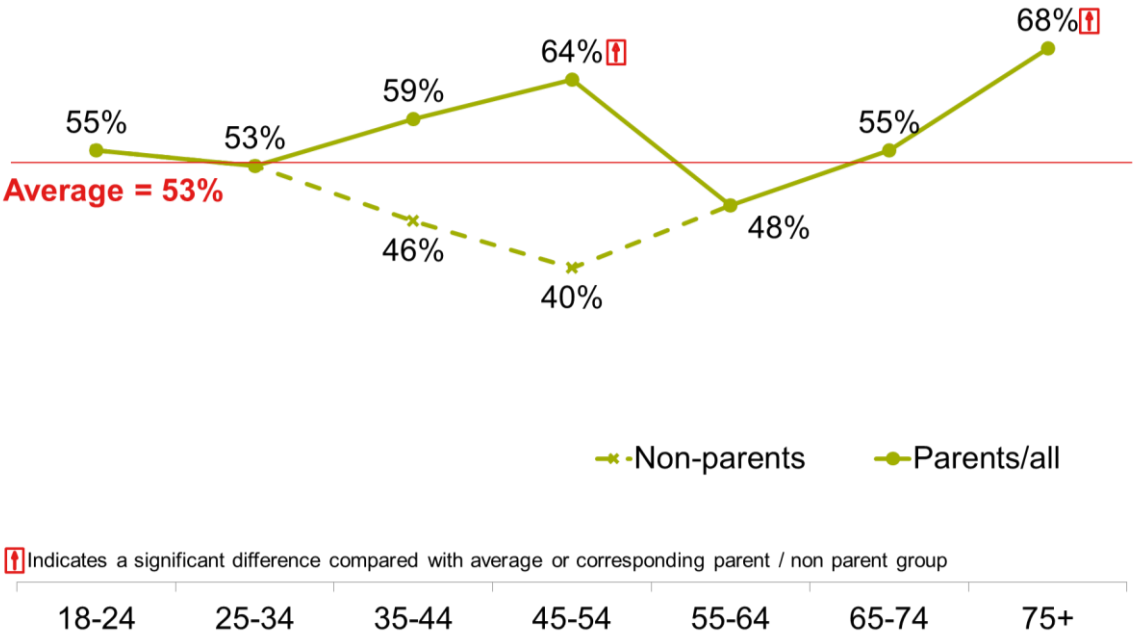
One in seven (14%) adults reported adding salt to food at the table without tasting it first, but this rose to 17% of C2DEs and 19% of smokers.

2.6 Physical activity

Just over half of all adults had not done 150+ minutes of moderate physical activity in the previous week.

Moderate physical activity is defined as activity that makes one breathe faster than usual. Parents and over 75s were the least likely to have done 150+ active minutes last week.

Figure 17. % who had done <150 active minutes in the previous week



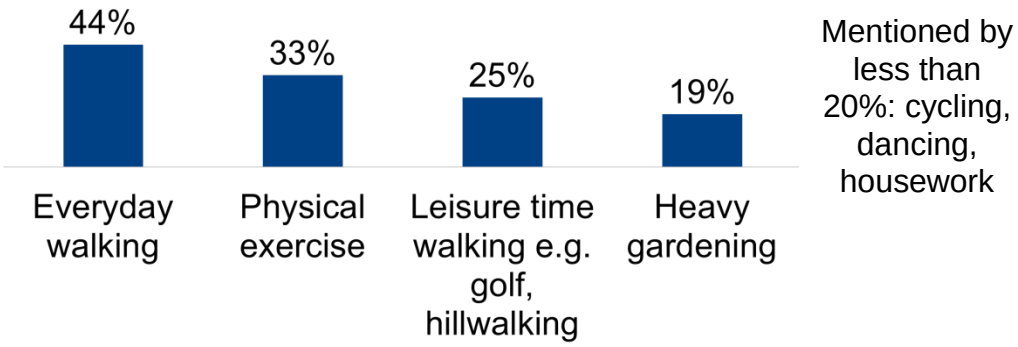
Base: All respondents (1010) (subgroup bases vary)

Non parents were more likely than parents to have done at least 150 active minutes last week. This was the only negative behaviour which was more prevalent amongst parents than non parents.

The disparity was greatest amongst 45-54s, as 64% of 45-54 parents reported fewer than 150 active weekly minutes compared with 40% of non parents of the same age (though the small base size should be noted for 45-54 parents (53) and this trend will be monitored to see if it continues at future waves) (Figure 17).

Almost all adults said they had done at least one form of physical activity that made them breathe faster than usual in the last week (though few had done enough of it to meet the activity guidelines).

Figure 18. % who had done each form of activity in the last week



Base: All (1010)

Everyday walking and physical exercise (e.g. sport, aerobics, going to the gym) were the most common forms of activity mentioned.

Most adults acknowledged that they do not need to participate in formal exercise, such as going to the gym, to stay active.

Nine in ten agreed that there were ways that they could be physically active without having to go to the gym or do organised sport. Most (83%) of those who had not done 150+ weekly active minutes agreed, suggesting that, for many, this was not a barrier to activity.

2.7 Parents of 2-11s: children's nutrition and activity

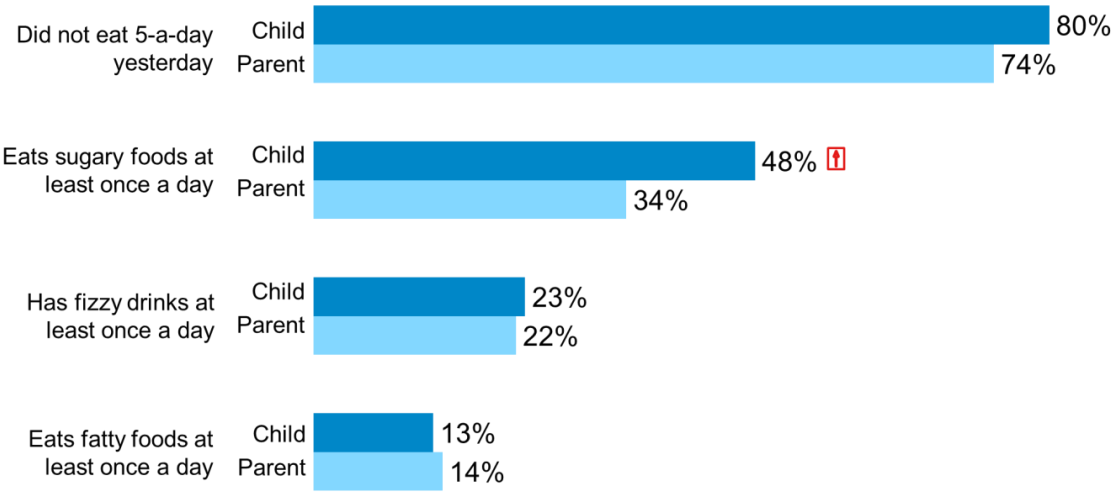
Most parents recognised that nutrition is about more than just maintaining a child's weight; however, increasing their child's fruit/veg consumption and reducing their intake of high calorie/sugary foods may present considerable challenges for some parents.

While four fifths (79%) of parents of 2-11s disagreed that 'as long as a child is a healthy weight, parents needn't worry about what the child eats', a similar proportion (80%) reported that their child ate fewer than five portions of fruit/veg yesterday.

Children eat less fruit/veg and more high calorie/sugary food than their parents.

Figure 19 shows the reported eating habits of parents of 2-11s and their children. It shows that while reports of daily consumption of sugary soft drinks and fatty foods were similar for parents and children, children were more likely to be eating high calorie/sugary foods daily and slightly less likely to be eating sufficient fruit/veg.

Figure 19. % of parents reporting each negative behaviour



Indicates significant difference (child vs. parent tested)

Base: All parents of 2-11s (210)

Children living in the most deprived areas were less likely to eat 5 a day (17%) than those in the less deprived areas (24%), though levels of consumption in less deprived areas were still low.

Unhealthy eating tends to run in families.

Children's nutritional behaviours were closely correlated with those of their parents. If a parent was not eating 5 a day, in nine out of ten cases, the child was not either. Similar patterns were evident in relation to all measured food types.

High calorie/sugary foods were less of a priority for improvement than fruit/veg, fat or fizzy drinks.

Parents whose child eats high calorie/sugary foods regularly were less likely to intend to improve their child's diet than those who reported other negative eating habits for their child. The proportions of parents who said they intended to get their child to eat a healthier diet over the next 3 months were:

- 59% of those whose child does not eat fruit/veg every day
- 47% of those whose child eats fatty foods (note small base, n=35) and/or drinks sugary soft drinks (note small base, n=43) more than 4 days a week
- 36% of those whose child eats sugary foods more than 4 days a week

These findings, together with the relatively high levels of consumption of high calorie/sugary foods may imply that these parents may not consider limiting intake of these foods in their

idea of a healthy diet (although the small base size should be noted; this will be monitored at future waves to if the same pattern continues).

Intentions to increase their child's physical activity were strong, particularly amongst those reporting that their child does less than an hour's activity a day.

Almost two thirds of parents of 2-11s said that their child spends at least one hour a day being physically active outside of school / nursery hours, and 70% said they limit the amount of time their child spends watching TV/DVDs, or playing on the computer. There was little variation in reported behaviour by social grade or child's age.

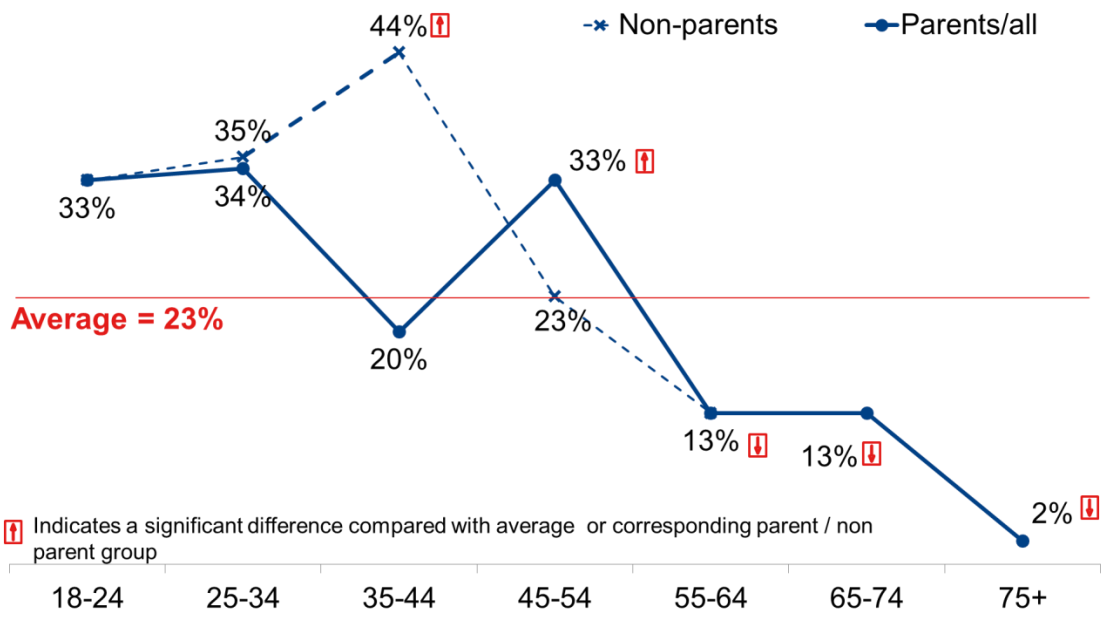
Intentions to increase their child's physical activity were greater than intentions to improve their diet: 36% of parents said they intended to improve their child's diet over the next three months, but 43% said they intended to get their child to be more active over the same time period. This rose to 56% amongst those who said their child spent under an hour being physically active yesterday, (compared with 32% of children who were physically active for an hour or more. Note small base size for children who spent under an hour being physically active (72); this pattern will be monitored at future waves).

2.8 Tobacco

Smoking prevalence declined with age; on average, nearly a quarter of adults smoked cigarettes.

The exceptions to this downward trend were 35-44 non parents and 45-54 parents (though the small base size should be noted amongst these groups (48 and 53 respectively).

Figure 20. % who said they smoked nowadays



Base: All respondents (1010) (subgroup bases vary)

Smoking prevalence amongst C2DEs was almost double that of ABC1s.

31% of C2DEs said they smoked, compared with 17% of ABC1s. Smoking showed the largest social grade difference in prevalence.

Those who lived with another smoker were more likely to smoke themselves.

Almost half (48%) of those living with a smoker were smokers themselves compared with 15% of those not living with a smoker.

Smokers were much less likely to recognise the health risks of smoking.

It has been noted that smokers were more worried, on average, about the impact of smoking on their health compared with those reporting other negative behaviours (see Figure 10 in Section 2). Despite this, there was still a gulf in perception between smokers and non smokers about the health risks of smoking. Whilst 79% of non smokers *disagreed* that the health risk from smoking is greatly exaggerated 43% of smokers said the same thing. The level of disagreement was also low amongst C2DE smokers (33%).

Parents were more likely than non parents of a similar age to say they had made a quit attempt.

Half of smokers (46%) had made at least one quit attempt in the past 12 months. Amongst smokers, 25-54 parents were more likely than non parents to have made a serious attempt to quit in the past 12 months (52% parents, compared with 32% non parents). This finding is in line with the lower reported smoking prevalence amongst pregnant women and mums of young children (see Section 4.3), which suggests that pregnancy may be a trigger for quitting.

Smokers had poorer diets than non smokers.

Figure 21 shows that smokers' diets tended to be less healthy than those of non smokers. In addition, smokers were more likely to have used illegal drugs/legal highs in the past 12 months (20% smokers, 3% non smokers), though there were no differences between smokers and non smokers in levels of reported physical activity.

Figure 21. % negative nutritional health behaviours amongst smokers and non smokers

Negative nutritional health behaviour	Smokers	Non smokers
Fewer than 5 portions of fruit/veg (yesterday)	82%	75%
Eat fatty or fried foods (3+ days a week)	34%	21%
Drink fizzy / soft drinks (3+ days a week)	39%	24%
Not limit unhealthy snacks	56%	39%
Not limit calories	80%	70%
Add salt to food without tasting it	19%	12%

indicates significant difference

Base: Smokers (287); non smokers (723)

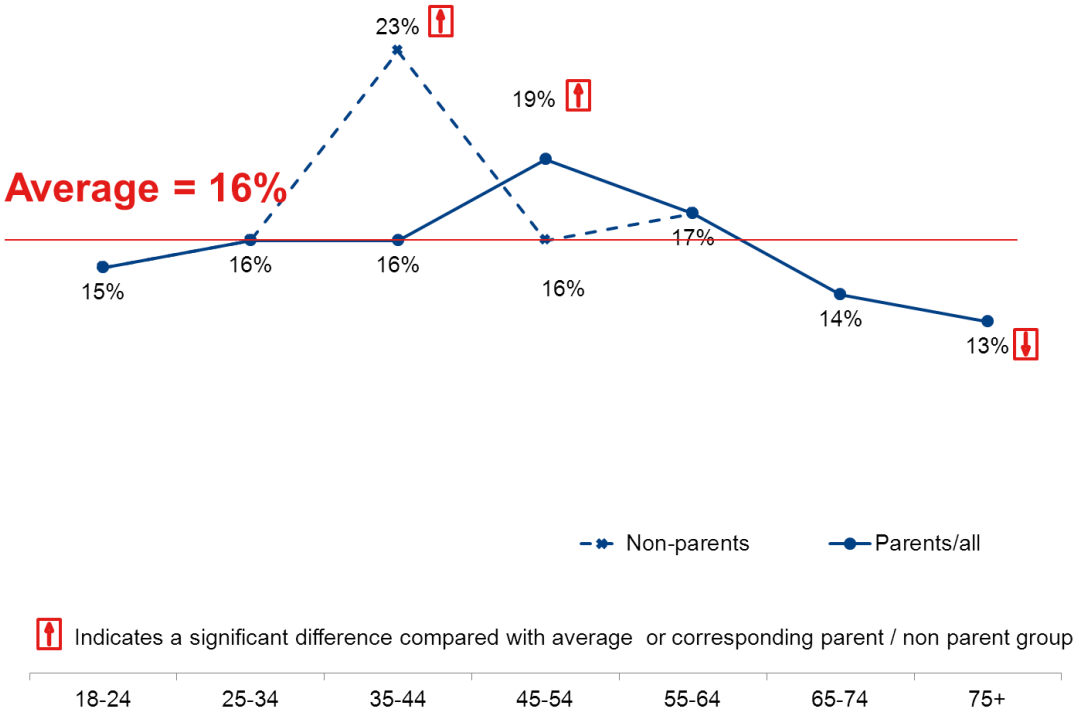
2.9 Alcohol

One in six adults was classified as an increasing or higher risk drinker, based on their reported alcohol consumption over the previous week: ABC1s were the most likely to be increasing/higher risk drinkers.

16% of adults reported alcohol consumption which would classify them as increasing or higher risk drinkers.

There were particular peaks in the increasing/higher risk drinking amongst 35-44 non parents and 45-54 parents (although, as noted in the previous section, the base sizes for these groups are small and therefore these findings need to be monitored at future waves to see if this pattern continues). 18-24s were no more likely than average to be classified as increasing/higher risk drinkers (Figure 22).

Figure 22. % increasing or higher risk drinkers



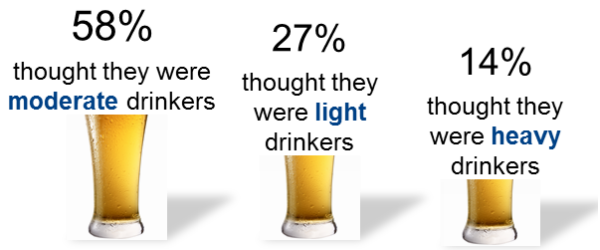
Base: All respondents (1010) (subgroup bases vary)

Men (20%) were more likely than women (12%) to be increasing/higher risk drinkers.

This was the only negative health behaviour measured which was more prevalent amongst ABC1s (19%) than C2DEs (13%).

Increasing/higher risk drinkers did not necessarily recognise themselves as such and felt that their drinking was acceptable; this 'perception gap' presents a real challenge in reducing alcohol consumption amongst adults.

Figure 23. Self-perception of increasing/higher risk drinkers



Base: Increasing/higher risk drinkers (145)

14% of increasing/higher risk drinkers described themselves as heavy or very heavy drinkers whilst 58% thought their drinking was 'moderate' (Figure 23).

The majority of adults (86%) acknowledged the potential health harms of regular drinking, agreeing that regularly drinking alcohol can slowly damage the body in ways you cannot see and may not realise. Increasing/higher risk drinkers were no less likely than average to agree, whilst 25% intended to reduce their alcohol intake over the next 12 months (similar to lower risk drinkers: 23%) and 9% were worried about the impact of their alcohol consumption on their health.

In addition, while a fifth of adults agreed that it's okay to drink alcohol every day as long as you're not getting drunk, this rose to 38% of increasing/higher risk drinkers.

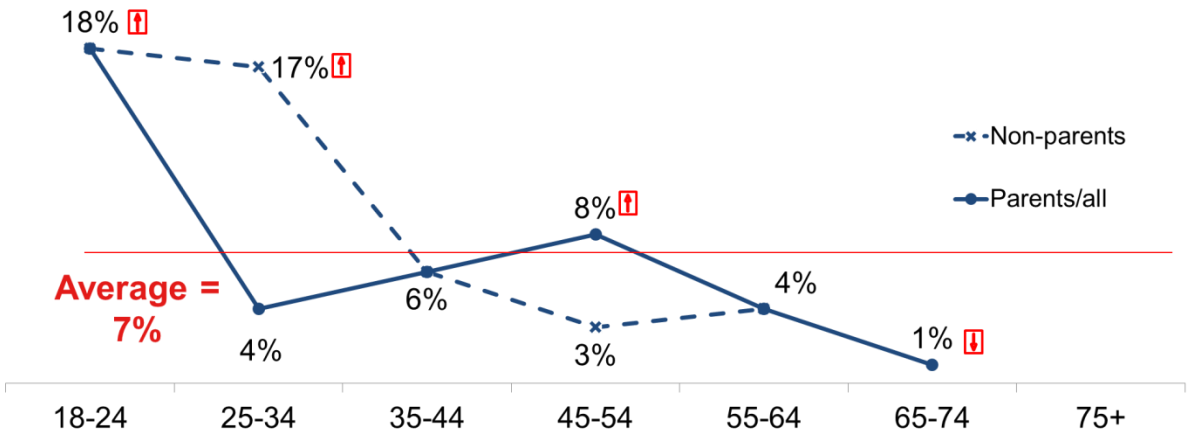
Challenging adults' perceptions of what constitutes a risky level of alcohol intake would appear to be the first step in encouraging self-awareness and, ultimately, positive behaviour change.

2.10 Drug use

On average, 7% of adults said they had used illegal drugs or legal highs in the past 12 months: prevalence declined sharply with age.

The proportions using drugs were highest amongst 18-24s (18%) and 25-34 non parents (17%) (although the small base size for 25-34 non parents means that this will be monitored at futures to see if this pattern continues). (Figure 24).

Figure 24. % using illegal drugs or legal highs in the past 12 months



Indicates a significant difference when compared with average or corresponding parent / non parent group. Base: All respondents (1010) (subgroup bases vary)

Prevalence of drug use was also higher amongst men (10%, compared with 4% of women), C2DEs (9%, compared with 5% of ABC1s) and those living in the most deprived areas (12%, compared with 6% in less deprived areas).

Most of those who had used drugs had used cannabis (6%) with much lower numbers using cocaine (12 people) or ecstasy (7 people).

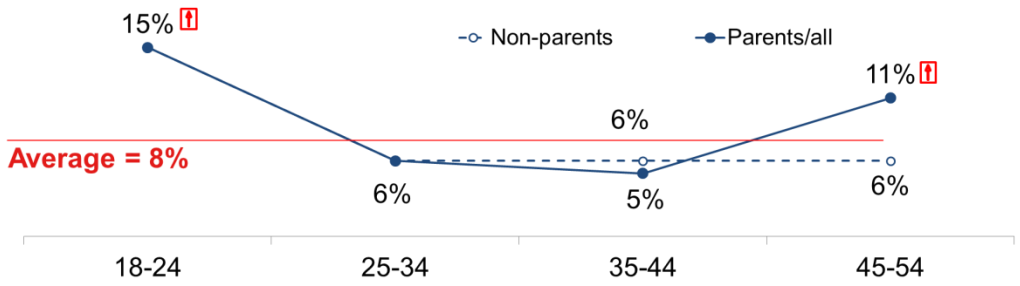
Because few respondents reported drug use, the base size for detailed questions about use is too small for separate analysis, but this will be commented on in future reports when base sizes can be combined across survey waves.

2.11 Sexual health

Under one in ten (8%) of under 55s said they had had unprotected sex with a new partner or more than one partner in the last 6 months.

Prevalence was highest amongst 18-24s (15%). After the age of 25 the proportions having unprotected sex remained, generally, at the same low level (6% on average). The exception to this was parents aged 45-54 (11% - although the small base size should be noted for this group (53)) (Figure 25).

Figure 25. % who have had unprotected sex with a new partner or more than one partner in the last 6 months



Indicates a significant difference when compared with average or corresponding parent / non parent group. Base: All respondents aged 18-54 (622) (subgroup bases vary)

A significant minority (15%) of 18-24s had had unprotected sex in a risky situation (such as when drunk or on holiday) in the last 6 months.

One in ten (12%) 18-24s said they had had unprotected sex when drunk in the past 6 months, and 5% had had unprotected sex with more than one person in the same week. Though base sizes are small, the data indicates that ABC1 men were most likely to report risky sexual behaviours.

3 Young people aged 11-17

3.1 Lifecourse Tracker: Young people survey

To ensure sufficient coverage within the young people lifecourse, a standalone survey of 11-17 year olds was commissioned to sit alongside the adult survey. Where possible, similar methods, questions and indicators were used but the young people's questionnaire was customised to ensure that measures were relevant.

The survey collected data from a nationally representative sample of 608 young people aged 11-17 in England. Similar to the adult survey, the sample was selected using random location methods and interviews were conducted face to face in-home using Computer Assisted Personal Interviewing (CAPI); the most sensitive questions were asked using self-completion methods to encourage honesty. Further technical details can be found in the appendices (section 6).

Similar to the adult survey, the young people survey conducted in March 2012 forms a baseline against which changes over time and seasonal variations can be assessed.

A range of health behaviours was measured and six core indicators were selected in conjunction with the young people's policy team.

Indicators represented **negative** health behaviours and are shown in Figure 26; they differed slightly from the adult indicators to reflect policy priorities:

Figure 26. Behavioural indicators, young people survey

Behaviour	Indicator
Nutrition	Ate fruit/veg once a day or less frequently in a normal week
Physical activity	Been moderately active (to a point where breathing faster than usual) from 0 to 6 days last week
Smoking	Currently smokes cigarettes
Alcohol consumption	Drinks at least monthly
Drug use	Used cannabis, ecstasy or cocaine in past 12 months
Sexual intercourse	Ever had sexual intercourse

These indicators were self-reported, i.e. based on respondents' reports of their own behaviour.

3.2 Overview of behaviours

Figure 27 summarises the prevalence of the key negative health behaviours amongst 11—17s, and the groups significantly more likely than the average to report each behaviour.

Figure 27. Overview of behaviours amongst young people

Behaviour	Prevalence	More prevalent amongst:
Nutrition	72% ate fruit/veg once a day or less frequently	• Those living In C2DE households • Those who do not intend on going to university
Physical activity	68% had not been moderately active every day last week	• Females, particularly 15-17 females
Smoking	9% smoke regularly	• 15-17s • Those living in C2DE households, a household in poverty or a single parent household
Alcohol consumption	23% usually drink alcohol at least once a month	• 15-17s
Drug use	8% had used cannabis, ecstasy or cocaine in the last 12 months	• 15-17s • Those living In C2DE households
Sexual intercourse	14% had had intercourse	• 15-17s • Those living in single parent households

3.3 Factors that relate to behaviours for young people

Risky behaviours were most closely associated.

The analysis looked at associations between the health behaviours and how they 'bundle' together for young people. Intercourse, drug use and cigarette smoking were most closely associated: as a more mainstream activity with a higher prevalence, alcohol consumption was less strongly associated with the other risky behaviours. Reflecting higher levels of prevalence, the associations were strongest amongst 15-17s.

Similar to adults, the largest overlap in behaviours was between nutrition and physical exercise. Nearly half (48%) of all young people said they did not eat fruit/veg daily AND were not physically active on a daily basis, and this was higher amongst girls (53%) than boys (44%). The difference was particularly marked amongst 11-14s (50% girls, 39% boys) mainly because girls of this age were less likely to be active than boys.

Norms had strong influences on 11-17s' behaviour: those thinking that lots of their friends are doing something were more likely to do it themselves.

For risky behaviours (smoking, intercourse, alcohol and drug use) the following factors had the strongest associations for young people:

Figure 28. Attitudinal factors most strongly associated with risky behaviours		
Attitude		**Associated with**
Immediate norms	Perception that close friends and/or peers are participating in risky behaviours	All risky behaviours
Positive perception of negative behavers	Perception that risky behavers are popular or clever	All risky behaviours

Other attitudinal factors were also strongly associated with negative behaviours, including:

Figure 29. Other attitudinal factors associated with behaviours	
Attitude	**Associated with**
Feeling low	All risky behaviours
Liking to take risks	Using cannabis, had intercourse
Not feeling confident and has low self esteem	Alcohol
Not feeling calm when facing difficulties	Smoking and nutrition

Positive influences in the household were also strongly associated with low prevalence of negative behaviours.

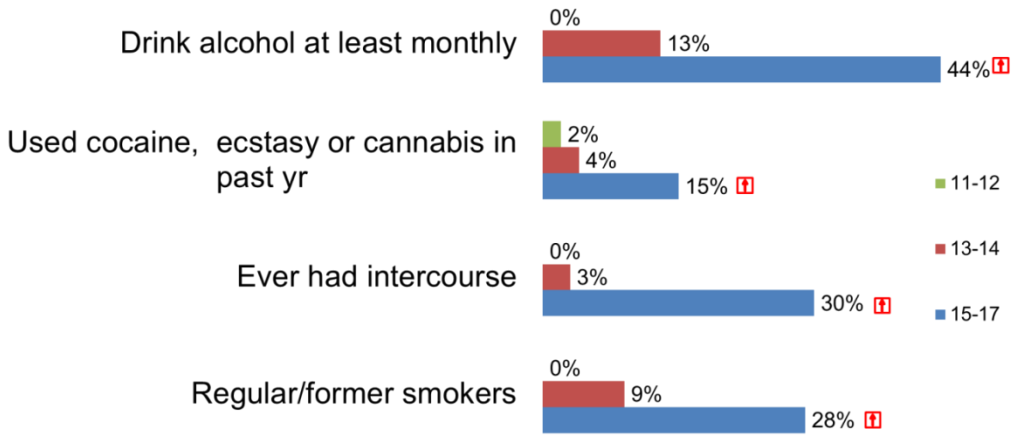
Good family relationships and regular meals (including with the family) were associated with low prevalence of negative behaviours, but living with a smoker, heavy drinker or drug user were associated with high prevalence of all risk behaviours.

Figure 30. Household factors associated with behaviours	
Household factors	**Associated with**
Negative family relationships	
Does not obey family rules or like spending time with family	All risky behaviours
Not having a structured family life / regular meals	
Breakfast not eaten regularly	All behaviours except physical activity
Family meals not eaten regularly	Sexual intercourse and nutrition
Living with negative behavers	
Living with a smoker, heavy drinker or drug user	Smoking, drug use and intercourse

Age and social grade were also strongly associated with negative health behaviours.

A sharp rise in prevalence of risky behaviours was observed at age 15 (Figure 31).

Figure 31. % who have engaged in risky behaviours by age



indicates significant difference between age groups

Base: 11-12 (168), 13-14 (173), 15-17 (268)

Young people living in C2DE households were more likely to use drugs, smoke and/or have had intercourse. The impact of social grade was particularly marked amongst 15-17s (Figure 32).

Figure 32. % who have engaged in risky behaviours by age and social grade

	11-14		15-17	
	ABC1	C2DE	ABC1	C2DE
Regular/former smokers	5%	4%	12%	43%
Ever had intercourse	1%	2%	19%	36%
Used cocaine, ecstasy or cannabis in past year	2%	3%	6%	20%
Drink alcohol at least monthly	7%	6%	48%	39%

indicates significant difference between social grade

Base: 11-14s: ABC1 (154), C2DE (187) ; 15-17s: ABC1 (133), C2DE (135)

In a similar way for adults, alcohol consumption was more prevalent amongst 15-17s in ABC1 households (51% 15-17 ABC1s drink alcohol at least monthly, compared with 43% C2DEs)

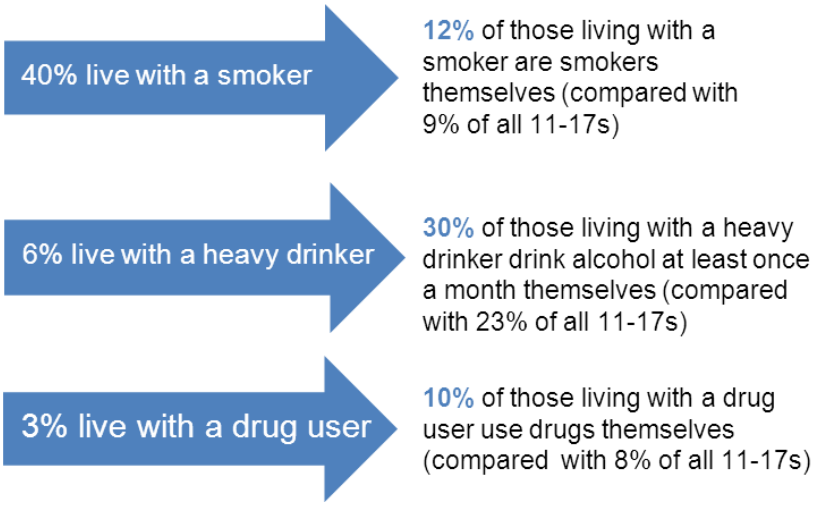
Physical activity and nutritional behaviours did not vary by age and social grade in the same way.

3.4 Immediate norms

Youth behaviour was strongly associated with their perceptions of others' behaviours, including the people they live with.

Two fifths of young people said they live with someone who: smokes, drinks heavily or uses drugs. Those living with each household influence were more likely to report the behaviour themselves (Figure 33).

Figure 33. Behaviours of others in the household

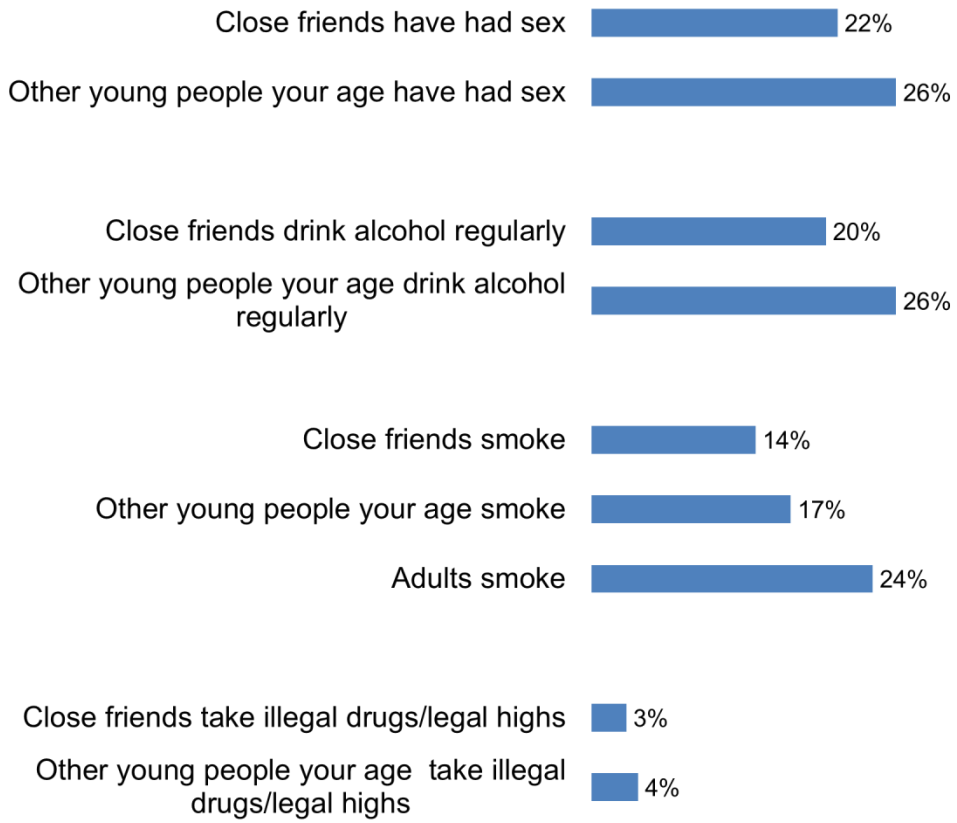


Base: All young people (608), living with smoker (341), heavy drinker (31*), drug user (21*) *Caution: small base size

Friends and their wider peer group also had an influence on young people.

Sexual experience and regular drinking were perceived to be the most prevalent behaviours amongst peers. While a fifth thought that all/most of their close friends had had sex or had drunk alcohol regularly, the proportion thinking this drops to 14% about smoking and 3% about drug use (see Figure 34). All behaviours were perceived to be more prevalent by 15-17s than 11-14s. Those living in C2DE households tended to think that smoking was more prevalent than ABC1s, but there were no other differences in perceptions by social grade.

Figure 34. % who said all or most of their close friends / wider peer group had engaged in each behaviour



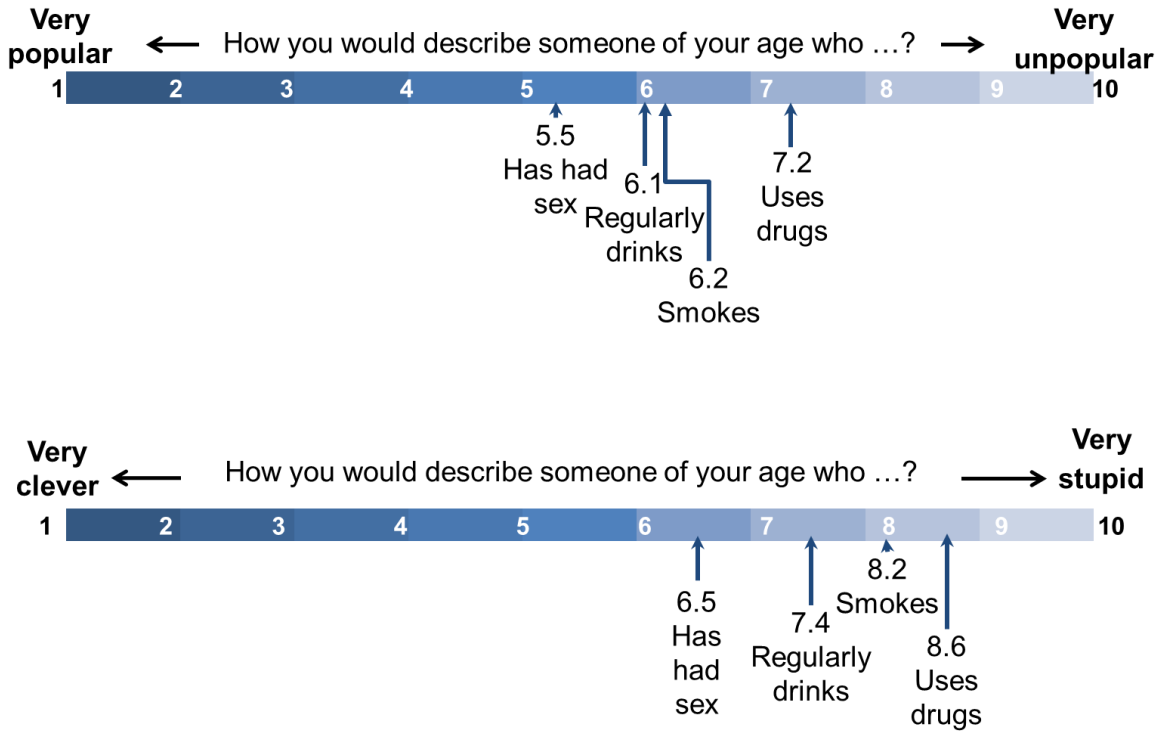
Base: all young people (608)

It is also notable that young people consistently think that risky behaviours are more prevalent than they are. While 14% of young people said they had ever had intercourse, 26% thought that all or most other young people of their age had done so. Further, those reporting each risky behaviour tended to think it was more prevalent amongst their immediate and wider peer group than the average.

Young people who use drugs were perceived most negatively, but regular drinking and intercourse were perceived less negatively.

However, on balance, all behaviours were generally perceived more negatively than positively (Figure 35).

Figure 35. How would you describe someone of your age who …? Mean scores



Base: all young people (608)

Young drinkers, smokers and those who had had sex tended to be less negative than average about others who had done those things.

Other differences in perceptions are summarised below:

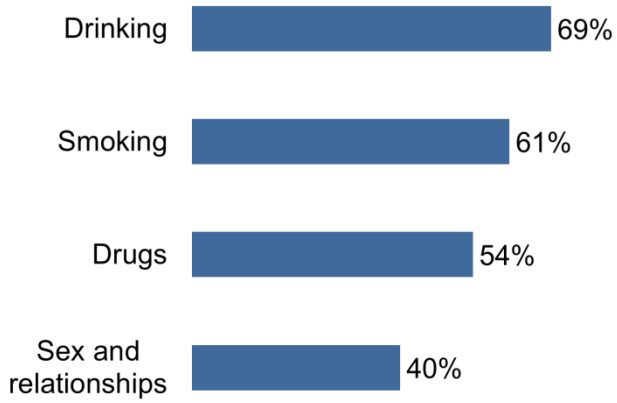
- 13+s tended to be less negative about all risky behavers than 11-12s
- Boys were slightly less negative than girls about drinkers, smokers and those who had had sex, though both were equally negative about drug users
- Those in ABC1 households, despite being less likely to report most risky behaviours, were slightly less negative about all risky behavers than C2DEs

3.5 Conversations

Young people said they would find it easier to talk with their parent/carer about drinking than about sex and relationships.

Seven in ten said they would find talking with parents/carers about alcohol easy, but this proportion dropped to 40% for conversations about sex and relationships. There were few differences in response by age or social grade. Ethnic minorities were more likely than average to say they would find all conversations difficult.

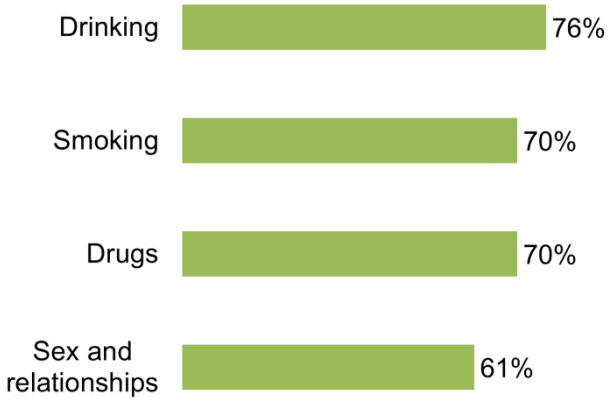
Figure 36. % of young people who would find conversations about each subject with their parent/carer easy



Base: all who used self-completion (597) Chart shows % of those saying they would find it very or fairly easy to talk to parents/carer about each subject

Parents said they would find all conversations more comfortable than children would find them easy.

Figure 37. % of parents who would find conversations with their child about each subject comfortable



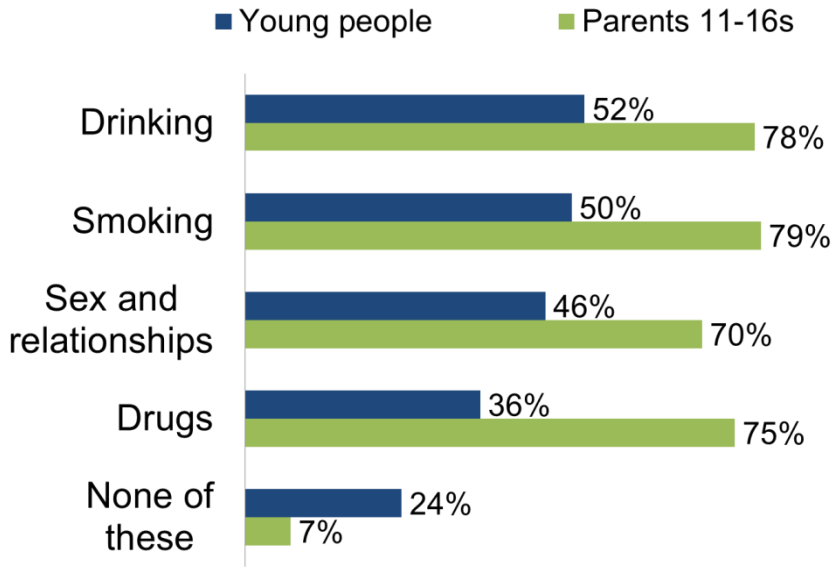
Base: parents of child aged 11-16 (121). Chart shows % giving a score of 5, 6 or 7 where 1 means very uncomfortable, and 7 means very comfortable

The difference was most marked for sex and relationships – while 40% of young people would find conversations about sex and relationships easy, 61% of parents said they would find these conversations comfortable.

C2DEs and parents of younger children were more likely than average to say they would find talking to their children about alcohol and sex and relationships very uncomfortable. There were no differences in levels of comfort for conversations about smoking or drugs.

Conversations about drinking and smoking were most commonly reported by both parents and young people, though perceptions of whether conversations had taken place varied widely.

Figure 38. % who have ever had a conversation about each behaviour with their parent (for young people) / child (for parents of 11-16s)



Base: Young people - base: all young people (608), Parents -base: parents of child aged 11-16 (121)

Parents were more likely than young people to say they had had a conversation about each behaviour (Figure 38). This mismatch suggests that although parents think they are talking to their children, it may not be remembered as such by young people[5]. This mismatch was particularly marked amongst ABC1s: for example 77% of ABC1 parents said they had had a conversation about drugs, compared with just 35% of ABC1 children.

Conversations were less common amongst 11-12s: 48% said they had had any conversations at all, compared with 72% of 13-17s. Girls (53%) were more likely to report conversations about sex and relationships than boys (40%)

The link between conversations with parents about risky behaviours and prevalence of these behaviours was less clear.

There were indications that 15-17s who had had non-crisis (i.e. not reactive) conversations about smoking with their parents were less likely to have smoked. Having conversations was also correlated with potential lead indicators: for example, 15-17s who had had a proactive conversation with their parents about sex and/or smoking were less likely to think that all/most of their friends were doing each.

[5] Note that we did not interview parents and children in the same household, or link answers.

4 Pregnant women and mums of 0-2s

4.1 Survey of pregnant women and mums of 0-2s

Because of their relatively low prevalence in the population, the adult survey was not expected to include sufficient interviews with pregnant women and mums of 0-2s (PW02s) to enable separate analysis. A complementary standalone survey was therefore conducted to ensure that we could look at this important lifecourse in sufficient detail.

The survey was conducted online, and the sample was selected from the membership database of Emma's Diary (See appendix - section 6.3.1). In total 300 pregnant women and 247 mums of children aged between 0 and 24 months were interviewed. Data were weighted to provide a sample representative of PW02s in England, with weighting based on age of mother, social grade, geographic region and age of baby/stage of pregnancy.

The questionnaire and list of indicators was customised to ensure relevance for PW02s and the relevant policy priorities (Figure 39).

Figure 39. Overview of behaviours amongst pregnant women and mums of 0-2s

Behaviour	Indicator
Nutrition	Ate fewer than 5 portions of fruit/veg yesterday
Physical activity	Less than 150 active minutes (to a point where breathing faster than usual) last week (mums only)
Smoking	Currently smokes cigarettes
Alcohol consumption	Drunk alcohol in the past week
Drug use	Used illegal drugs or legal highs in the past 12 months

Because the PW02 survey was conducted using a different data collection method to the adult survey (see Appendix for details), they were analysed separately. Although the two surveys are not strictly comparable due to the methodological differences, we have given indications of differences where appropriate.

4.2 PW02s: mindset and wellbeing

Pregnant women reported higher levels of wellbeing than mums of 0-2s.

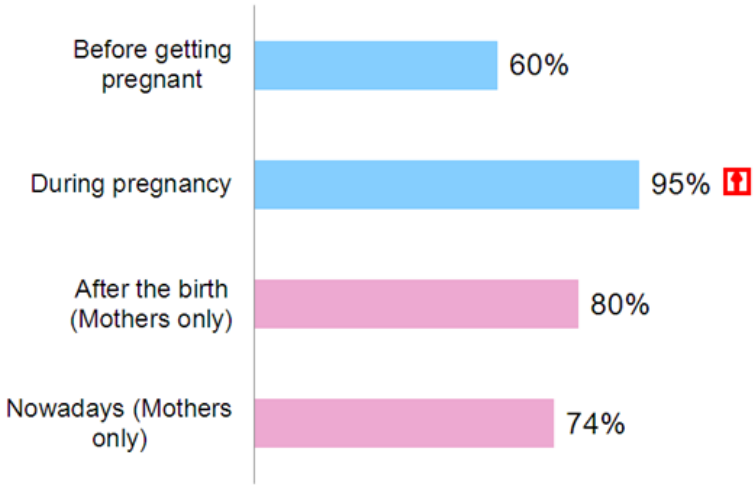
Seven in ten (72%) PW02s agreed that they feel good about themselves. Pregnant women (79%) were more likely than mums (64%) to say they feel good about themselves, and similar patterns in response were noted for all wellbeing measures, with mums less likely than pregnant women to feel happy or satisfied with life. Other data in the tracker indicate that differences in wellbeing may be linked to perceptions of support. For example levels of satisfaction with services decreased with time from the birth (see section 4.4) and this mirrors the decline in general levels of satisfaction from pregnancy to motherhood. This potential link will be investigated further at the next wave of the survey.

In addition, while most C2DEs answered positively about their life and mindset, they were generally less likely to be positive than ABC1s.

A healthy lifestyle was very important to women during pregnancy, but became less of a priority for mums after the birth.

Almost all pregnant women said that leading a healthy lifestyle was a high priority for them during pregnancy; for mums, this declined immediately after the birth and beyond, with three quarters stating that it was a high priority for them nowadays (Figure 40).

Figure 40. % women who said that leading a healthy lifestyle was a fairly or very high priority for them before and during pregnancy, and after the birth



Significantly higher than all other groups

Base: total = 547, pregnant women = 300, mums = 247

These differences may be related to perceptions of ease and control over a healthy lifestyle, as mums were less likely than pregnant women to feel that a leading a healthy lifestyle over the next three months would be easy for them or in their control.

- 48% of pregnant women thought a healthy lifestyle would be easy (compared with 31% of mums)
- 61% of pregnant women thought they had a lot of/complete control over whether or not they lead a healthy lifestyle (versus 53% of mums).

4.3 Health behaviours and influences

Mums of 0-2s were less likely than other adults to report eating 5+ a day or be doing 150+ weekly active minutes.

By far the most common negative health behaviours amongst PW02s related to nutrition (not eating 5 portions of fruit/veg yesterday) and, for mums, physical activity (less than 150 active minutes in the previous week).

While the proportion of pregnant women saying they had NOT eaten 5 portions of fruit/veg yesterday was similar to the all-adult average (73% of pregnant women compared with 77% all adults), mums were more likely to report this negative health behaviour (85%). In addition, mums were more likely than the all adult average to say they had NOT done 150+ active minutes last week (77% of mums compared with 53% all adults).

However, both mums and pregnant women were much less likely than the all adult average to report other risk behaviours: for example 4% of pregnant women and 16% of mums were current smokers, compared with 23% of all adults.

Figure 41. Prevalence of behaviours amongst pregnant women and mums

Behaviour	Prevalence
Nutrition	73% pregnant women and 85% mums did NOT eat 5 a day yesterday
Physical activity	77% mums did not do 150 active minutes in the previous week
Alcohol consumption	9% pregnant women and 32% mums had drunk alcohol in the past week
Smoking	4% pregnant women and 16% mums currently smoke
Drug use	4% pregnant women and 1% mums had used illegal drugs or legal highs in the past 12 months (NB for pregnant women this drug use may have been before they found out they were pregnant)

Base: Pregnant women = 300, mums = 247

There are indications that women make many positive health changes during pregnancy – specifically, in terms of lower than average prevalence of negative behaviours relating to nutrition, smoking and alcohol consumption. This trend will be monitored at future waves. There may be scope to encourage mums not to drift back to previous poor behaviours (such as smoking) as well as being encouraged to make time to ensure that they look after themselves by eating well and being active.

PW02s' behaviours were most strongly associated with household influences and views on health and specific health behaviours.

As was the case for adults, social grade and household factors were most strongly associated with negative health behaviours, though the impact of social grade was lower for PW02s compared with all adults. Associations with risk behaviours were particularly strong if PW02s lived with a smoker, heavy drinker or drug user: those who did were more likely to themselves report these health behaviours.

The influence of social grade was also evident, in the same way as for the all adult survey. While pregnant C2DEs were less likely to eat 5 a day than pregnant ABC1s, ABC1 mums were more likely to drink alcohol than C2DE mums: reflecting the same trend in the main adult survey. However, there were no differences in smoking prevalence between ABC1s and C2DEs in the PW02 survey.

Views on specific behaviours were also strongly associated with behaviour: all pregnant women who drank in the last week said it was ok to drink (a limited amount of) alcohol (note small base, n=33) compared with 36% of those who did not drink in the last week.

Affect (i.e. influence of measures such as happiness and life satisfaction) was not significantly associated for PW02s: suggesting that their situation was a greater influence on their behaviours than their mindset.

4.4 Use and perception of services

Three fifths of PW02s had attended, or planned to attend, an antenatal class.

PW02s most commonly attended/planned to attend NHS classes (50%), though 20% attended/planned to attend a NCT class. 27% of women chose not to attend any classes, even though they were available to them. ABC1s (24%) were slightly more likely than C2DEs (17%) to attend/plan to attend NCT classes, but there were no differences between social grades in the proportions attending/planning to attend NHS classes.

Almost half of PW02s (47%) had attended, or planned to attend, a tour of hospital facilities before the birth; perhaps unsurprisingly first time mums (56%) were more likely to attend/plan to attend than those with other children (34%).

Most PW02s were satisfied with the services provided in relation to their pregnancy, though fewer were satisfied with the information provided to them by local health services.

Almost nine in ten (86%) were satisfied with the services provided by midwives and mums were equally likely to be satisfied with the services provided by health visitors (84% were satisfied).

PW02s were less likely to be satisfied with the amount of information provided by local health services and levels of satisfaction tended to decline further away from the time of the birth:

- 75% of mums and 72% of pregnant women (who gave a satisfaction rating) were satisfied with the information to help prepare for the birth
- 68% of mums were satisfied with the information provided on bringing up the baby
- 56% agreed there is enough support to help new mums breastfeed
- Less than half (47%) of mums whose child had eaten solid food agreed that there is enough support available to help with weaning.

These findings may suggest a need for more support for new mums in their baby's first few years.

4.5 Breastfeeding, weaning and child's nutrition

Most PW02s acknowledged the benefits of breastfeeding and the majority of pregnant women intended to breastfeed their child. Social grade is associated with views on breastfeeding, and prevalence of breastfeeding in general.

Most PW02s (77%) agreed 'while your baby is still young, it is worth sticking with breastfeeding for as long as you can', and a quarter (27%) agreed that formula milk was as good for babies as breast milk. ABC1s were most likely to express positive views about breastfeeding, though the majority of C2DEs also did so.

Seven in ten pregnant women stated intentions to try breastfeeding their baby, and ABC1s and first-time mums were most likely to intend to.

Figure 42. Pregnant women – intentions to breast feed

Base: all pregnant women (300)

Whilst intentions to breastfeed were fairly high, in practice, half of mums continued to breastfeed exclusively beyond six weeks.

49% of mums said that they had breastfed / were breastfeeding their baby exclusively beyond six weeks, and this fell to 41% amongst C2DE mums (v 58% ABC1s).

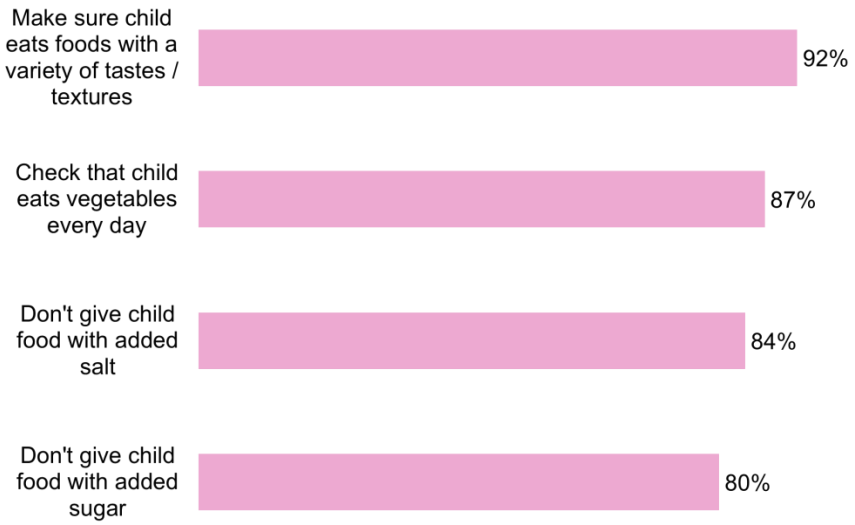
Norms were also important here, with those disagreeing that most of the mums they know breastfeed being less likely to continue breastfeeding beyond six weeks (46% v 60% who agreed).

Attitudes and norms, rather than demographics, impacted on mums' decisions on when to introduce solids.

The majority of mums (84%) said they had introduced solids into their baby's diet at 6 months or earlier (or intended to at 6 months or earlier). There were no differences in responses given by mums in different social grades.

As with parents in the main adult survey, mums were less likely to limit sugar in their child's diets than to implement other healthy eating practices (Figure 43).

Figure 43. % women who always/mostly … for their child



Base: All mums who have given child solid food (204)

5 Older people (55+s)

5.1 Health behaviours and influences

Over 55s were less likely than younger age groups to smoke, but were also less likely to have done 150+ weekly active minutes.

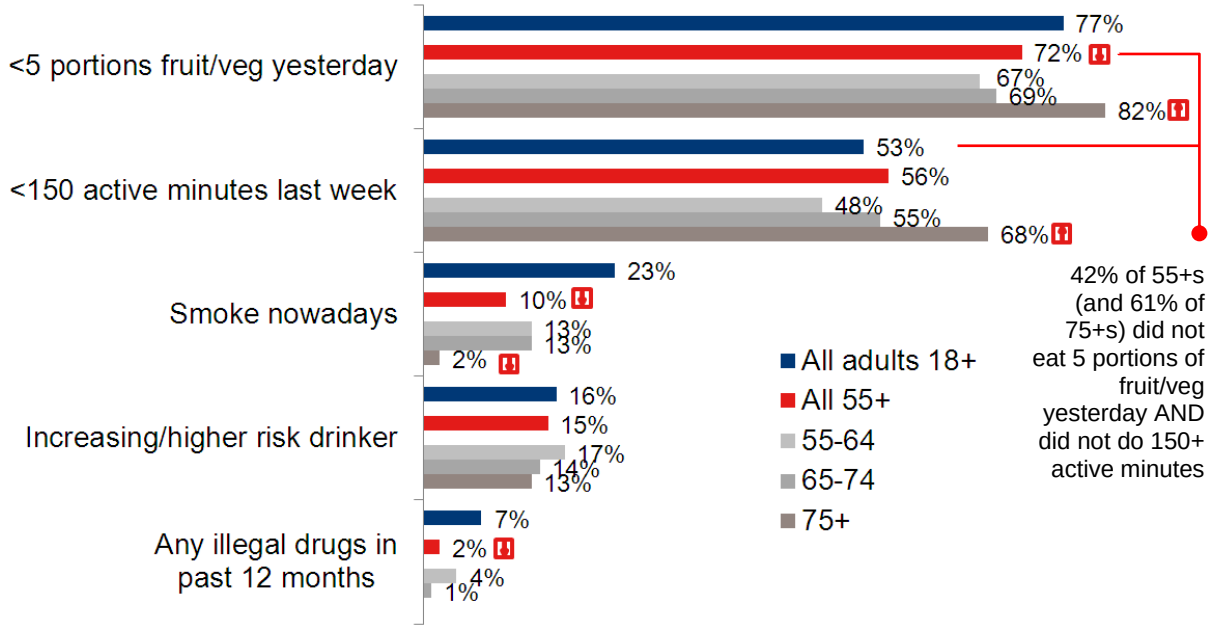
On some aspects, 55+s' diets were somewhat better than average, including less fatty food and fewer fizzy drinks than younger age groups. However, they were equally as likely to eat high calorie/sugary foods daily, and were no more likely to eat 5 a day.

Activity levels tailed off significantly amongst older age groups, with over two thirds of 75+s not doing 150+ weekly active minutes. Taken together, three fifths of 75+s did not meet the guidelines for physical activity or fruit/veg consumption.

Smoking prevalence amongst 55+s was less than half of the all adult average (10% compared with 23% on average): 75+s reported the lowest smoking prevalence (2%). Reported drug use amongst 55+s was also very low at 2% (compared with 7% on average).

However, 15% of 55+s were classified as increasing/higher risk drinkers: similar to the all adult average (16%). Prevalence of heavy drinking did not tail off as sharply amongst 75+s as for other risky behaviours (Figure 44).

Figure 44. % reporting each negative health behaviour



indicates significant difference comparing age groups within behaviour

Base: All respondents (1010), 55+ (388)

Influences on health behaviour amongst older people were very similar to those of the all adult population, though presence of existing health problems and depression were particular influences for older people.

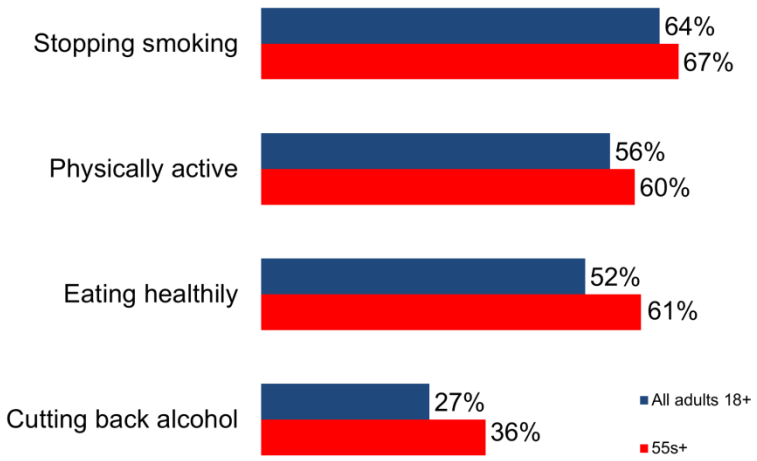
As with the all adult population household factors had an impact on behaviour for 55+s, as DEs were more likely to report they smoked and ate fewer than 5 portions of fruit/veg a day. Not living with a partner was significantly associated with higher levels of alcohol consumption. Similar to the rest of the adult population, one of the strongest drivers of risk behaviours, and in particular of smoking, was living with smokers. Associations were stronger for 55+s than for any other age group.

5.2 Attitudes towards health and intentions to change

Making healthy changes was the prevailing norm for 55+s to a greater extent than for younger age groups.

Over 55s were more likely than average to agree that eating healthily and cutting back on alcohol were the norms amongst people they knew. Two thirds (64%) of 55+s said that all or most of their friends and family were leading a healthy lifestyle nowadays (compared with a 55% all adult average). Those aged 75+ were the most likely to say this (70%)

Figure 45. % who agreed that more/most people they know are … nowadays



indicates significant difference (comparing 18+s vs. 55+s)

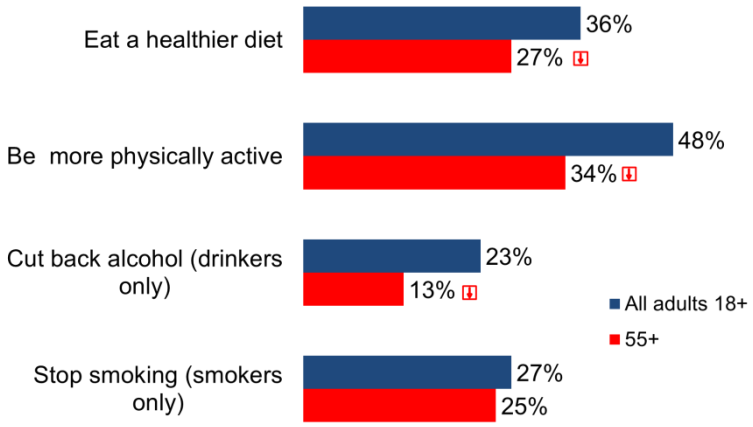
Base: All respondents (1010), 55+ (388)

Despite the prevailing norms of healthy changes for 55+s, this age group (and especially 75+s) were less likely than average to intend to make health changes themselves.

Over 75s were much less likely than average to intend to make healthy changes to their diet (18% compared with 36% all adult average) or activity levels (19% compared with 48% all adult average). This was despite the fact that 75+s were more likely than the all adult average to be eating fewer than 5 portions of fruit/veg daily or doing 150+ weekly active minutes.

Despite prevalence of increasing/higher risk drinking amongst 55+s being similar to the average their intentions to cut back on alcohol were lower than average (13% compared with 23% all adult average). Over 55s drinkers were also less likely than average to say that they had cut back their drinking in the last 3 months (23% compared with a 30% all adult average).

Figure 46. % saying they intend to make healthy changes within the next three months



indicates significant difference (comparing 18+s vs. 55+s)

Base: All respondents (1010), 55+ (388)

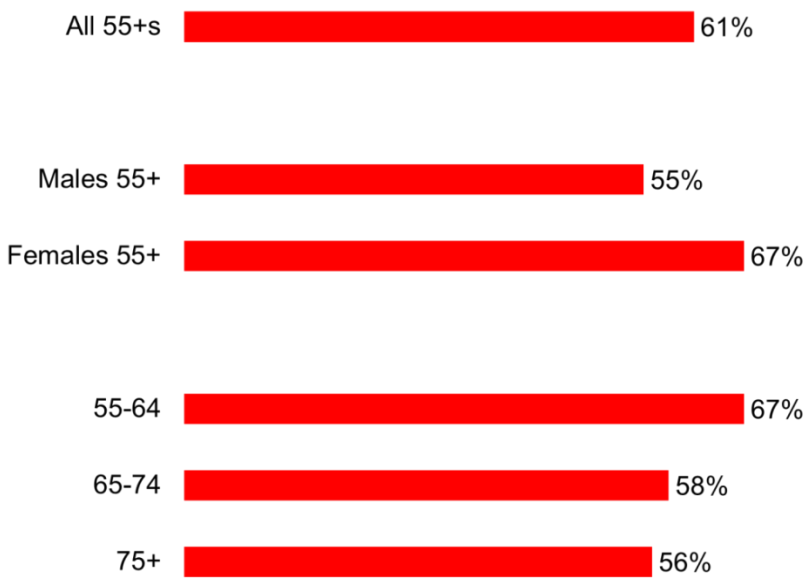
Similarly, although smoking prevalence was lower than average amongst 55+s, older smokers tended to smoke more (14 a day on average v 11 all adult average) and were more likely to say they don't intend to quit (46% compared with 28% all adult average).

5.3 Older people and conversations

One in ten 55+s were relatively isolated, and this rose to one in five of 75+s.

Three fifths of 55+s said that they see or speak to a relative or other adult outside their household every day, though males and 65s+ were less likely to say this.

Figure 47. % who said they see or speak to a relative or other adult outside their household every day



Base: All 55+s (388)

In addition, one in ten (13%) of 55+s lived alone and did not speak to someone every day, and the proportions saying this increased with age (7% of 55-64s, 14% of 65-74 and 22% of 75+s).

The research found few barriers to conversations about health for older people.

Around 6 in 10 55+s had had some sort of conversation about health with friends or family in the past 3 months: for just over a third (36%) this was a general conversation about health, while 27% had had a conversation about a specific health problem. Only around one in ten had discussed signs and symptoms with friends or family.

Over 55s tended to be heavier users of health services than the all adult average (e.g. 75% had used the GP in the past 6 months, compared with 65% on average), and perhaps linked to this they were less likely than average to say that there were any potential barriers to discussing symptoms with a doctor (e.g. 1% said they would be embarrassed, compared with a 6% all adult average).

6 Appendix

6.1 Methodology

The main audience for the Lifecourse Tracker research was adults aged 18+ in England. In addition, two other key groups were identified: young people aged 11-17 and pregnant women and mums of 0-2 year old babies (from herein referred to as PW02s). Separate surveys were conducted amongst each group because of the relatively low penetration of young people and PW02s in the general population.

A nationally representative sample was targeted in the adult and young people surveys with an additional boost amongst those living in the 10% most deprived areas of the country. The rationale for this skew was to ensure there were adequate sub samples in deprived areas; these are areas that often have a strong policy focus and a nationally representative sample does not necessarily deliver sufficient samples in these areas. This skew was corrected in the final figures, to produce a nationally representative picture.

The research was conducted after an extensive development phase. This included a full knowledge review of current questionnaires and policy documents, a consultative stage amongst key stakeholders and policy advisors and a piloting stage to ensure optimum questionnaire design. Questions included the survey balanced the needs of users with the requirement to use harmonised questions from established surveys.

Further details of the survey method for each group are described below:

6.2 Adult (18+) survey and young people survey (11-17s)

6.2.1 Method

Both of these surveys were conducted face to face in respondents' homes. Interviews were conducted using Computer Assisted Personal Interviewing (CAPI) which means that the interviewers used a laptop which controlled the questionnaire, order of presentation of questions and routing based on answers given. The questionnaire used Computer Assisted Self interviewing (CASI) for the most sensitive elements of the questionnaire – this meant respondents being given the CAPI laptop and answering the questions themselves. Respondents who were not comfortable using the CAPI laptop were given the option of listening to a selection of the CASI questions through headphones and then selecting the answers on the laptop touch screen.

It should be noted that the adult and young people survey were completely separate and their samples were NOT matched.

6.2.2 Sampling – adult survey

The sample was drawn using a random location sampling method. Fieldwork was completed across 103 sampling points in England and each sampling point took the form of

one Output Area[6] (OA). Interviewers were instructed to work for two days, with the aim of achieving an average of 10 interviews per sampling point.

The sample was drawn as follows:

1. **Selection of Output Areas[7] from the chosen constituencies**: OAs were selected following stratification within constituency by region, unitary authority and IMD rank. The selection was made with probability in proportion to size of the number of adults aged 18+. In order to obtain a boost of respondents in the 10% most deprived areas: 26 OAs were drawn from the 10% most deprived constituencies and 77 OAs were drawn from the full stratified list of all OAs in England. Once drawn, the profile of the selected OAs was checked against the national profile to ensure that it was representative by the key variables noted above. An equal number of substitute points were selected at the same time to be used if any of the original sample was ineligible for any reason (e.g. inaccessible gated communities, military housing within closed bases).
2. **Selection of addresses within each sampling point**: Interviewers were provided with lists of addresses which they could approach for interview, and they recruited respondents based on the quota provided to them.

Quotas were set on age and interlocked gender and working status (more specifically men working full-time, men not working full-time, women working, women not working). Quotas varied by sampling point to reflect the profile of the area in which interviewers were working.

6.2.3 Sampling – young people survey

A random location sampling method was used and fieldwork was completed at 103 sampling points in England with each sampling point taking the form of one OA. The sample was drawn in the following stages:

1. **Selection of OAs from chosen constituencies**. Initially, for fieldwork efficiency, the OAs that contained greater than 8% 11+s were selected. The sampling procedures were then identical to those described for the adult survey: stratification by region, unitary authority and IMD rank and selection of sampling points (OAs) with probability in proportion to the number of 11-17 year olds present. An additional boost sample was selected to boost the number of interviews with those in the 10% most deprived areas. .
2. **Selection of areas.** Interviewers were provided with lists of addresses which they could approach for interview, and they recruited respondents to quota.

Interlocking quotas were set on gender and age of the young person.

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[6] An Output Area (OA) is the smallest area for which detailed 2001 Census results are available. OAs were created specifically for statistical purposes on the basis of data from the 2001 Census. OAs contain an average of 125 households and around 300 residents: the minimum size is 100 residents or 40 households. Where possible, OA boundaries were drawn to contain populations with homogenous characteristics, and around small, free-standing settlements. For more information on Output Area geography, please see http://www.statistics.gov.uk/census2001/geo_methods.asp

6.2.4 Fieldwork

Figure 48 summarises key fieldwork figures:

Figure 48. Key fieldwork figure for adult and young people surveys

	Adult	Young people
Fieldwork dates	12th – 31st March 2012	14th March- 9th April 2012
Number of interviews	1010	608

To acquaint interviewers with the background to and objectives of the research, written briefing instructions were provided to all interviewers working on the survey. Interviewers were instructed to familiarise themselves with the objectives of the survey as well as the topics covered. Specific briefing points about question administration and points of clarification were provided to ensure consistency and high quality information was collected. Interviewers were invited to contact members of the research team if they had any queries specific to the survey or subject matter.

When completing fieldwork, interviewers adhered to the following rules to maintain fieldwork quality. They:

- only completed one interview per household
- completed no more than 4 interviews in any one road
- completed no interviews with people known to them
- registered at a local police station before starting work, to enable them to provide reassurance to respondents if needed

The survey introduction was carefully worded to encourage as wide a range of respondents as possible to take part – not only those interested in health issues.

A contact screener card was provided to interviewers which included all questions required to enable interviewers to establish eligibility. For the young people survey permission to interview the young person was sought from a parent or carer before the interview took place.

Upon concluding the interview all respondents were handed a sources of information leaflet. The leaflets contained a list of contacts to go to for help and support regarding the issues which were covered in the survey. The purpose of the leaflet was to provide the respondent with a mechanism for accessing support if necessary and was part of GfK NOP's duty of care to respondents. In addition to the information leaflet, a thank you leaflet was also provided. This contained contact details for GfK NOP in case there were any later queries. A large print version of this leaflet was also made available, if required.

As previously mentioned, interviewers were set quotas which were specific to the area in which they were working. Quotas were based upon profile information from the 2001 Census.

6.3 Pregnant women and mums of 0-2s

6.3.1 Method

Due to the relatively low penetration of pregnant women and mums of 0-2s in the general population, the optimal method for interviewing this group was through an online survey. Respondents were contacted through the Emma's Diary database. Emma's Diary is an online and printed pregnancy guide produced in association with the Royal College of General Practitioners, which provides advice and guidance to mums-to-be about their pregnancy. Emma's Diary estimates that around 90% of pregnant women receive the publication, and almost all register with them. The survey only included mums of babies who were aged up to 24 months as this was the limit of the database.

6.3.2 Sampling

A representative random sample was drawn from the Emma's Diary database. The sample was drawn following stratification of the database by region, age of mother and stage of pregnancy / age of child.

6.3.3 Fieldwork

Fieldwork was conducted between 21st – 31st March 2012. In total 547 surveys were conducted: 300 women completed a survey about their pregnancy and 247 about being a mother of a 0-24 month old.

6.4 Data

The achieved samples were weighted to the known profile of adults / young people / pregnant women/mums of 0-2s from sources such as the Office of National Statistics. Figure 49 through to Figure 51 show what the data was weighted by.

Figure 49. Profile of adults interviewed –before and after weighting has been applied

	Weighted	Unweighted		Weighted	Unweighted
Gender and age			**IMD grouping**		
18-24 Male	6%	5%	10% most deprived	10%	33%
25-34 Male	9%	7%	10%-20%	10%	8%
35-44 Male	9%	7%	20%-40%	20%	18%
45-54 Male	9%	8%	40%-60%	20%	18%
55-64 Male	7%	6%	60%-80%	20%	15%
65-74 Male	5%	6%	80%-100% least deprived	20%	8%
75-84 Male	3%	4%			
85+ Males	1%	1%	**Ethnicity**		
18-24 Female	6%	6%	White	89%	88%
25-34 Female	8%	9%	Asian	4%	5%
35-44 Female	9%	11%	Black	3%	5%
45-54 Female	9%	8%	Other	3%	2%
55-64 Female	8%	9%			
65-74 Female	6%	7%	**Working Status**		
75-84 Female	4%	5%	Full Time	45%	30%
85+ Females	2%	2%	Part Time	14%	15%
			Not Working	41%	55%
Government office region					
North East	5%	5%	**Children in the household**		
North West	13%	20%	Children under 16	28%	31%
Yorkshire And The Humber	10%	13%	None under 16	72%	69%
East Midlands	9%	9%			
West Midlands	10%	13%			
Eastern	11%	9%			
London	15%	14%			
South East	16%	10%			
South West	10%	7%			

Figure 50. Profile of young people interviewed – before and after weighting has been applied

	Weighted	Unweighted		Weighted	Unweighted
Gender and age			**IMD grouping**		
11 year old Male	7%	8%	10% most deprived	10%	36%
12 year old Male	7%	8%	10%-20%	10%	8%
13 year old Male	7%	8%	20%-40%	20%	19%
14 year old Male	7%	9%	40%-60%	20%	14%
15 year old Male	7%	6%	60%-80%	20%	10%
16 year old Male	8%	5%	80%-100% least deprived	20%	14%
17 year old Male	8%	6%			
11 year old Female	7%	6%	**Ethnicity**		
12 year old Female	7%	9%	White	83%	80%
13 year old Female	7%	9%	Asian	7%	10%
14 year old Female	7%	8%	Black	6%	5%
15 year old Female	7%	6%	Other	4%	4%
16 year old Female	7%	7%			
17 year old Female	7%	5%	**Social grade of head of household**		
Government office region			ABC1	47%	40%
North East	5%	5%	C2DE	53%	60%
North West	14%	20%			
Yorkshire And The Humber	10%	12%			
East Midlands	9%	11%			
West Midlands	11%	13%			
Eastern	11%	8%			
London	13%	14%			
South East	17%	11%			
South West	10%	7%			

Figure 51. Profile of pregnant women and mothers interviewed – before and after weighting has been applied					
	Weighted	**Unweighted**		**Weighted**	**Unweighted**
Age and social grade			**Government office region**		
18-24 ABC1s	5%	7%	North East	4%	6%
25-29 ABC1s	12%	16%	North West	13%	11%
30-34 ABC1s	15%	23%	Yorkshire and the Humber	10%	12%
35+ ABC1s	12%	12%	East Midlands	8%	12%
18-24 C2DEs	18%	10%	West Midlands	10%	12%
25-29 C2DEs	16%	14%	Eastern	11%	10%
30-34 C2DEs	13%	11%	London	19%	13%
35+ C2DEs	8%	8%	South East	15%	18%
			South West	9%	8%

The effective sample size was calculated for all surveys. This describes the effect of the weighting on the accuracy of survey estimates. The effective sample size is dependent upon the size of weights applied to respondents: the more the weights deviate from 1, the smaller the effective sample size and the less accurate estimates will be.

The effective sample size each survey was

- Adult survey 633 or 63% of the interviewed sample size
- Young people survey 405 or 67% of the interviewed sample size
- PW02 survey 460 or 84% of the interviewed sample size.

For the adult and young people survey much of the impact of the weighting on the effective sample size resulted from weighting by deprivation: that is downweighting the interviews in deprived areas which were oversampled.

The data was tabulated and analysed by key groups such as life course, gender and social grade. The data was also produced in SPSS for bespoke analysis.

6.4.1 Presentation of results

The survey method employed means that true statistical significance cannot be inferred but we have used it as a proxy for our analysis. Any differences reported would be statistically significant at the 95% level. Where differences are large but not significant these have been referred to as 'slight' differences. It should be noted that statistical significance is not intended to imply substantive importance.

6.4.2 Social grade groupings

We have classified respondents into broad social grade grouping based on the chief income earner in the household. These groups are based on the following:

Figure 52. Social grade definitions

Grade	Chief income earner's occupation
A	Higher managerial, administrative or professional
B	Intermediate managerial, administrative or professional
C1	Supervisory or clerical and junior managerial, administrative or professional
C2	Skilled manual workers
D	Semi and unskilled manual workers
E	Casual or lowest grade workers, pensioners and others who depend on the welfare state for their income