Brighton and Hove City Wide Needs Assessment Programme

Health and wellbeing Joint Strategic Needs Assessment Summary 2011

NHS Brighton and Hove

Brighton & Hove City Council

Contents

Joint Strategic Needs Assessment (JSNA)

Needs assessment is essential to ensure the commissioning of effective health and social care services. The Local Government and Public Involvement in Health Act (2007) placed a duty on local authorities and Primary Care Trusts to work in partnership and produce a JSNA. JSNA has been described as

"a process that identifies current and future health and wellbeing needs of a local population, informing the priorities and targets set by Local Area Agreements and leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities" (Department of Health, 2007).[1]

It intends to identify "the big picture" in terms of the current and future health and wellbeing needs of the local population. Where there is a lack of local data, other studies and evidence have been used to make extrapolations to the local population.

An ongoing rolling programme of needs assessments in Brighton and Hove is underway which forms part of a portfolio of needs assessment resources for the city.

Themes may relate to specific issues, e.g. mental health and wellbeing, or population groups, e.g. children and young people. Needs assessments are available to the public and include recommendations to inform commissioning. A publicly available data profile will be produced for each needs assessment that will be updated as new data become available.

An online resource has been launched within the Brighton and Hove Local Information Service (BHLIS) (available at www.bhlis.org) and will be expanded as the city wide needs assessment portfolio develops.

The needs assessment programme for the city is starting to be broadened outside of health and wellbeing as part of the city council's intelligent commissioning programme.

The recent Public Health White Paper *Healthy Lives, Healthy People* (November 2010) reinforces the importance of joint strategic needs assessment and envisages that the new health and wellbeing boards will develop joint health and wellbeing strategies based upon the evidence from the JSNA.

Each year, a JSNA summary, giving an high level overview of Brighton and Hove's population, and its health and wellbeing needs will be published. It is intended to inform the development of strategic planning and identification of local priorities.

The information is primarily drawn from the city's needs assessment portfolio, which includes the Annual Reports of the Director of Public Health along with specific needs assessments and strategies including the Children and Young People's Plan (2009-12), the Sustainable Community Strategy and the Housing Strategy.

For this reason it is not possible to thank individually all of those involved in producing this summary by name, however we are grateful for the close working between partners on this summary and on needs assessment in Brighton and Hove.

Needs assessments being conducted in 2010/11 (which will be made available on BHLIS once published) include:

- Children and young people with disabilities and complex health needs—available now
- Adults with learning disabilities
- Adults with autism
- Diabetes
- Child poverty
- Domestic violence
- Alcohol
- Drug related deaths

Local people, local needs

Brighton and Hove city is located between the sea and the South Downs. It is known for its easy-going approach to life, quirky shopping, restaurants, festivals and beautiful architecture. Many people choose to come and live in the city for the opportunities it offers.[2] The city has a relatively large proportion of younger adults, and a high proportion of students and lesbian, gay, bisexual and transgender residents. However, Brighton and Hove is one of the most deprived areas in the South East and has a population with significant health needs and inequalities.

It has been estimated that the NHS contribution to any future increase in life expectancy, whilst significant, is limited and that other factors (the social determinants of health) such as education, employment and housing have a greater impact.

Some of the main social issues include:

- High levels of deprivation;
- Significantly higher child poverty rates than the South East and high numbers of children in households with no working adults;
- A higher unemployment rate than the South East and nationally;
- The number of people claiming out-of-work and incapacity benefits;
- Sections of the population with low skills;
- Employment predominantly in the service sector;
- Lower average earnings than the South East;
- Poor educational attainment;
- Higher levels of young people not in education, employment or training than the South East;
- High housing cost relative to incomes;
- High level of non-decent housing, particularly for vulnerable households;
- Higher levels of homelessness than the South East and England;
- One in ten households are fuel poor;
- High volume of road traffic making trips which start and end within the city with the resulting impact on air quality.

Particular health and wellbeing needs in Brighton and Hove include:

- Almost half of the population in the city has current or possible future health concerns linked to lifestyle issues;
- Widening inequalities in life expectancy and cancer and circulatory disease mortality rates;
- Significantly higher under 75 mortality rates than England and the South East;
- Low screening coverage;
- High estimated smoking prevalence;
- High rates of sexually transmitted infections and HIV prevalence;
- Teenage conception rates, whilst reducing, are higher than the South East;
- High levels of mental health problems and a high suicide rate;
- High estimated levels of domestic and sexual violence;
- High levels of morbidity and mortality related to alcohol and drugs;
- Whilst childhood obesity rates are lower than nationally and falling, still more than one in seven 10-11 year olds are obese;
- Large numbers of people with long term conditions;
- Significant needs of those with physical disabilities, learning disabilities and autism - both adults and children;
- The number of carers and young carers;
- End of life care.

These issues affect distinct groups and communities in different ways. Particular groups have specific needs and issues with accessing services. Some of these are evidenced here and further evidence provided within individual needs assessments.

It is important to recognise the recent recession and the impact this may have on social determinants of health and wellbeing. The next Annual Report of the Director of Public Health will be focussed on community resilience, described as when a community does better than expected in the face of adversity, and is particularly important given the current economic climate.

Our population

Local demographic trends

Brighton and Hove has an unusual population distribution compared to the national picture. There are relatively large numbers of people aged 20 to 44 years, with relatively fewer children and older people. However, there are relatively more very elderly people (aged 85 years or over), particularly women, who are likely to have increased needs for services.

Total population

The resident population of Brighton and Hove has risen from 248,400 people in 2002 to 256,300 in 2009 (an increase of 3.2%) according to the Office for National Statistics (ONS) mid-year estimates.[3]

Age

The 2009 ONS mid-year population estimates showed that Brighton and Hove has 21.5% of the population aged 19 years or under, 64.5% of the population aged 20-64 years and 14.0% aged 65 years or over. This compares to 24.1%, 58.9% and 17.0% in the South East and England figures of 23.9%, 59.8% and 16.3%. So whilst there is a lower proportion of children in the city, the adult population is younger than in the South East and England.[3]

Gender

Brighton and Hove has a fairly even population split by gender with 51% of the population female and 49% male. There is a younger age structure for men in the city, which is also seen nationally, mainly due to lower life expectancy for men. Despite the narrowing gap in life expectancy between men and women, men tend to develop and die from conditions much sooner than women. The difference is likely to be a result of a combination of behavioural/ environmental and biological/genetic factors. The former Chief Medical Officer, Sir Donald Acheson, has suggested that the explanation for the gender gap is hormones; among younger, testosterone-fuelled men, accidents and violence are the main cause of death, and in later life it is heart disease, against which women are protected by oestrogen. Men also die in larger numbers from lung cancer, as historically they have been heavier smokers. NHS services have to be designed differently to meet the needs of men and women, for example men tend not to use primary care as effectively as women. (D. Wilkins et al, 2008).[4]

Ward level population

Hollingbury and Stanmer is the ward with the highest percentage of children and young people aged 19 years and under in Brighton and Hove (32.2% of the total population) whereas Regency has the lowest percentage of children and young people (8.3%).[5]

Older people (aged 65 years or over) live across all areas of the city however, a larger percentage of older people reside in Westbourne (23.8%), Central Hove (21.8%) and Rottingdean Coastal (25.3%), Wish (21.2%) and Goldsmid (20.6%).

LGBT

The city is known for its lesbian, gay, bisexual and transgender (LGBT) community, estimated to be about one in six people in the city.[6] We do not have Census data about LGBT people because neither sexual nor gender identities are part of the Census questions.

Students

Brighton is a city with a substantial student population with two universities; the University of Brighton and the University of Sussex. There has been a sustained increase in the numbers of students at the two universities in the city from almost 26,000 in 1995/96 to over 33,000 in 2008/09 with many students staying on after university.[7]

Migration

The city is also a destination for migrants from other parts of Europe with 15% of the city's population born outside England, higher than for the region and for England.

Ethnic groups

At the time of the 2001 Census, 88% of the Brighton and Hove population were from White British groups compared with 87% in England. More recent estimates produced for 2007 suggest that the local picture is changing.

In 2007, using the ONS mid year estimates by ethnic group,[8] people from Black and Minority Ethnic (BME) groups (all ethnic groups except White British) made up 16% of the population of Brighton and Hove, an increase from 12% in 2001. These changes are important as different ethnic groups experience different disease patterns but can also experience differing levels of access to services.

The age structure of the BME population is considerably younger than the White British population; 26.3% of the BME population in Brighton and Hove is aged 0-19 years compared to 21.2% of the White British population.

Gypsy and travellers

The Census has not previously recorded gypsies and travellers as a separate group but will do so for the first time in 2011. A recent study by Friends Families and Travellers (2010)[9] gave an estimated 103 babies, children and young people up to the age of 16 in the city.

Brighton and Hove does not have a permanent site and has one temporary site where families can stay for one to three months depending on health issues.

Evidence brought together locally by Hall et al (2009)[10] showed that it is recognised that gypsies' and travellers' health overall is poorer than others in socially deprived areas (Parry et al, 2007)[11] and that they have low expectations of their health and make limited use of health services.[12] This is compounded by health professionals' lack of knowledge about this group.[13]

Fertile female population

Data from the ONS shows that there were 62,300 women of child bearing age (15 - 44 years) in Brighton and Hove in 2009, representing 48% of the total female population. This compares to 40% in England and 38% in the South East.[3]

General fertility rate

The general fertility rate is the number of live births per 1,000 females aged 15-44 years. In 2009 Brighton and Hove had a general fertility rate of 52.5 live births per 1,000 women aged 15-44, a fall from 2008 (53.6 per 1,000). This is lower than the England figure of 63.8 per 1,000 in 2009 and 62.6 across the South East. Table 1 shows the trend in the general fertility rates from 2004 to 2009.[14]

Rates are lower in the younger age groups and higher in the older age groups (particularly those aged 35-39 years) than in the South East and nationally.

Although the central wards have the highest numbers of 15-44 year old women, probably due to high concentrations of university students, fertility rates are highest in the west of the city and in Woodingdean in the east.

Births

The number of live births in England and Wales has decreased for the first time in eight years. There were 706,248 live births in 2009, compared with 708,711 in 2008.

There was also a slight fall in the city to 3,274 births in 2009. Prior to this births had been increasing over recent years from 3,035 births in 2005 to 3,303 in 2008.[14]

Nationally, there was a continued rise in the proportion of births to mothers born outside the UK: 29.4 per cent in 2009 from 14% in 1998.[15]

Between 2000 and 2008, the number of births per year varied across the city. Increases were seen predominantly in the wards along the coastal strip in the west of the city.

Table 1: General fertility rates (rate per 1,000 female population aged 15-44 years) in Brighton and Hove, the South East and England 2004 - 2009

	2004	2005	2006	2007	2008	2009
Brighton and Hove	47.7	49.0	52.1	50.6	53.6	52.5
South East	57.4	57.3	60.1	60.8	62.5	62.6
England	58.4	53.5	60.6	62.1	63.9	63.8

Source: Office for National Statistics Vital Statistics

Population projections

Changes in the population age structure affect the need for health and social care services. Population projections therefore have an essential role in assessing the future need for services. Current trends in births, deaths and migration are projected forwards and used to produce population projections.

The resident population is predicted to increase from 256,300 in 2009 to 262,700 in 2014 and 269,000 in 2019 (a 5.0% increase). The greatest projected increase will be seen in the 25-34 and 50-59 year age group (Figure 1). There will also be increased numbers of younger children. The number of people aged 75 years or over is expected to fall slightly (ONS sub national population projections).[16]

Understanding the likely changes in birth rates is important in understanding population change and for anticipating the future need for maternity and child health services.

Important factors determining the number of births in an area include the fertile female population and general fertility rates.

Fertile female population projections

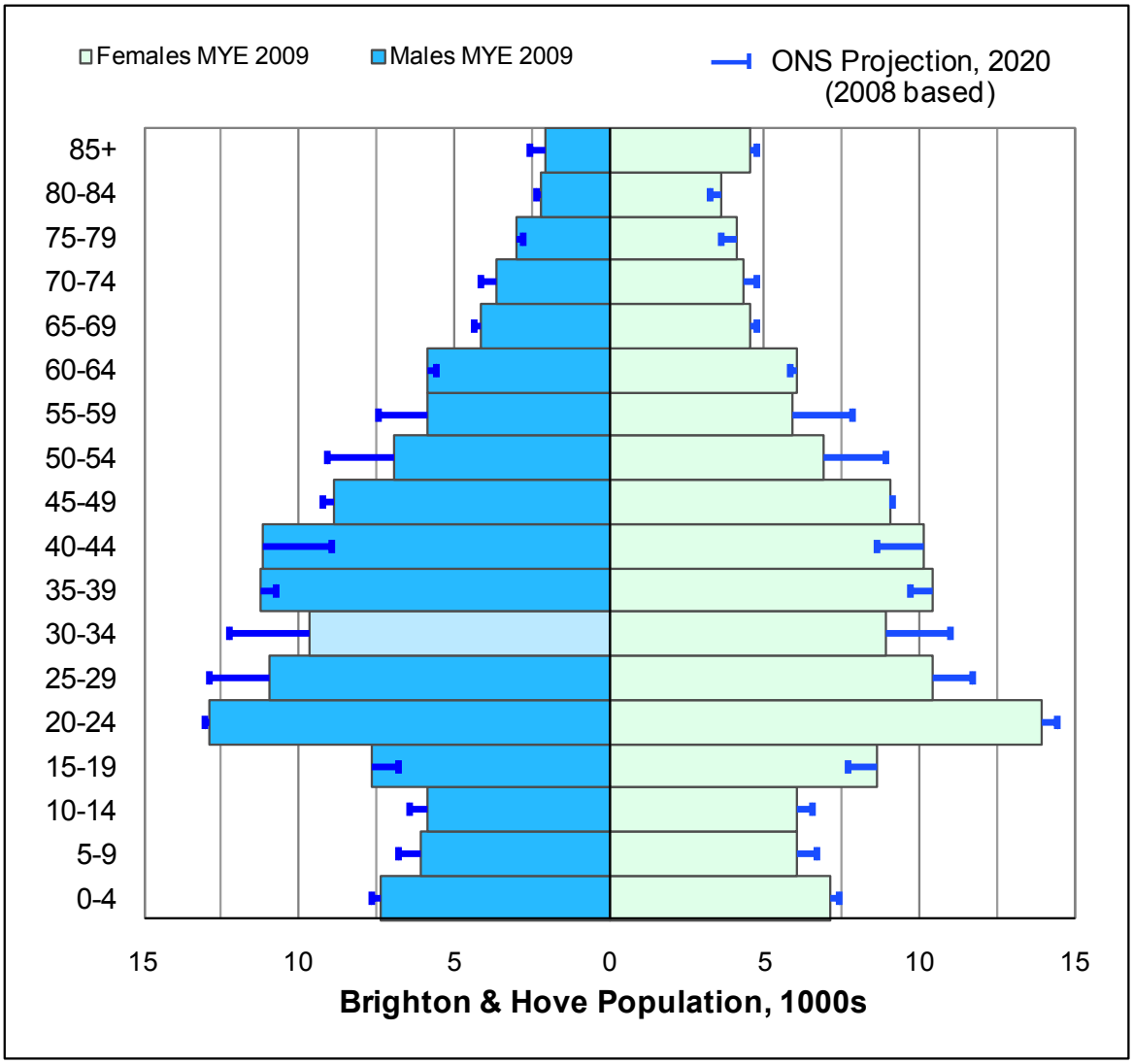
The fertile female population of Brighton and Hove is projected to rise over the next decade by 0.6%, compared to a fall of 0.5% in England and a 0.2% fall in the South East.[16]

Projected births

In order to estimate future numbers of births the projected general fertility rate is multiplied by the projected fertile female population (and divided by 1,000) to give the number of births.

In Brighton and Hove the number of births per year is projected to increase by 3.0% from 2009 to 2020 (to 3,400 births), similar to the projected 2.5% increase in the South East and a 2.8% increase in England.[16]

Figure 1: Population pyramid for Brighton and Hove - 2009 mid-year estimate and 2020 population projection



Source: Office for National Statistics mid-year estimate and sub-national population projections

Population segmentation

Analysis of the MOSAIC Public Sector[17] dataset, which describes population in terms of demographic, social, economic, lifestyle and behaviour factors reveals that there are a number of dominant groups in Brighton and Hove – in particular:

- Group E (educated, young single people living in areas of transient populations) with over a third of the population in this group
- Group J (independent older people with relatively active lifestyles),
- Group C (older families living in suburbia) and
- Group F (people living in social housing with uncertain employment living in deprived areas).

These four groups comprise over 70% of households in Brighton and Hove; 34%, 15%, 13% and 10% respectively (Table 2, see Appendix 1 for full breakdown).

This is considerably different to the profile for England, particularly the large proportion of the population classed as educated, young single people living in areas of transient populations at 34.2% of Brighton and Hove's population compared with 8.4% of the population of England. This has significant impact not only on the needs of the city's population but also on the way that services are delivered.

The dominant groups are located within particular areas of the city with Groups E and F being concentrated centrally within the city; Group C has concentrations around Portslade, Patcham, Woodingdean, Preston Park, Hangleton and Knoll, and Wish; whilst Group J is more spread but with clusters in Rottingdean Coastal, Central, Hangleton and Knoll and Westbourne wards.

Table 2: MOSAIC Public Sector profile Brighton and Hove and England, 2008

	Brighton and Hove		England	
	Number of households	% of households	Number of households	% of households
Career professionals living in sought after locations	7,817	6.4	2,212,547	10.2
Younger families living in newer homes	3,184	2.6	2,283,206	10.5
Older families living in suburbia	15,412	12.7	3,446,883	15.8
Close-knit, inner city and manufacturing town communities	7,630	6.3	3,791,217	17.4
Educated, young, single people living in areas of transient populations	41,575	34.2	1,817,840	8.4
People living in social housing with uncertain employment in deprived areas	12,244	10.1	1,227,988	5.6
Low income families living in estate based social housing	3,955	3.3	1,340,365	6.2
Upwardly mobile families living in homes bought from social landlords	8,493	7.0	2,099,128	9.7
Older people living in social housing with high care needs	2,982	2.5	731,788	3.4
Independent older people with relatively active lifestyles	18,121	14.9	1,793,323	8.2
People living in rural areas far from urbanisation	23	0.02	1,010,428	4.6
Total	**121,436**	**100**	**21,754,713**	**100**

Source: MOSAIC

HealthAcorn[18] is a classification of Census output areas using indicators of existing health, lifestyle and food consumption which relate to current and future health. The classification segments the population into four major groups:

Existing problems - High levels of serious illness and poor diet and consumption patterns.

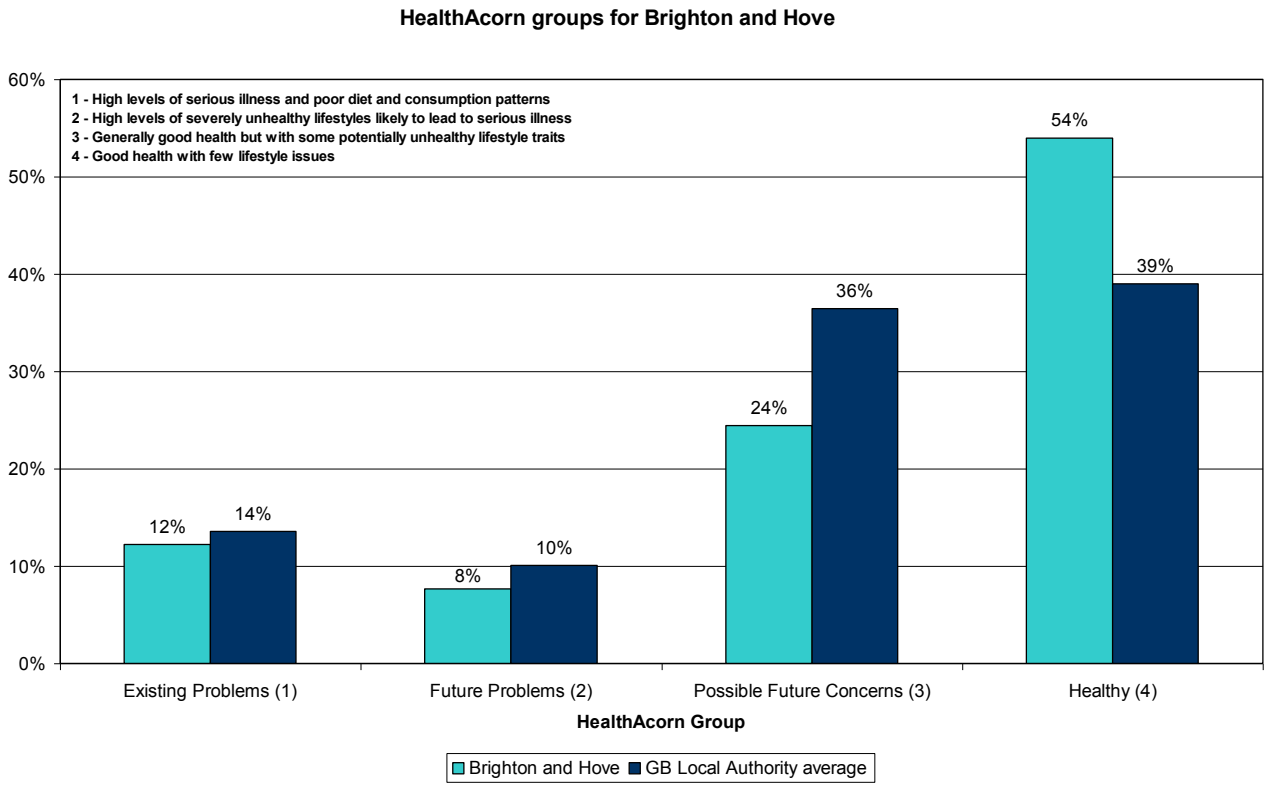
Future problems - High levels of severely unhealthy lifestyles likely to lead to serious illness.

Possible future concerns - Generally good health but with some potentially unhealthy lifestyle traits.

Healthy - Good health with few lifestyle issues.

According to the HealthAcorn classification for Brighton and Hove, 54% of the population belong to the healthy group, 24% have future possible concerns, 8% with future problems and 12% with existing problems. This compares well with the average for all areas in Great Britain but almost half of the population in the city has current or possible future health concerns linked to lifestyle issues (Figure 2).

Figure 2: Proportion of households by HealthAcorn group in Brighton and Hove



Source: HealthAcorn

Health inequalities

Social inequalities and health inequalities

Inequalities, in the broadest sense, are often the root causes of health inequalities, and we refer to them as the social determinants of health, or the 'causes of the causes'.

Inequalities exist across the city both between neighbourhoods and within population groups, including between genders, ethnic groups, people living with physical and learning disabilities, LGBT residents, carers and the homeless.

Whilst other factors, such as biological or genetic disposition, are important, social inequalities are a key driver of ill health. Factors such as employment, education, housing, transport, leisure, crime and disorder, neighbourhood renewal, child poverty, fuel poverty and food poverty all make a significant contribution to health and wellbeing.

The NHS alone has limited scope to address these factors, which is why partnership working to reduce inequalities is crucially important. Tackling the social determinants of health is vital in reducing health inequalities.

The previous Brighton and Hove Health Inequalities Strategy was primarily focused on health activities. The new strategy will give greater prominence to identifying partnership action to tackle social determinants of health.

A particular challenge in reducing health inequalities in Brighton and Hove is that while the mortality rate for all groups in the city is expected to improve, it is improving faster in more affluent areas, so local inequalities are expected to increase without targeted interventions.

Brighton and Hove achieved World Health Organisation (WHO) Healthy City status in 2004 which helped cement joint public health working across the city, and again in 2010. WHO Healthy City status has been the platform through which many initiatives to address improvements in health and reductions in health inequalities have been enacted through planning, leisure, environment, transport, education, employment and economic development services.

The overarching aim for the current phase of the Healthy City programme (2009-2013) is health equity in all policies.

Marmot Review 2010

Fair Society, Healthy Lives, the Marmot Review of Health Inequalities, was published in February 2010.[19] It provides a strategic review of health inequalities in England.

A Life-Course based approach is taken, because of the cumulative impact of social, economic, psychological and environmental experiences on health and health inequalities (Figure 3). Five age groups are identified:-

- Pre-birth and early years (up to age 5)
- Children and young people in early education (age 5–16)
- Early adulthood (age 17–24)
- Adults of working age (age 25–64)
- Adults of retirement age (age 65+)

along with six policy objectives requiring joined up action at a national and local level.

This is the approach being taken in the new health inequalities strategy for the city which will be published in 2011.

National health inequalities targets

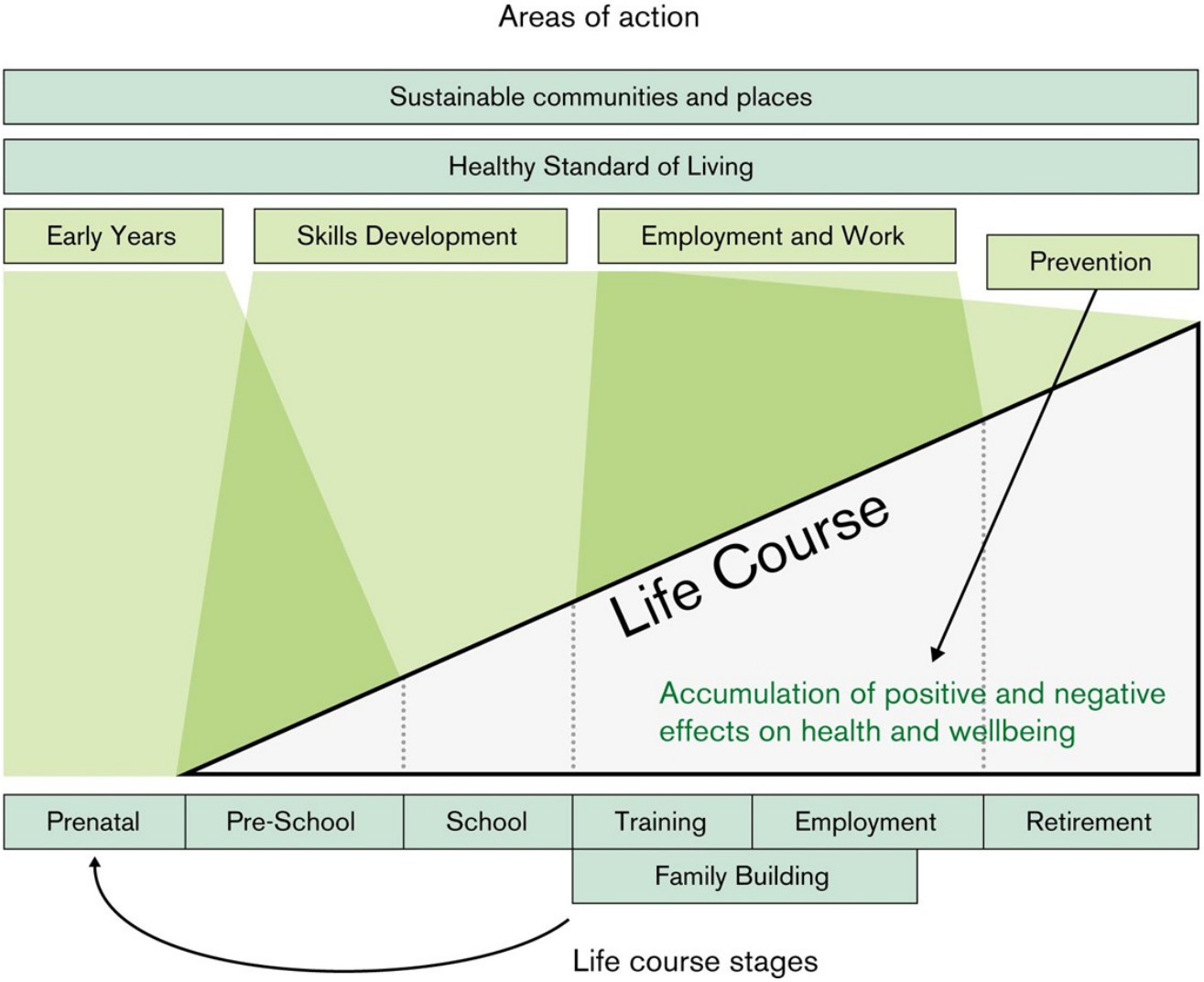
Meeting the 2010 targets on infant mortality and life expectancy is central to the current national health inequalities agenda:

- *starting with children under one year, by 2010 reduce by at least 10% the gap in infant mortality between the routine and manual group and population as a whole.*
- *starting with local authorities, by 2010 to reduce by at least 10 per cent the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators (the Spearhead group) and the population as a whole.*

Data for 2006-08 show life expectancy in England and the Spearhead group is at record levels. However, the increase in the Spearhead group is not as great as other areas so the inequality gap has widened. For males the relative gap between England and Spearhead areas was 7% wider than at baseline, for females 14% wider.

For infant mortality, the 2006-08 figures show that the gap between the England and the routine and manual group has remained constant. Both have seen historic low levels, with a reduction in the rate across the whole population matched by a reduction in the rate for the routine and manual group.

Figure 3: Actions across the life course from the Marmot Review of Health Inequalities



Local health inequalities targets

The 2005 Brighton and Hove Strategy to Reduce Inequalities set out a number of health inequalities targets between neighbourhood renewal areas and the rest of the city. These have been updated to look at progress and have been adapted to compare the most deprived 20% of the population with Brighton and Hove as a whole to meet with the current measurement of inequalities in terms of the Index of Multiple Deprivation (IMD) 2007.

We are on track to meet the current local health inequalities targets for 2010 in relation to:

- All age all cause mortality
- Deaths from circulatory disease (under 75)

We are not on track to meet the current local health inequalities targets in relation to:

- Deaths from cancer (under 75)
- Emergency hospital admissions
- Over 65 years emergency hospital admissions

However, there are still significant inequalities across the city. Using data for 2006-2008 for deaths and 2009/10 for admissions, if those in the 20% most deprived areas had the same mortality or emergency admissions rates as in the 20% least deprived there would be:

- 59 fewer deaths per year
- 12 fewer deaths from cancer of those aged under 75 years
- 12 fewer deaths from circulatory diseases of those aged under 75 years
- 3,226 fewer emergency admissions
- 1,022 fewer emergency admissions of those aged 65 years or over

More detail can be found in the Brighton and Hove health inequalities profile which will be launched in 2011.

Inequalities in life expectancy and overall mortality are shown in this section, but inequalities is a theme which runs throughout this summary in terms of both inequalities in social determinants and the resulting inequalities in health and wellbeing.

Life expectancy and overall mortality

Life expectancy tells us how long a baby born today would be expected to live if they experienced the current mortality rates of the area they are born in throughout their lifetime.

Life expectancy in Brighton and Hove is 77.1 years for males and 82.5 for females (2007-09). Whilst females in the city can expect to live on average six months longer than nationally, life expectancy for males is almost a year lower than in England (78.0 years for males and 82.1 years for females).

Life expectancy at age 65 is 17.8 years for males and 21.1 years for females in Brighton and Hove compared with 18.0 and 20.6 respectively for England.

The slope index of inequality in life expectancy gives a measure of the hypothetical difference in life expectancy between the most deprived and least deprived individuals. It is a more sensitive measure than the difference in mortality between the most deprived and least deprived quintiles of population as it looks at differences in life expectancy across the whole population.

In 2004-2008 the slope index was 10.1 years for males and 6.2 years for females in Brighton and Hove. For females in the most deprived 10% of Lower Super Output Areas (LSOAs) in the city, life expectancy is 79.2 years compared with 84.0 years in the least deprived 10% of LSOAs. A Lower Super Output Area is an area of approximately 150 households. The equivalent figures for males are 70.8 and 80.7 years respectively (Figures 4 and 5). For males this gap is almost two years wider than nationally, though not statistically significantly different.

The National Health Inequalities Intervention Tool produced by the London Health Observatory gives the contribution of specific causes of death to the life expectancy gap between the most deprived quintile in Brighton and Hove and the national average (Figure 6).[20]

For men, the biggest contributor to the gap is coronary heart disease, followed closely by lung cancer, chronic cirrhosis of the liver, suicide and undetermined injury, and other accidents. For women coronary heart disease and other cardiovascular diseases are the biggest contributors to the life expectancy gap, followed by lung cancer, other cancers, and suicide and undetermined injury.

The South East Health Inequalities Gap Measurement Tool, produced by the South East Public Health Observatory (SEPHO), shows the trend in all age all cause mortality rates from 2001 to 2008, with projected rates for 2009 to 2011 for the most and least deprived quintiles within the city (Figure 7). Whilst mortality rates are falling in all groups, they are falling at a faster rate in the least deprived quintile and so inequalities are widening.[21]

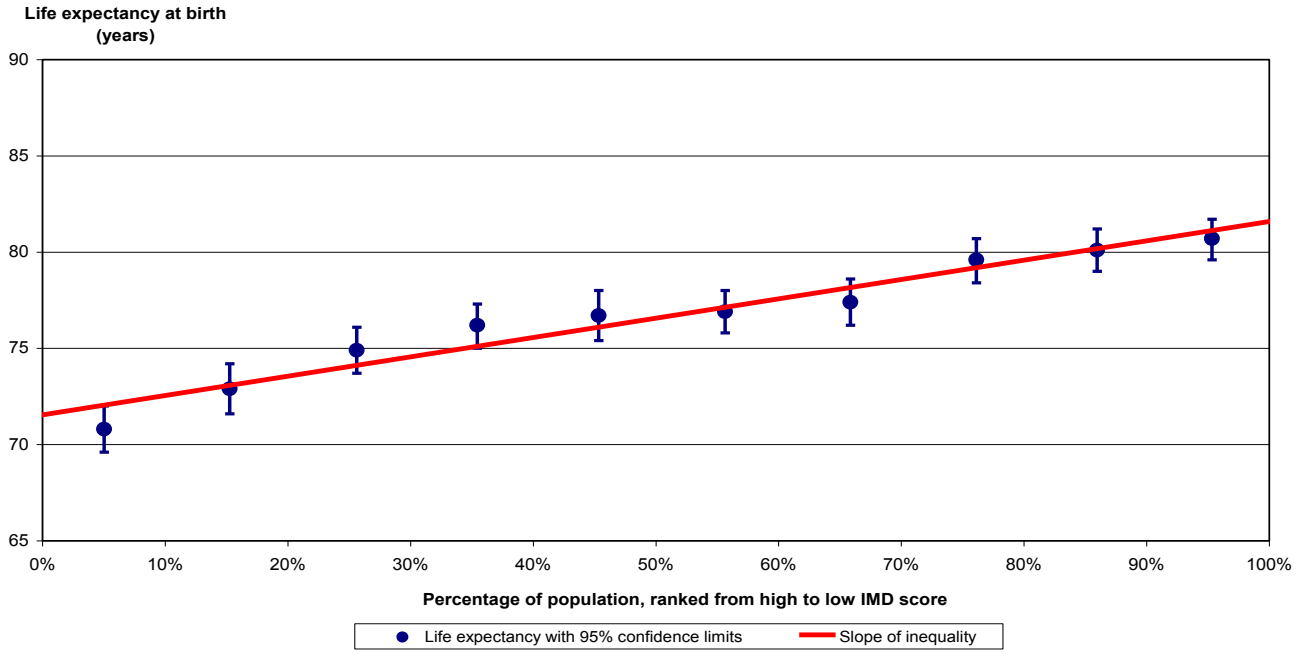
Across Brighton and Hove the mortality rate fell by 22% between 2001 and 2008. For those living in the least deprived areas the fall was 36% compared with 15% for those living in the most deprived areas. It is projected that the gap will continue to widen without focused intervention in the more deprived groups.

Male mortality rates have fallen by 20% in the most deprived quintile and by 26% in the least deprived but the absolute inequality gap has reduced from 491.6 deaths per 100,000 in 2001 to 439.4 deaths per 100,000 population in 2008 (Figure 8).

The equivalent figure for females (Figure 9) shows that mortality has fallen by just 8% in the most deprived quintile but by 35% in the least deprived between 2001 and 2008 meaning that the absolute inequality gap has risen from 102.6 deaths per 100,000 in 2001 to 250.5 deaths per 100,000 population in 2008 (2.1 times higher in 2008 than 2001).

Figure 4: Life expectancy by deprivation deciles, showing the Slope Index of Inequality, Brighton and Hove PCT, males, 2004-08

Slope Index of Inequality = 10.1 years (95% confidence interval: 8.1 to 12.0)

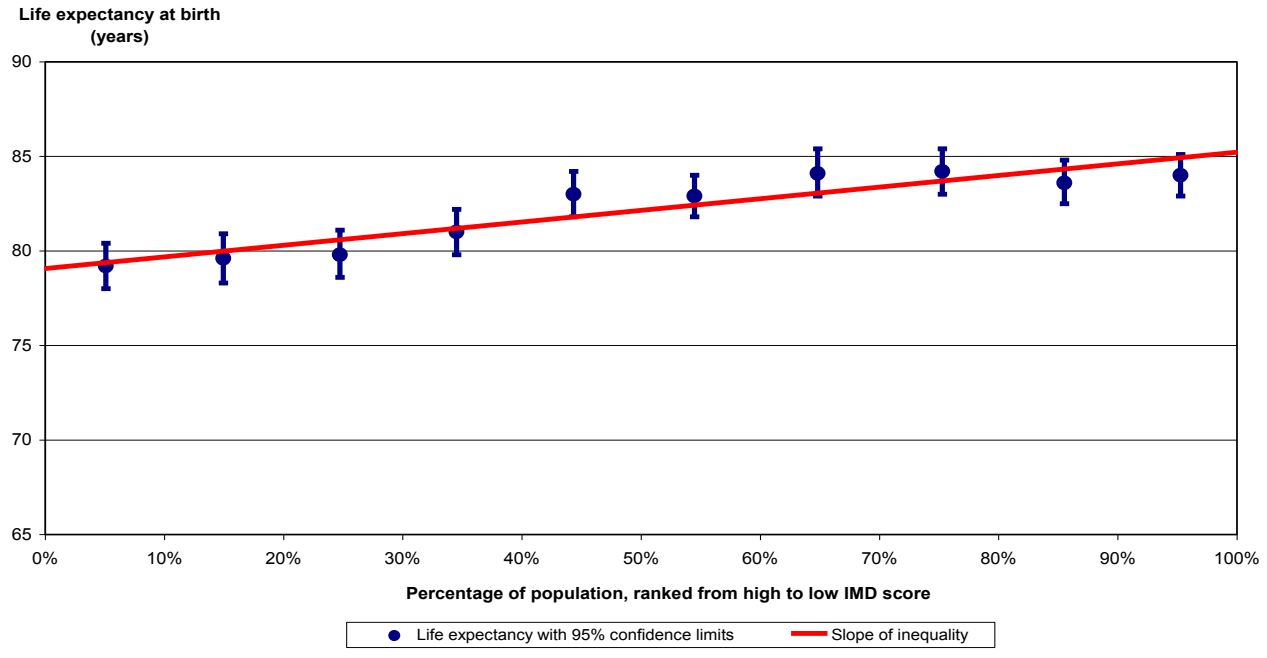


Source: APHO using ONS death registration data and mid-year population estimates and IMD 2007

Figure 5: Life expectancy by deprivation deciles, showing the Slope Index of Inequality

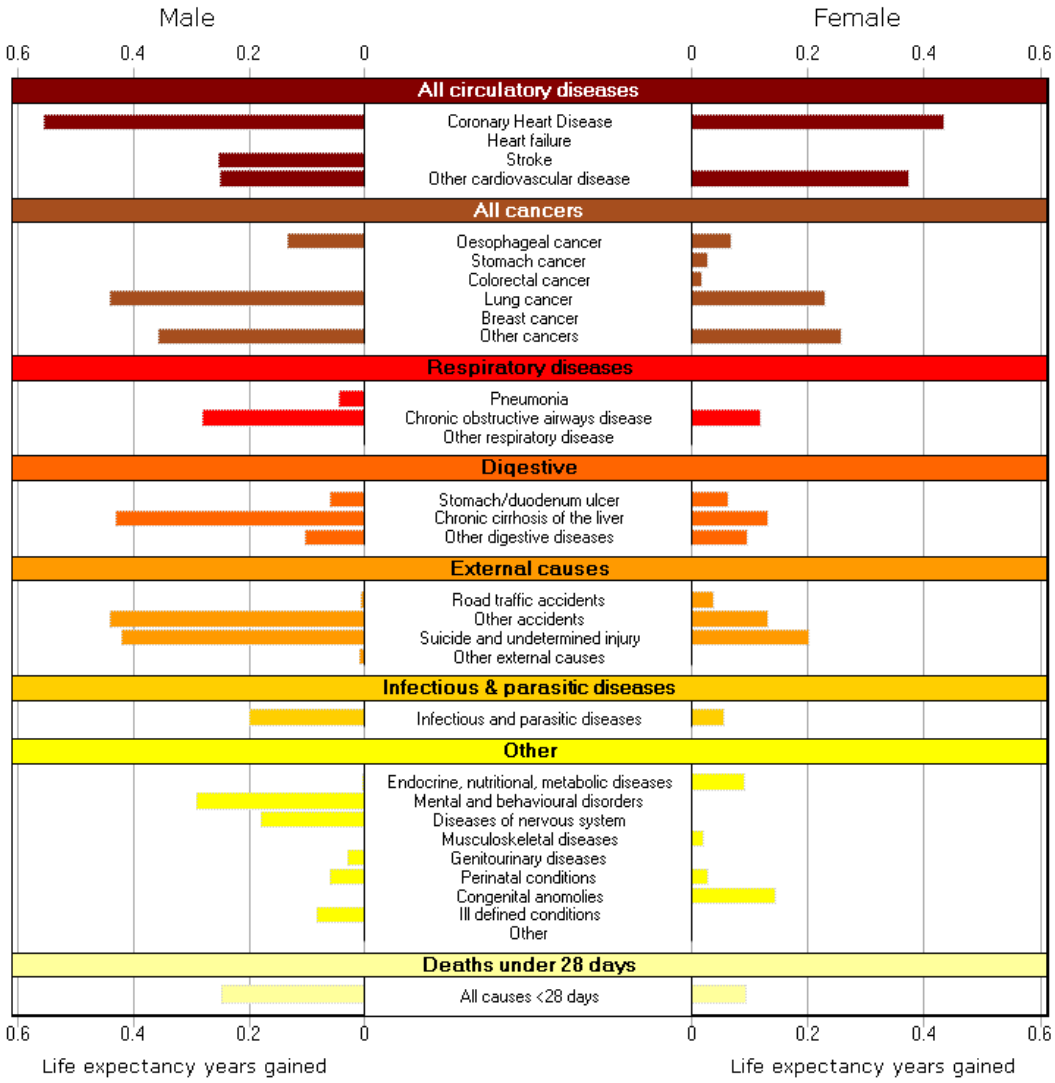
Brighton and Hove PCT, females, 2004-08

Slope Index of Inequality = 6.2 years (95% confidence interval: 4.1 to 8.3)



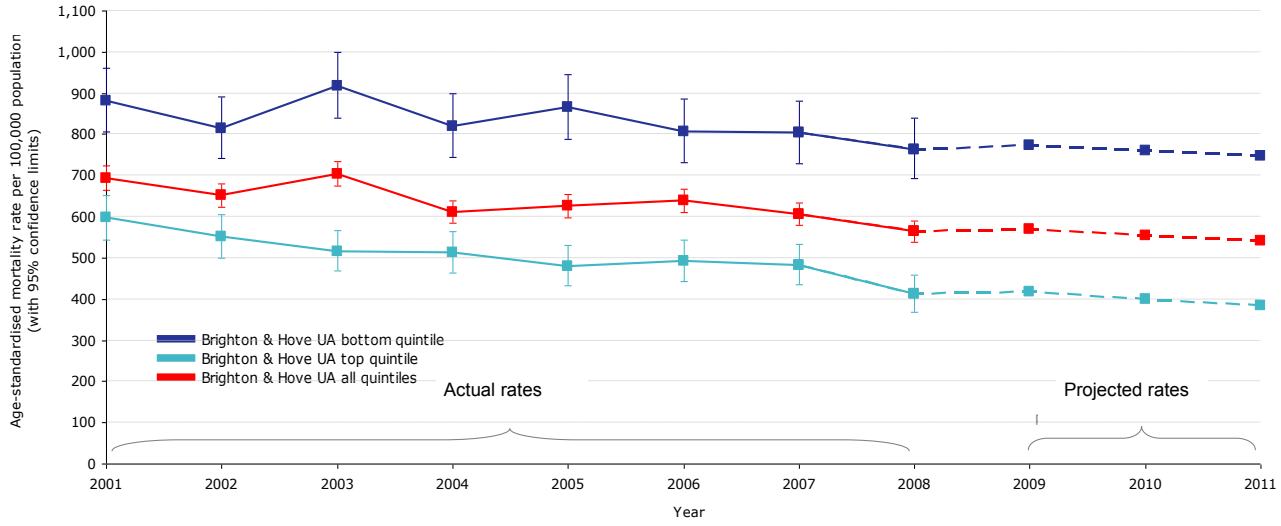
Source: APHO using ONS death registration data and mid-year population estimates and IMD 2007

Figure 6: Contribution of specific causes of death to the life expectancy gap between the most deprived quintile in Brighton and Hove and the national average



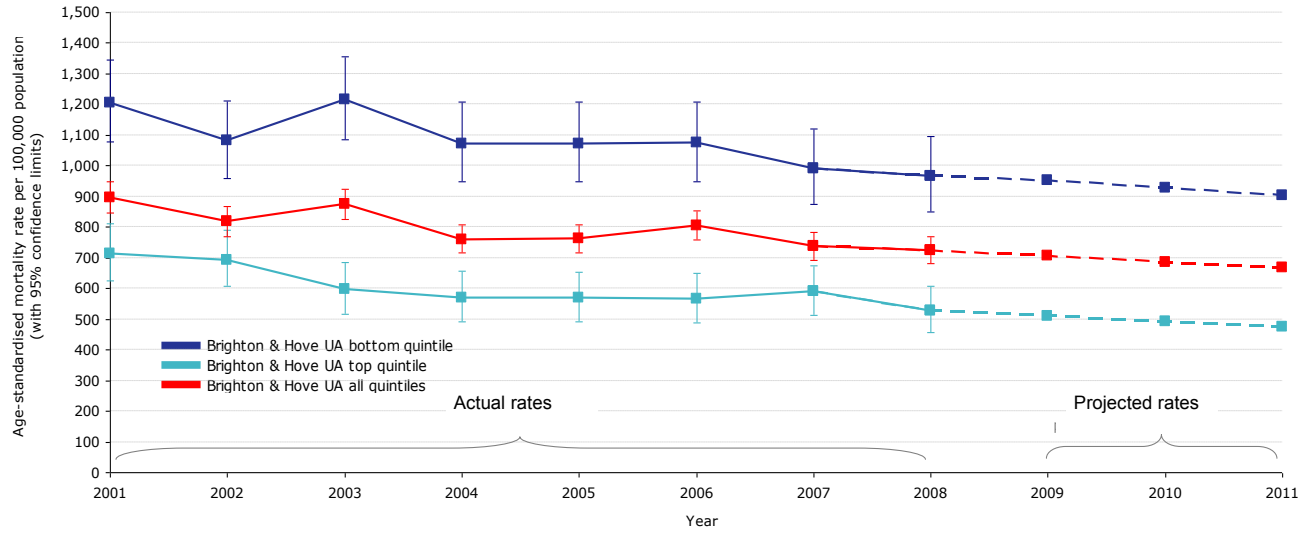
Source: APHO using ONS death registration data and mid-year population estimates & IMD 2007

Figure 7: Trend in all age all cause mortality rates, 2001 to 2008 and projected rates for 2009 to 2011 by quintiles of deprivation – Brighton and Hove.



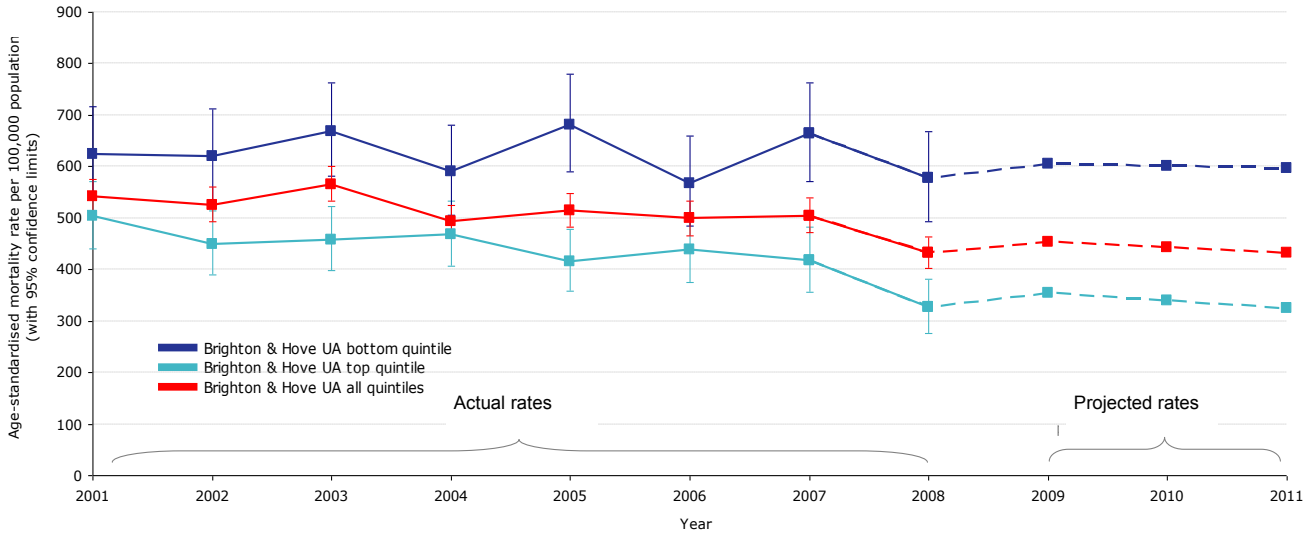
Source: South East Public Health Observatory

Figure 8: Trend in male all age all cause mortality rates, 2001 to 2008 and projected rates for 2009 to 2011 by quintiles of deprivation – Brighton and Hove.



Source: South East Public Health Observatory

Figure 9: Trend in female all age all cause mortality rates, 2001 to 2008 and projected rates for 2009 to 2011 by quintiles of deprivation – Brighton and Hove.



Source: South East Public Health Observatory

Social determinants of health

Deprivation

The Index of Multiple Deprivation (IMD) 2007 identifies Brighton and Hove as the 79th most deprived authority in England (out of 354). Map 1 shows that most of the deprived areas are in the east of the city (Department for Communities and Local Government).[22]

Over half of the residents of Brighton and Hove (56.4%) live in the 40% most deprived areas in England (2008 population). Conversely, only 2.7% of the city's population live in the 20% least deprived areas in England, compared to 38.4% of the population of the South East. So whilst the picture for the most deprived 20% of the population is similar, the distribution of all people in Brighton and Hove is considerably more deprived than in the South East or in England (Figure 10).

The high numbers of people in the second most deprived quintile has implications for how we measure inequalities – looking at the top versus bottom 20% will miss this relatively deprived group and initiatives aimed at just the most deprived will miss a significant proportion of the population that could benefit.

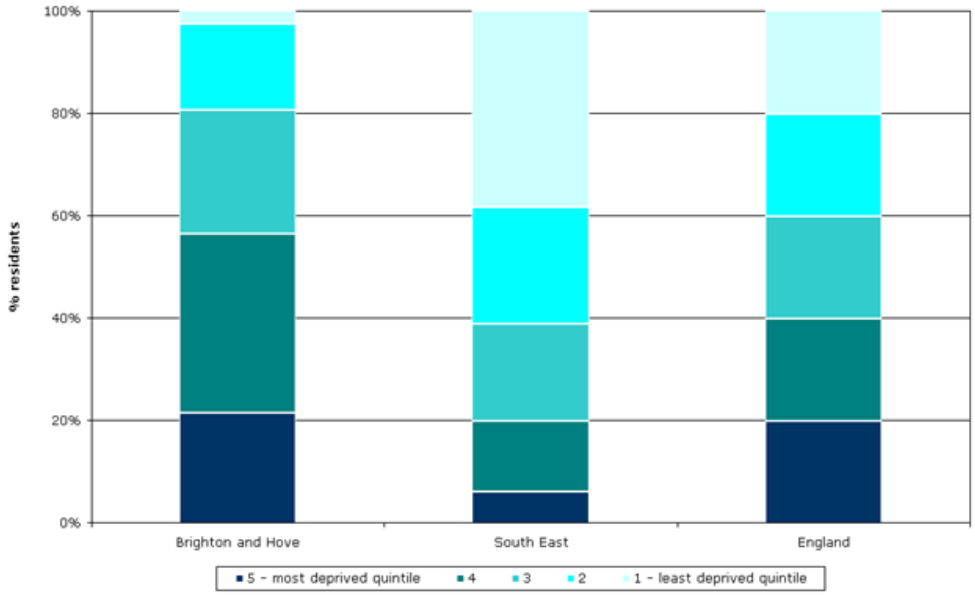
The Income Deprivation Affecting Children Index (IDACI) shows how many children aged under 16 years are income deprived as a percentage of all children (children living in households in receipt of benefits such as Income Support or Job Seekers Allowance and whose household income is below 60% of the national median income before housing costs). Brighton and Hove was ranked 69 most deprived out of 354 local authorities in 2007 compared with 67 in 2004.

The Income Deprivation Affecting Older People Index (IDAOPI) is defined as the percentage of adults aged 60 years or over living in pension credit guarantee households. In Brighton and Hove 22% of SOAs are in the most deprived quintile in England.

The Child Wellbeing Index (CWI) uses the methodology and approach applied in the IMD. It is an index of child wellbeing rather than of deprivation, represented by how children are doing in a number of domains of their life including material wellbeing, health, education, crime, housing, environment and children in need (Department for Communities and Local Government).[23]

Brighton and Hove is ranked 79 of 354 local authorities (1 being most deprived) in the overall index and 113 in the Health and Disability domain. Map 2 shows the CWI for Lower Super Output Areas in the city.

Figure 10: The percentage of people who live in each quintile of deprivation (based upon quintiles in England), Brighton and Hove, South East and England



Source: Office for National Statistics LSOA Sub National Population Mid Year Estimates 2008 (experimental) and Index of Multiple Deprivation 2007, Communities and Local Government

Child poverty

The latest national data made available by Government for 2008 shows that 22% of children in Brighton and Hove, or approximately one in every five, lives in poverty. This includes those families whose income is below 60% of the national average and are on either in-work or out-of-work benefits.

The level of child poverty in the city is close to the national average of 21% and similar to levels in some other nearby cities. However, we perform significantly worse than the South East regional average which has the lowest regional rate in the country at 14%.

Within Brighton and Hove the level of child poverty varies widely between communities. East Brighton has the highest level of child poverty at 47% compared to Withdean, the lowest, at 7%.

Detailed mapping of child poverty within the city has been undertaken as part of the needs assessment and will be available in 2011 at www.bhlis.org. This has allowed us to differentiate between those areas of the city which are most affected by in-work poverty and those affected by out-of-work poverty.

National evidence shows that families without a parent in employment are at most risk of experiencing child poverty. Other families who experience a significantly increased risk include those from certain BME groups, lone parent families, families with a disabled child or adult who are not in receipt of disability benefits and families with three or more children.

Routine data does not identify the circumstances of individual families and therefore we cannot know how long on average they may remain in poverty or to what degree incomes within the city may be below the 60% average. Given the known risks we can expect that as a city it is those neighbourhoods where families are predominantly on out-of-work benefits that experience the greatest depth of poverty.

It is both the extent to which families are able to improve their circumstances and the Brighton and Hove context within which they do this that interact to influence child poverty.

Through a process of gathering national evidence, listening to professionals and collating information from individuals and families, some particular challenges to reducing child poverty in the city are found to predominate in addition to those groups who are listed to be at most risk above.

Higher than average numbers of adults and children and young people in Brighton and Hove are affected by health conditions and lifestyles that both cause and contribute to families living in poverty, and impact on the ability of those children to climb out of poverty as adults. Notably:

- Parents and carers with mental health problems
- Children and young people with mental health problems
- Children and young people misusing drugs and/or alcohol
- Parents and carers who misuse drug and/or alcohol
- Families experiencing domestic violence

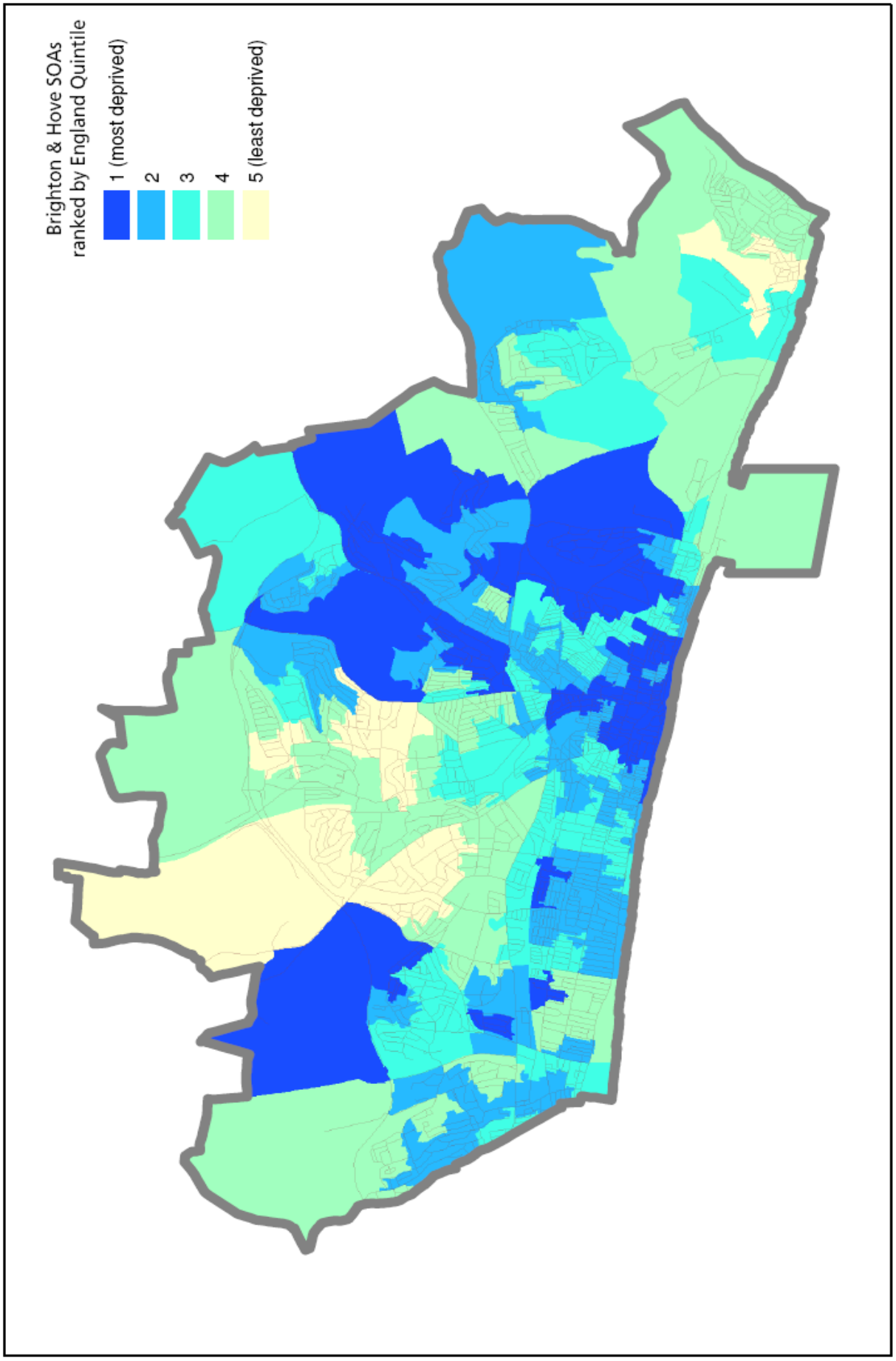
For a small but significant number of parents and carers without qualifications or with low skill levels this city presents a very challenging environment to gain affordable employment. For those with basic skills levels the available work will be low paid, part time and/or casual often entailing unsociable hours that make childcare arrangements more difficult.

Tracking back from adult skills we see comparatively low performance in our secondary school GCSE results as a whole. But it is those children and young people who fall into the 'narrowing the gap' groups who face the most severe pressure to improve if they are to compete in the job market of their home town.

Affecting the majority of families is the overwhelming pressure of the cost of living in Brighton and Hove. This can be seen most acutely in the cost of private sector rental and house prices alongside limited social housing and pressure on the availability of family sized homes from the growth of multiple occupancy housing.

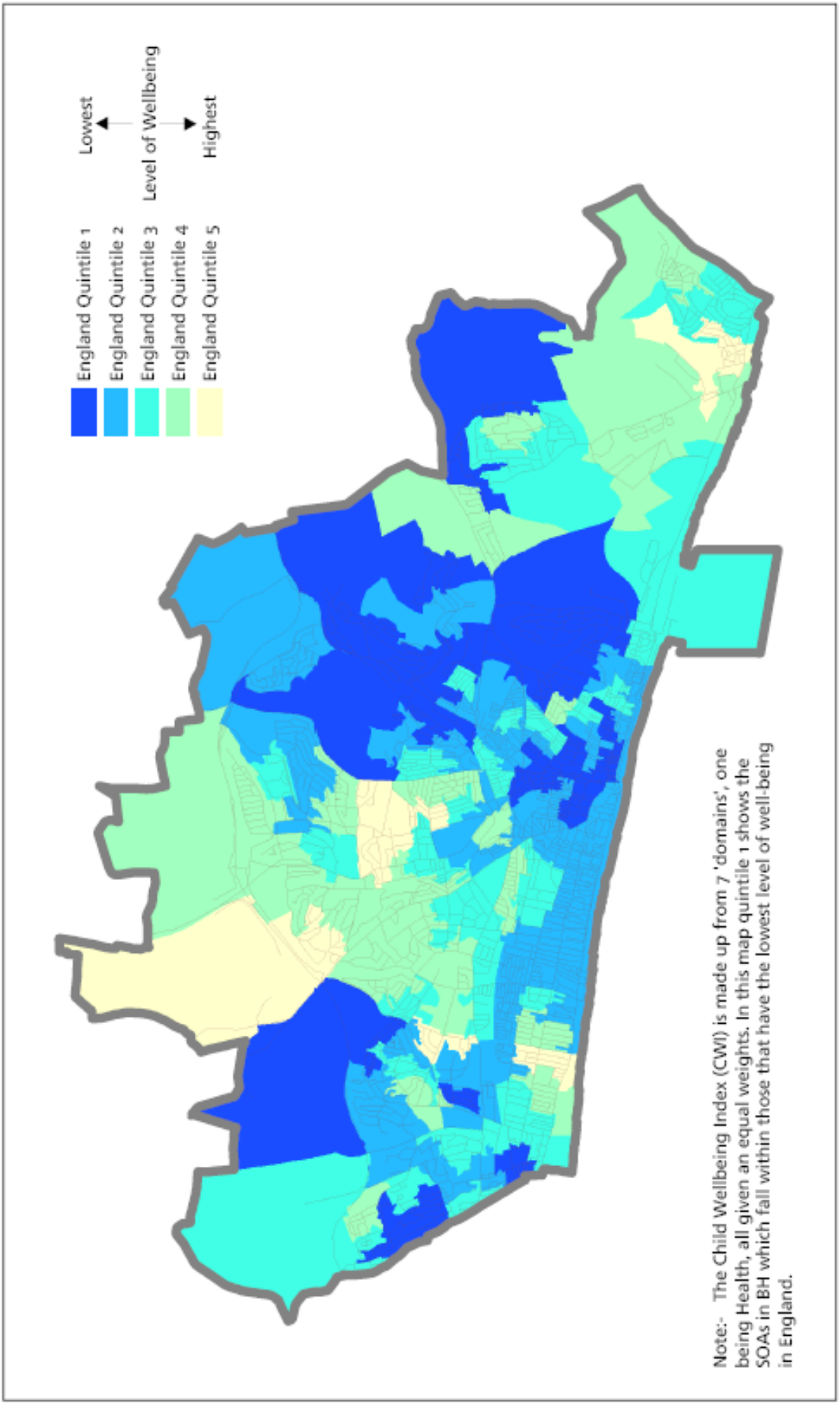
The needs assessment for child poverty is part of the programme for 2010/11 and once complete will be available at www.bhlis.org. A local child poverty strategy will then be developed from the evidence in the needs assessment.

Map 1: Brighton and Hove Index of Multiple Deprivation 2007 Super Output Areas ranking in England



Source: Department for Communities and Local Government (DCLG), 2007

Map 2: Brighton and Hove Child Wellbeing Index 2009 Super Output Areas ranking in England



Source: Department for Communities and Local Government (DCLG), 2009

Employment and unemployment[24]

The employment rate (the percentage of those economically active in employment) in the city between April 2009 and March 2010 was 71.6% of people of working age, higher than the national rate of 70.3% but lower than the South East rate of 74.5% (Figure 11). This was a fall of 2% in Brighton and Hove from the previous year. The large university population is likely to deflate the overall rate.

The student population impacts on employment for those with lower skills, as jobs which could be filled by those with lower skills are taken by students or graduates.

Employment rates are higher for males (76.5%) than for females (66.8%). This is a 10% gap which is also seen in the South East with 79.9% of males and 69.2% of females in employment. The male and female employment rates in Brighton and Hove are both higher than nationally (75.2% for males and 65.5% for females).

In 2009/10, 93% of the working population in the city was employed in the service sector, with 2.8% in manufacturing and 2.7% in construction. The majority of workplaces are small and medium sized with 10 or less employees (Annual Business Survey).[25]

The unemployment rate is defined as the percentage of the working age population not able to get a job but who would like to be in full time employment. The unemployment rate in the city in 2009/10 was 7.3% (13,100 people), higher than the South East (5.4%) and Great Britain (5.6%).

The unemployment rate for males and females is the same locally but in both the South East and Great Britain the female unemployment rate is around 2% higher than for males.

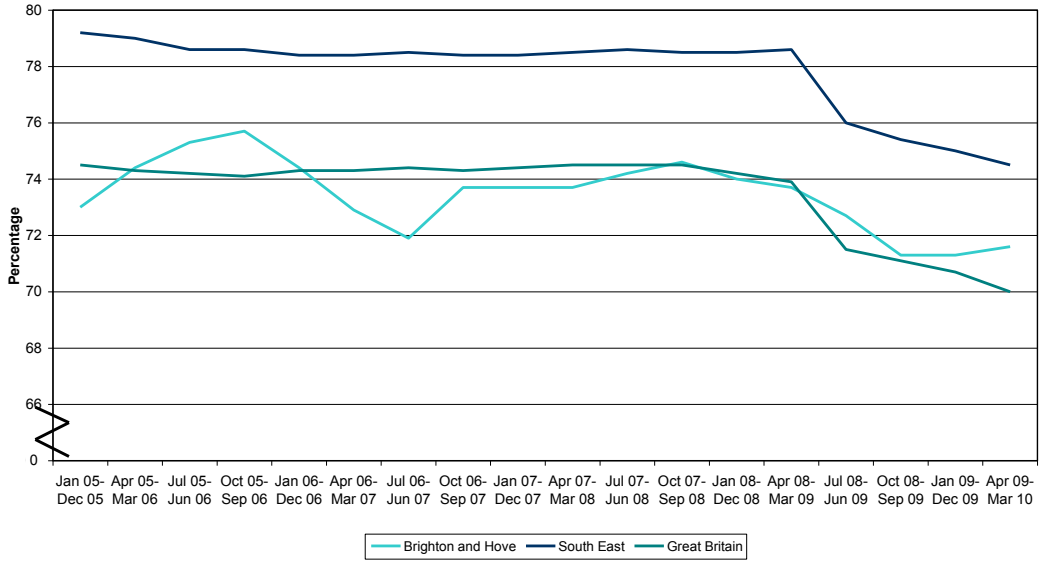
Occupational ill health and accidents in Brighton and Hove have an economic cost as well as a personal and social cost. The estimated economic cost of health and safety ill health incidents in Brighton and Hove in 2009/10 is between £57.4 million and £87.8 million. The estimated cost for accidents in Brighton and Hove 2009/10 is between £19.9 million and £36.1 million (Health and Safety Executive).[26]

Out-of-work benefits

There were 27,050 people of working age in the city claiming one or more Department for Work and Pensions benefits in May 2010 (Table 3). This was 1% lower than in May 2009, but remains almost 3,000 people more than in May 2008. The majority of the increase since 2008 is explained by more people receiving Job Seekers Allowance.

Almost a quarter (23.0%) of all working age benefits recipients in May 2010 were for Job Seekers Allowance (JSA) and half (50.2%) were for Employment and Support Allowance (ESA) or Incapacity Benefit. An overall rate of 7.6% of the working age population in Brighton and Hove compared with 4.6% in the South East and 6.7% in Great Britain.

Figure 11: Employment rate (moving average) in Brighton and Hove, South East and Great Britain, January-December 2005 to April 2009-March 2010



Source: ONS annual population survey

Table 3: Key benefit claimants (working age), Brighton and Hove, South East and Great Britain, May 2010

Benefit	Brighton and Hove (number)	Brighton and Hove (%)	South East (%)	Great Britain (%)
Total claimants	27,050	15.1	10.7	14.7
Job seekers	6,220	3.5	2.4	3.5
ESA and incapacity benefits	13,590	7.6	4.6	6.7
Lone parents	2,770	1.5	1.3	1.7
Carers	1,520	0.8	0.8	1.1
Others on income related benefits	870	0.5	0.4	0.5
Disabled	1,800	1.0	0.9	1.0
Bereaved	280	0.2	0.2	0.2
Key out-of-work benefits*	23,450	13.1	8.7	12.4

Source: DWP benefit claimants—working age client group

* Job seekers, ESA and incapacity benefits, lone parents and others on income related benefits

The number of long term JSA claimants (individuals receiving JSA for more than 12 months) has also fallen in the last year to 1,140 people in October 2010 from 1,205 in October 2009. However this is still higher than in July 2008 when the number was 820.

There were 2,770 lone parents claiming Income Support in Brighton and Hove in May 2010; 1.5% of the working-age population, similar to the South East and Great Britain. There has been a further decline in the last year (3,050 in May 2009) and a larger decline from 4,000 in May 2002.

Table 4: Gross weekly pay - all full time workers, Brighton and Hove 2002-2008

Year	Brighton and Hove (£)	South East (£)	Great Britain (£)
2002	410.5	435.1	392.7
2003	420.6	451.0	406.2
2004	425.4	461.8	421.3
2005	421.6	468.9	432.8
2006	459.5	486.5	445.9
2007	481.0	502.3	460.0
2008	514.3	523.2	479.3
2009	499.9	536.6	491.0

Source: ONS annual survey of hours and earnings - resident analysis

In Brighton and Hove, 23% of children (11,000) live in households where no adults are in paid employment, compared to 15% in the South East and 20% in England.

In seven Lower Super Output Areas (LSOAs) across the city more than half of all children live in families with all adults out of work. In the LSOAs which are among the 20% most deprived in England, over 45% of children live in families where both parents/carers are out of work; all of these LSOAs are located in the east of the city in East Brighton, Moulsecoomb, Bevendean, Hollingbury, Stanmer Park and Queen's Park wards.[3]

Income

In 2009 the gross median weekly pay for full time workers resident in the city was £499.90, a fall from £514.30 the previous year: the first fall since 2002 when earnings began to be collected by the ONS. Average earnings are lower in Brighton and Hove than in the South East (£536.60) but higher than Great Britain (£491.00). The fall in income in Brighton and Hove has not been seen regionally or nationally (Table 4).

There is a gender divide in average weekly earnings with full time female earners averaging £467.10 per week compared with £527.30 per week for males in the city; a 13% difference. The differential is much lower in Brighton and Hove than across Great Britain at 25% or the South East at 30%.

Educational attainment

In 2009/10 the provisional figure for the percentage of pupils achieving five or more A*-C grades at GCSE was 68%, up from 61.8% in 2008/09, but below England (74.8%). For A*-C grades including English and maths, attainment in Brighton and Hove (48.8%) is lower than England (53.1%) and the South East (57.1%) (Figure 12). Girls in the city have higher levels of attainment at 51% compared with 47% of boys (Department of Education).[27]

Provisional figures for 2009/10 show that the gap in five A*-C grades at GCSE including English and Maths between pupils with special educational needs and those without widened in Brighton and Hove with 13.6% of pupils with a special education need achieving at this level compared with 62.0% of pupils without a special education need. Attainment at this level for those eligible for free school meals in the city was 22.0% in 2009/10 and 53.2% for those not eligible.

Very few looked after children achieve five good GCSEs. In 2010, 42.1% of children in care achieved five or more grades A*-G as against 92.5% of all pupils in the city.

Nationally, pupils from the following ethnic groups have lower GCSE attainment: Traveller of Irish Heritage and Gypsy/Roma; Black Caribbean; Pakistani; Other Black; and Mixed White and Black Caribbean.

Not in education, employment or training (NEET)

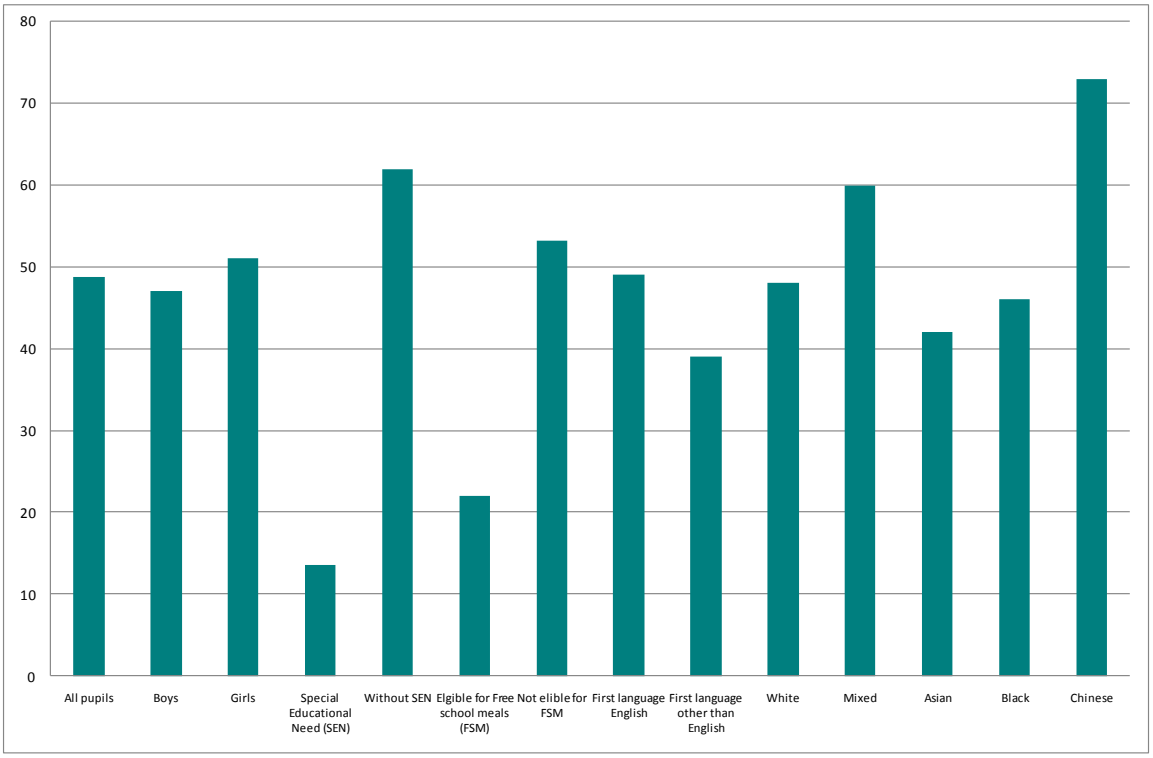
Being NEET between the ages of 16 and 18 is a major predictor of later unemployment, low income, teenage motherhood, depression and poor physical health.

Between 2008 and 2009 the proportion of 16-18 year olds NEET in the city rose from 7.8% (590 people) to 8.8% (640 people), compared with 5.8% in the South East, 7.0% across comparator areas and 9.2% in England. The NEET rate in England is higher for boys (10.3%) than girls (8.0%) (Department for Education).[28] In Brighton and Hove the 2009 NEET rate for 16 year olds was 5.5%, for 17 year olds 8.1% and for 18 year olds 13.0%. In 2010, 63% of 19 year olds who were looked after at their 17th birthday were NEET, the same as the South East and similar to England (62.1%).

Qualifications

2009 figures suggest that 7.9% of the working age population have no qualifications in the city, lower than Great Britain (12.3%) and the South East (9.1%). Conversely, 42.6% of working age people in the city have the highest qualification level (NVQ Level 4 or above - equivalent to HND, degree or higher degree) compared with 29.9% in Great Britain and 32.6% in the South East (ONS Annual Population Survey, NOMIS).[24]

Figure 12: Percentage of pupils achieving 5+ GCSEs at grade A*-C including English and maths by pupil characteristics, Brighton and Hove 2009/10 (provisional figures)



Source: Department for Education

Housing

Bounded by the South Downs and the sea, there is limited opportunity for new housing development in the city. The 2001 Census highlighted that Brighton and Hove had the highest proportion of one person households and the smallest average household size in the South East. The city is the fifth most densely populated area in the region and contains pockets of overcrowding, particularly in the private rented sector (BHCC Housing Strategy 2009-2014).[29]

Pressures from an expanding population, high property prices, pockets of poor quality housing and the effects of the recession are having a detrimental effect on the health and wellbeing of many residents, particularly amongst the most vulnerable members of our communities.

The Chartered Institute of Environmental Health have developed a toolkit for estimating the cost of poor housing.[30] For Brighton and Hove it is estimated that falls and excess cold related incidents cost the NHS £8 million per annum and society as a whole £20 million. The cost to adapt this housing is estimated to be £2 million. Locally, it has been calculated that every £1 spent on Supporting People services in Brighton and Hove saves £3.24.

Housing supply

Residents of the city live in 123,000 homes. Brighton and Hove has a lower proportion of owner occupied dwellings (62% compared to 71% for England) but a significantly higher proportion in the privately rented sector (23% compared to 11% in England). This is the 6th largest privately rented sector in the country. There are 18,800 social housing dwellings in the city, making up 15% of all dwellings (Table 5).

A study by the Oxford Consultants for Social Inclusion (OSCI) in 2007 found Brighton and Hove to be the 11th most deprived district in the country in relation to access to owner occupation due to insufficient income.[6] An affordable mortgage for an average one bedroom flat requires a £42,500 deposit and income of around £39,000 and a three bedroom house a deposit of £79,000 and income of around £72,600 (BHCC Housing Costs Update 2010 Q3 Jul-Sept).[31]

Analysis of ethnic monitoring indicates that BME groups in the city are more likely to experience housing need.

Just over a quarter of LGBT respondents to Count Me In Too had problems getting accommodation in the city (Count Me In Too Housing Additional Findings Report 2008).[32]

Brighton and Hove LGBT (Lesbian Gay Bisexual and Trans) People's Housing Strategy[33]

High rents in the private sector can also be a challenge for those unable to access home ownership. The rent on a one bedroom flat being equivalent to the payment of a mortgage in the region of £113,000 requiring an income of around £35,000 to finance; the rent on a three bedroom house is equivalent to the payment of a mortgage in the region of £169,000 requiring an income of £52,000 to finance (BHCC Housing Costs Update 2010 Q3 Jul-Sept).[31]

Housing quality

Overall, around 36% of the city's housing stock is considered to be non-decent. A dwelling is considered 'decent' if it meets the statutory minimum standard, provides a reasonable degree of thermal comfort, is in a reasonable state of repair and has reasonably modern facilities (Department for Communities and Local Government taken from Joseph Rowntree Foundation).[34]

The highest proportion of non-decent housing is in the council housing stock. However, 85% of non-decent homes are in the private sector, outnumbering non-decent council homes by five to one. 42.5% of all vulnerable households in the private sector are living in non-decent accommodation according to the 2008 Private Sector Stock Condition Survey.[35]

Table 5: Housing tenure, Brighton and Hove

Tenure	Dwellings	Percent
Owner occupied	75,800	62%
Privately Rented	28,300	23%
Private Sector Stock	***104,100***	***85%***
Housing Association (RSL)	6,300	5%
Local Authority	12,500	10%
Social Housing	***18,800***	***15%***
All Tenures	**122,900**	**100%**

Source: 2007 House Condition Survey

Brighton and Hove Housing Strategy 2009-2014, *Healthy homes, healthy lives, healthy city.*

Homelessness

The number of homelessness acceptances for Brighton and Hove in 2009/10 was 3.1 per thousand households (368 households) compared with 1.1 in the South East and 1.9 in England. There have been large reductions in homelessness acceptances since 2003/04 (61% fewer in Brighton and Hove, 76% in South East and 71% in England).

Since 2003/04 the most common reason for homelessness in the city is due to eviction by parents, family or friends (32.3% in 2009/10). Together with loss of private accommodation (31.8%) it accounts for almost two thirds of homelessness in the city in 2009/10. A further 25 households were accepted due to domestic violence (6.8% of all homelessness acceptances).

In Brighton and Hove more than half of all homelessness acceptances involve families with children, or a member of the household who is pregnant, although homelessness acceptances in these groups are lower than the national average. Homelessness in Brighton and Hove during 2009/10 due to physical disability is over two times higher than the England average and due to mental illness is over three times higher (BHCC Housing Statistical Bulletin, 2009/10).[36]

A large proportion of homeless young people are not in education, employment or training and care leavers are over-represented.

Over the past six years, the number of people rough sleeping in the city has fallen by over 82%, from 66 in 2001 to 12 in 2007. The rough sleeping population presents with high and complex needs, with monitoring by the Rough Sleepers Street Services Team in 2007 showing that 46% have substance misuse issues and 55% have alcohol issues (Brighton and Hove Homelessness Strategy 2008 - 2013).[37]

Local research into the needs, experiences and aspirations of Lesbian, Gay, Bisexual and Transgender people in the city found that 22% of respondents said they had been homeless at some time (Count Me In Too Housing Additional Findings Report 2008).[32] The 'Out on my own' research into LGBT youth homelessness found that young homeless LGBT people were at particular risk of repeat homelessness, self-harm and suicide.[38]

Fuel poverty

Cold housing is a health risk. Cold is believed to be the main explanation for the extra 'winter deaths' occurring each year between December and March.

A household is in fuel poverty if they would have to spend more than 10% of their household income on fuel to keep their home in a 'satisfactory' condition. It is a measure which compares income with what the fuel costs 'should be' rather than what they actually are.[39]

The latest subregional estimates of fuel poverty are for 2006 and show that 11.7% of households in Brighton and Hove (13,706 households) were fuel poor, very similar to the level in England (11.5%) (Department of Energy and Climate Change, 2010).[40]

Local information is not available by deprivation quintile but figures for England show that 53.0% of those in the most income deprived quintile are fuel poor compared with 13.2% of the total population.

The wards identified as having the highest estimated levels of households experiencing fuel poverty in the city are:

- Regency
- Central Hove
- Westbourne
- Goldsmid
- Brunswick and Adelaide

And those with the lowest are:

- Stanford
- Patcham
- North Portslade
- Woodingdean

(Oxford Consultants for Social Inclusion (OCSI), 2007).[6]

Brighton and Hove Affordable Warmth Strategy

Crime and disorder

Crime and disorder, as well as fear of crime, can have a significant impact upon physical health and mental wellbeing.

The effects of sexual and domestic violence and abuse, for example, can be wide ranging and long lasting. A cross-departmental government report identifies depression, anxiety, post-traumatic stress disorder, psychosis, substance abuse, eating disorders, self-harm and suicide as long term effects of sexual and domestic violence for women.[41]

The report also states that sexual and domestic violence can lead to an increase in risky health behaviours such as smoking, alcohol and drug misuse, or risky sexual behaviour, which can lead to sexually transmitted infections and unwanted pregnancies. While both men and women experience sexual and domestic violence, it impacts disproportionately on women across all socio-economic groups.

Results from Brighton and Hove's Citizen Panel in 2010 showed that fear of sexual assault also disproportionately affects women. 13% of females reported that they were very or fairly worried about being the victim of a sexual assault. This compared with 2% of males.[42]

There were 328 police recorded sexual offences in Brighton and Hove in 2009/10. There were also 3,563 police reported domestic violence crimes and incidents in 2009/10, a 6% increase compared with 2008/09. However, police recorded figures for both sexual and domestic violence offences are likely to be subject to significant under-reporting. Based on the British Crime Survey and population estimates for Brighton and Hove, it is estimated that there were 2,763 sexual assaults in the city against women aged 16-59 years in the past 12 months the (Home Office Ready Reckoner tool).[43]

Other types of violent crime, including robbery and public place assault also have significant consequences for physical health and mental well-being. In total, there were 5,518 police recorded violent crime offences in Brighton and Hove in 2009/10. This was a 7.8% decrease compared with 2008/09 and is below average when compared with comparator areas.

Assaults, particularly those which are alcohol related, disproportionately involve young men, both as perpetrators and as victims, and are clustered in the city centre in relation to the night-time economy.

Other crimes, such as bicycle theft, can also impact upon health. Tackling cycle theft in the city is important in order to promote sustainable transport, as well as encourage healthier lifestyles amongst residents of the city. There were 884 cycle thefts in the city in 2009/10, a 6.3% decrease compared with the previous year. This is below average when compared with comparator areas.

As well as the physical and mental effects of actual crime, fear of crime can have a substantial impact on mental health and quality of life. In 2010, 50% of respondents to the city's Citizen Panel Survey felt very or fairly safe in the city centre after dark, compared with 89% who felt safe during the day. This was lower than in their neighbourhood with 67% of respondents feeling safe outside after dark and 93% during the day. Feelings of safety, both in the city centre and in local neighbourhoods after dark have increased since the last survey in 2007.

However, fear of crime is influenced by a range of socio-demographic factors such as age, gender, and health. Older people and women feel less safe in local neighbourhoods after dark. These differences were less evident, however, when looking at feelings of safety in the city centre both during the day and after dark, and in neighbourhoods during the day. People with a long term illness, disability or infirmity, and particularly those with a condition that affects their daily activities, are more likely to feel unsafe both in local neighbourhoods and the city centre, particularly at night.

Although older people are less likely to experience crime, if they do so, the impact can be much greater than it is on young people. For example, Home Office research has shown that older victims of burglary (in sheltered housing) decline in health faster than those of a similar age who have not become victims of burglary. The research stated that two years after the burglary, victims were 2.4 times more likely to have died or to be in residential care than their non-burgled neighbours.[44]

Sustainability

Sustainability is about meeting social and environmental, as well as economic needs, especially when making long-term decisions. It has become a central theme to all we do as it encompasses the health, wellbeing and quality of life for all residents of the city, while preserving the environment and maintaining stable economic growth.

Sustainability can be defined as "meeting the needs of the present without compromising the ability of future generations to meet their needs" (Brundtland, 1987).[45] This section covers some key environmental aspects of sustainability.

Brighton and Hove's City Sustainability Partnership, an independent cross-sector group, provides the city and its key stakeholders with strategic leadership on the sustainable development of the city.

Climate change

Climate change refers to changes in the Earth's temperature over the last century. There is now strong evidence that significant recent increases in temperature cannot be explained by natural causes alone, and that human activities are having an effect, especially through emissions of greenhouse gases like carbon dioxide, which artificially warm the atmosphere of the earth. Creating a low carbon and resource efficient world means making major changes to the way we work and live, including how we source, manage and use energy. Climate change is not only a threat to the global environment and economy, it also presents unprecedented and potentially catastrophic risks to health and wellbeing.

Climate change is predicted to result in an increase in deaths, disability and injury from extreme temperature and weather conditions, heatwaves, floods and storms including health hazards from chemical and sewage pollution. Those likely to be most vulnerable to the impacts are those already deprived by their level of income, quality of homes, and their health (Marmot, 2010).[19]

This demands an urgent and radical response across the developed and developing world and is why so much effort is being made to reduce or mitigate greenhouse gas emissions to prevent the most damaging climate change. The impact of past emissions will influence our climate for decades so, at the same time, we need to prepare for unavoidable changes.

Transport

Transport contributes significantly to some of today's greatest challenges to public health in England, including road traffic injuries, physical inactivity, the adverse effect of traffic on social cohesiveness and the impact on outdoor air and noise pollution. However, the relationships between transport and health are multiple and complex. Transport also enables access to work, education, social networks and services that can improve people's opportunities (Marmot, 2010).[19]

The need to accommodate larger numbers of people moving in and around the city requires better access for walking and cycling, and improved public transport. Many car-based journeys are for short distances and are most amenable to transfer to alternative modes (walking, cycling, and public transport). This has benefits for health and well-being not only in terms of better air quality but also increased physical activity. To do this, all road users need to be persuaded of the benefits of such change.

Since 2007 a decrease in traffic volumes has been observed at some locations in the city. Bus passenger journeys have continued to increase by approximately 5% each year since 1993. This compares favourably to the national trend, which has shown a more substantial growth in car use between 1993 and 2007.

Brighton and Hove is a national exemplar Cycling Town and cycling in the city has substantially grown in recent years with a 27% increase recorded in the 2006-2008 period. The seafront cycle lane has one of the highest daily flows of bicycles in the UK.

Based on 2001 Census figures, vehicle ownership in Brighton and Hove (0.9 cars or vans per household) is the lowest in the South East (1.3 cars or vans), comparable to a London Borough, and one of the lowest nationally. Most traffic in the city is locally generated – two-thirds of vehicles on the road at any one time are making trips which begin and end within the city (BHCC Air Quality Action Plan, 2010).[46]

The next local transport plan will be published in April 2011.

Green spaces

Creating a physical environment in which people can live healthier lives with a greater sense of wellbeing is a hugely significant factor in reducing health inequalities. Living close to areas of green space – parks, woodland and other open spaces – can improve health, regardless of social class (Marmot, 2010).[19]

In 2008 Brighton and Hove was ranked 14 of 352 local authorities in England for residents very or fairly satisfied with parks and open spaces at 82.1%, with 72.6% in the South East and 68.5% in England (Place Survey, 2008).[47]

City leaders have prioritised bidding for UNESCO Biosphere Reserve status, a vision for fully integrating the natural environment into the city to benefit both people and wildlife through better access to green spaces, greater focus on local food and improved air quality bringing physical and mental health benefits.

Food poverty

Food consumption has an impact on both the physical and mental health and wellbeing of all residents. Five per cent of people on low incomes report skipping meals for a whole day. Low income and deprivation are barriers to purchasing fresh or unfamiliar foods and lower income households are the hardest hit by food price fluctuations (Marmot, 2010).[19] Food poverty can be attributed to:

Accessibility – For those without access to adequate public or private transport, not being able to get to the shops is a defining factor in their ability to buy healthy affordable food.

Availability – Local shops may not stock healthy options, due to shorter shelf life, lower profit, perceived lack of interest or shortage of storage options. The abundant availability of food with low nutritional value in deprived areas is as relevant in as inaccessibility of healthy food (Food Ethics Council, 2010).[48]

Affordability – Expenditure on food is the most flexible and therefore vulnerable part of household budgets as it is often whatever is left over when all the essential bills are paid.

Awareness – Many people lack the knowledge or skills to buy and cook food from scratch with a lot of misinformation about nutrition.

Nationally, local authority food services have contributed to a 19.2% reduction in food borne illness from 2001 to 2006, equating to 1.5 million fewer cases, saving the economy £750 million, and reducing hospital admissions by 10,000 (Food Standards Agency).[49]

Air quality

The main reasons for tackling poor air quality are the links with quality of life and the need to minimise the risk to human health. Largely due to ongoing work undertaken by the Committee on the Medical Effects of Air Pollutants (COMEAP), we now have a better understanding of the short term and the long term health effects of air pollution, which can:

- worsen the condition of those with heart disease or lung disease;
- aggravate asthma; and
- in the longer term, have additional effects on individuals including some influence on average life expectancy.

COMEAP give evidence to show that some people with cardiopulmonary diseases can be adversely affected by day-to-day changes in the levels of air pollutants and that numbers of deaths and hospital admissions go up when air pollution levels are high, particularly for those with cardiovascular and lung disorders and especially amongst the elderly.[50]

Scientific evidence suggests that long term exposure to air pollution has a lasting effect on health, though the effects vary depending on where one lives and the type of pollutant that people are exposed to. Though the full extent of the health effects of air pollution are hard to quantify, if lifelong exposure to fine particles was cut by half, life expectancy from birth could be increased, on average, by between one and 11 months (BHCC Air Quality Action Plan, 2010).[46]

Following initial declaration of an AQMA (Air Quality Management Area) in 2004, Brighton and Hove city council (produced its first Air Quality Action Plan (AQAP) during 2006/07. Exceedences (predicted pollution levels above objectives set in European and domestic law) led Brighton and Hove city council to designate an expanded AQMA in February 2008. It included the original area and covered the city centre.

Within Brighton and Hove, road transport is the primary cause of the nitrogen dioxide exceedences. Slow moving heavy vehicles, congestion and queueing, high volumes of traffic and the proximity of buildings adjacent to traffic are all factors which can result in the air quality objective being exceeded. As a consequence much of the air quality improvement needed is expected through measures to help introduce cleaner vehicles and improve vehicle flow rates; objectives in the city council's Local Transport Plan.

Health and wellbeing

Main causes of death

The commonest causes of death within Brighton and Hove are cancers, circulatory diseases, respiratory diseases and digestive diseases (which include liver diseases). These are similar to the South East but in Brighton and Hove mortality rates are higher for all disease groupings (Figure 13).

Figure 14 shows an equivalent comparison for the most deprived quintile and the least deprived quintile in Brighton and Hove. The large difference seen in overall mortality is present for all of the commonest causes of death shown except for diseases of the nervous system or genitourinary system.

Figure 13: Mortality rate per 100,000 population for the total population of Brighton and Hove compared with the South East 2004-08

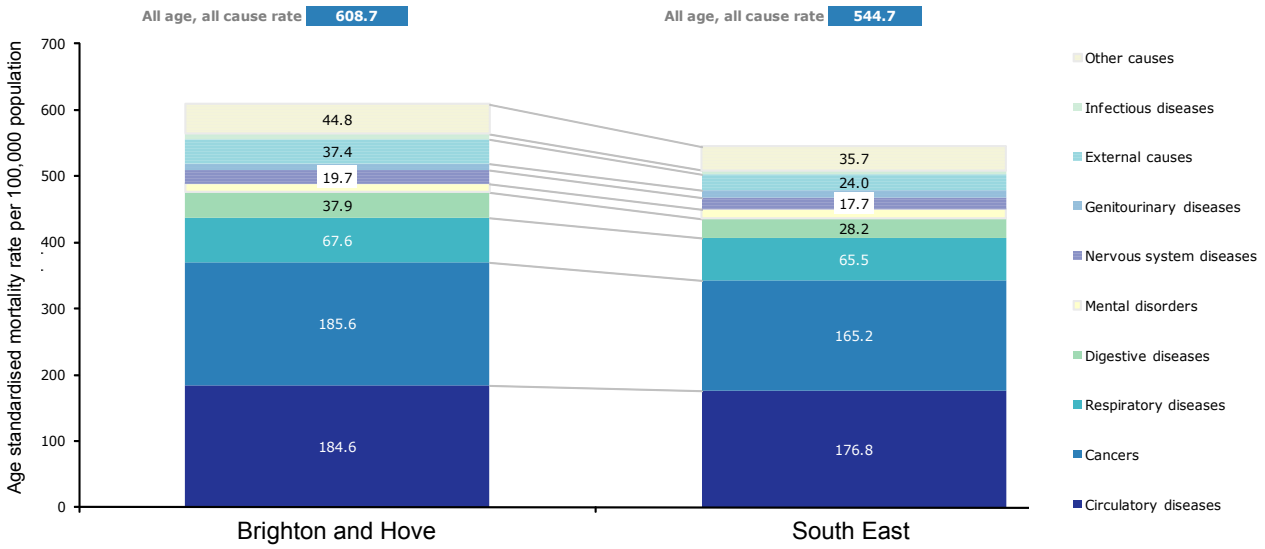
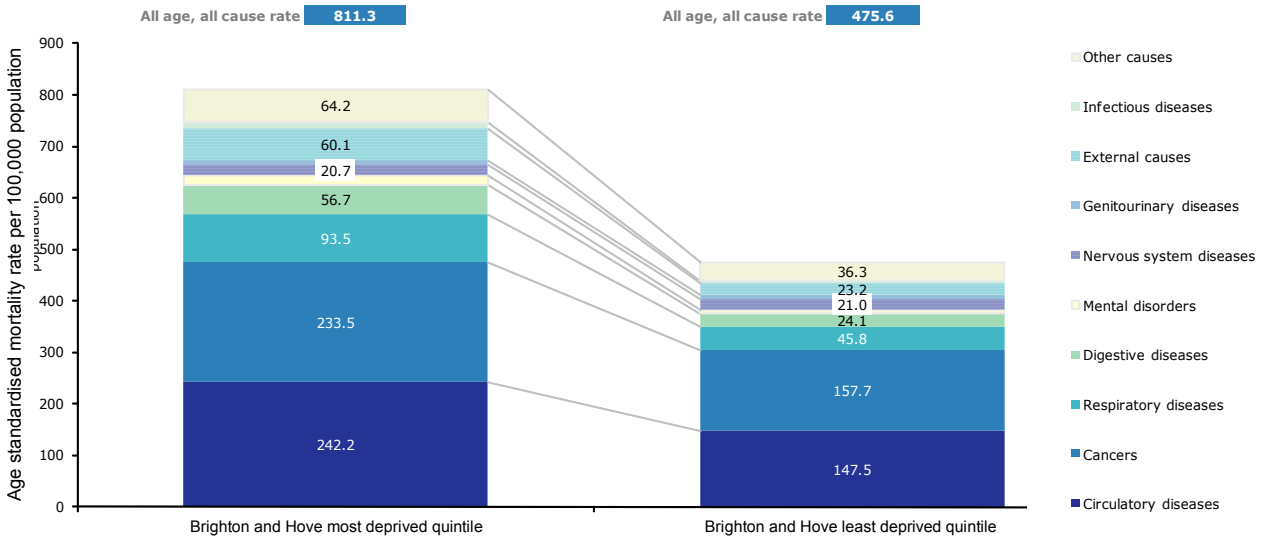


Figure 14: Mortality rate per 100,000 population for the most and least deprived quintiles of deprivation in Brighton and Hove 2004-08



Source: ONS 2001 to 2008 Public Health Mortality Files; ONS Mid-2001 to Mid-2008 LSOA Experimental Quinary Population Estimates; DCLG Index of Multiple Deprivation 2007.

Produced by: Department of Health South East, 2010.

Cancer

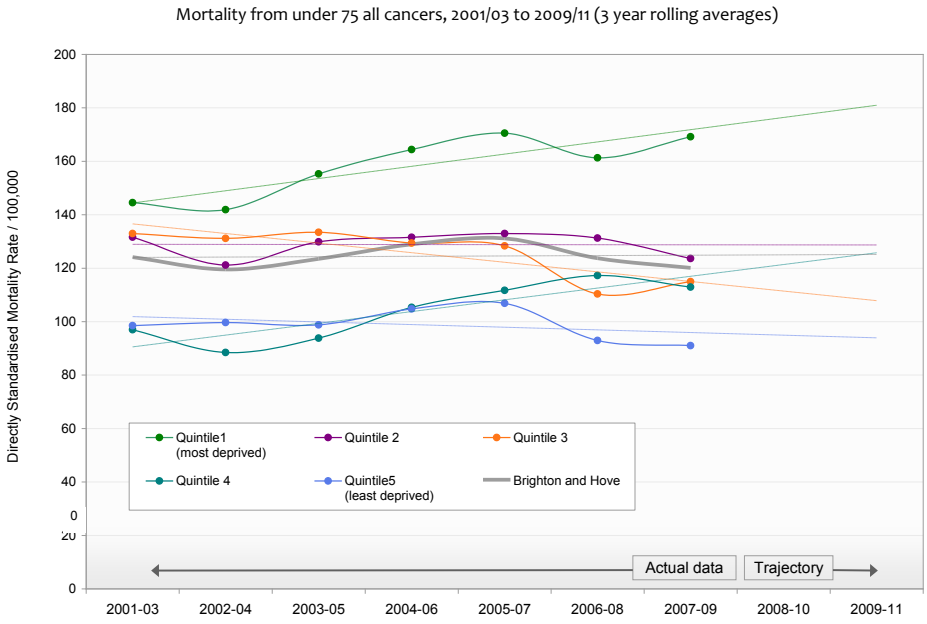
One in three people will develop cancer at some point in their lives, although it is predominantly a disease of older age. As life expectancy increases so will the incidence of cancer. The most common cancers are breast, prostate, colorectal and lung, which account for more than half (54%) of all new diagnoses.

In Brighton and Hove, the incidence rate for all cancers is lower than the England and ONS peers rate for both males and females, in both people of all ages and people aged less than 75 years. The incidence rate for each of the four most common cancers in people under 75 years in the city is also lower than the England and comparator areas. The differences are statistically significant for breast and lung cancer (the latter compared with ONS peers only).

The recent cancer mortality trend for all ages in the city has been relatively stable but saw a fall in 2008. However, the rate is higher in the more deprived areas of the city and the gap compared with the most affluent areas of the city is increasing.

The most common cause of death from cancer in women is breast cancer, followed by lung and colorectal cancer. The most common in men are lung, prostate and colorectal cancer.

Figure 15: Trend in under 75 cancer mortality rates, 2001-03 to 2007-09 and projected rates for 2008-10 to 2009-11 by quintiles of deprivation – Brighton and Hove.



Mortality from all cancers in under 75 year olds is significantly higher in Brighton and Hove than England and the South East. The national target is to reduce mortality rates from cancer by at least 20% in people under 75 by 2010 (which will be known at the end of 2011). Mortality rates in this age group in the city had been increasing since 2002-04 but in 2007-09 fell to around the 2002-04 level. If current trends continue, Brighton and Hove is unlikely to see a 20% reduction.

Figure 15 shows the trend in under 75 mortality rates for cancer by deprivation quintile in the city. Between 2001-2003 and 2007-2009 the absolute gap between the most and least deprived increased by 70%.

The uptake of screening programmes tends to be greater amongst people from higher socioeconomic groups. This is demonstrated locally by the cervical screening programme: local coverage[51] for all ages is lowest in the more disadvantaged parts of the city. Coverage is below the national target of 80% at 75.9% in 2009/10 (from 75.4% in 2008/09). The coverage is particularly low for the 25-34 years age group but it is also falling amongst women aged 50-64 years. Uptake amongst lesbian and bisexual women has also been shown to be much lower than the heterosexual population (Fish, 2009).[52]

Breast screening coverage has also fallen in recent years, but is now increasing again. Between 2005/06 and 2008/09 the percentage of women aged 53-64 being screened within 36 months fell from 77.1% to 67.7%; though this was an increase on 2007/08 (64.3%). Locally breast screening is expected to return to women being screened every 36 months by March 2011.

Source: NHS Brighton and Hove from ONS Mortality Files and Mid Year Population Estimates

Circulatory disease

In 2009/10 GP disease registers indicate that in Brighton and Hove there were 7,117 people diagnosed with coronary heart disease (CHD) and 3,823 people who are known to have had a stroke. There were also 29,557 people diagnosed with hypertension (high blood pressure), which is a major risk factor for heart disease and stroke.

Recent estimates of the expected prevalence produced at GP practice level predict that there are 11,499 with CHD, 5,207 who have had a stroke, and 65,032 people with hypertension in Brighton and Hove (Eastern Region Public Health Observatory, 2009).[53] These figures are all significantly higher than the number of people on GP registers, which suggests there may be under-diagnosis or under-recording of these conditions. The estimates take into account differences between practice populations including age, sex, ethnicity and social deprivation. It is important to note that diifferences between modelled estimates and prevalence recorded on GP disease registers may be due to local variations not captured by the model and may not be solely attributable to under-diagnosis or under-recording of diagnoses.

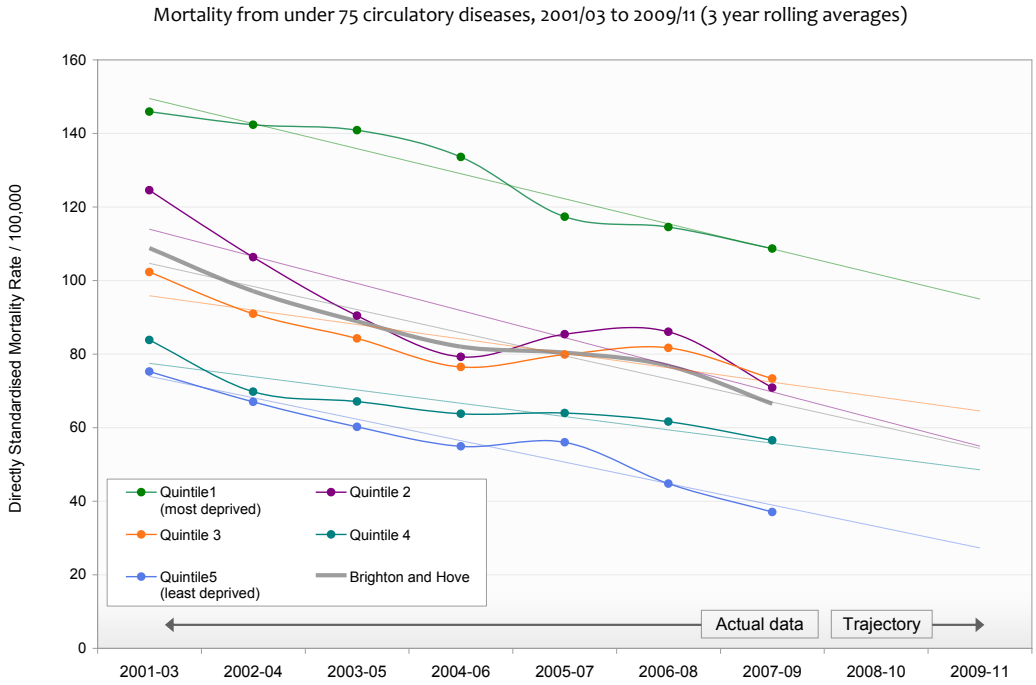
Between 2006 and 2008 in Brighton and Hove the mortality rate among the under 75s due to circulatory diseases was 76.8 per 100,000 population, compared with 74.8 in England and 84.7 for comparator areas. The rate in the city is higher for males at 112.3 and lower for females at 42.9.

The recent trend in circulatory disease deaths for all ages in Brighton and Hove has been downwards. Rates have been falling overall, for the most and least deprived quintiles in the city. However the mortality rate is higher in the more deprived areas of the city.

Figure 16 shows the trend in mortality rates for circulatory diseases by deprivation quintile in the city. Between 2001-2003 and 2007-2009 the absolute gap between the most and least deprived increased by 1% (the absolute gap is the difference between the rate in the most and least deprived areas).

In the same period there were 6,112 years of life lost from people dying prematurely of circulatory disease.[54]

Figure 16: Trend in under 75 circulatory disease mortality rates, 2001-03 to 2007-09 and projected rates for 2008-10 to 2009-11 by quintiles of deprivation – Brighton and Hove.



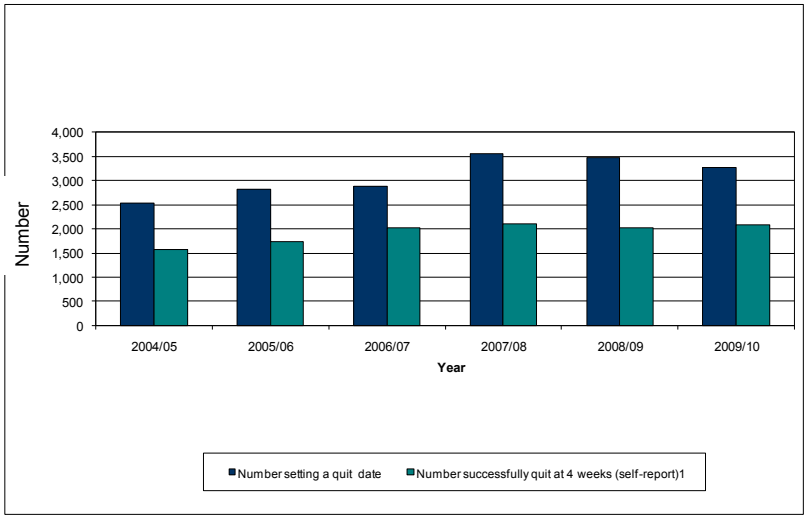
Source: NHS Brighton and Hove from Office for National Statistic Mortality Files and Mid Year Population Estimates

Smoking

Smoking is the greatest cause of health inequalities and premature death in the UK, killing around 106,000 people a year. Half of all those who continue to smoke for most of their lives will die of their habit, half of these before the age of 69 years. Over a quarter of cancers are attributable to tobacco use. The three most common causes of death from smoking are lung cancer, chronic obstructive pulmonary disease and cardiovascular disease.

Smoking rates and therefore smoking related morbidity are highest in the routine/manual occupation groups. In a local 2003 survey the number of daily smokers had fallen to 20% (21.4% males and 19.1% females) from 27% in 1992, with approximately 7% more people being occasional smokers. However a survey conducted during the same period identified that in the more deprived parts of the city up to half of the adult population were smokers.

Figure 17: Smoking cessation in Brighton and Hove 2004/05 to 2009/10: numbers setting a quit date and successfully quitting at 4 weeks



Source: Information Centre for Health and Social Care

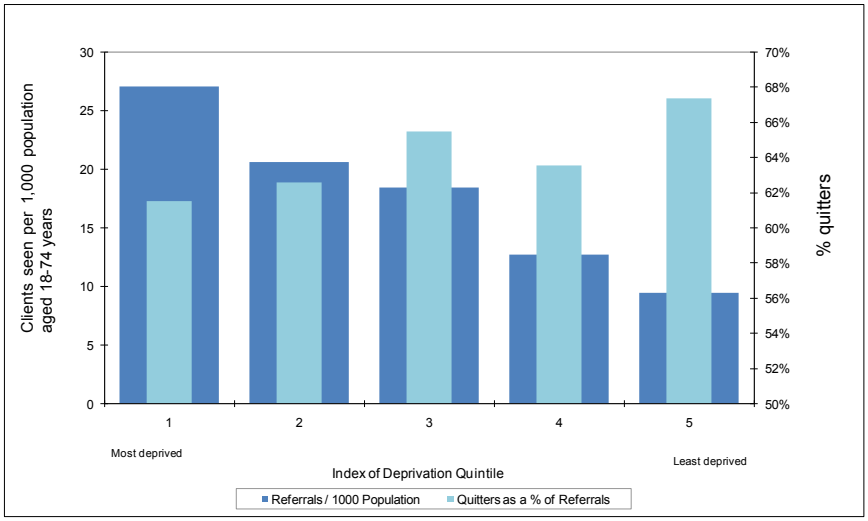
The Health Related Behaviour Survey (HRBS) of 14 to 15 year olds in Brighton and Hove in 2007 found that 15% of boys and 25% of girls had smoked at least one cigarette in the previous week. The national figures were 13% and 20% respectively.[55]

In Count Me In Too (a research project focused on the experiences of local LGBT people) data was gathered from LGBT people who live, work and socialise in Brighton and Hove. It found the smoking prevalence was 33%, with men and those aged 26-35 years more likely to smoke (Count Me In Too General Health Additional Findings, 2008).[56]

During 2008/09 the local smoking cessation service helped 2,021 people to quit smoking (of 3,472 setting a quit date). In 2009/10 there was a slight increase in the number of referrals to the service, with 3,615 people setting a quit date but an increase in the number of those who successfully quit at four weeks to 2,308. This is a 64% quit rate and was the eighth highest in England (Figure 17) (Information Centre for Health and Social Care).[57]

One of the possible disadvantages of providing a specialist smoking cessation service is that it may inadvertently widen inequalities as people living in more affluent parts of the city take up the service more readily. However this is not the case locally. In recent years the service has seen more patients from the more deprived parts of the city, though quit rates are lower in more deprived areas (Figure 18).

Figure 18: Clients seen at smoking cessation clinics and quitters by Index of Multiple Deprivation quintile - April 2009 to March 2010



Source: NHS Brighton and Hove

Sexual health

In 2009 Brighton and Hove had the highest rates of common sexually transmitted infections (chlamydia, gonorrhoea, syphilis, herpes and warts) outside of London at 1460.4 per 100,000 population compared to 774.6 per 100,000 across England (Health Protection Agency, 2010).[58] Nationally, gonorrhoea cases have been falling, a trend which had not been seen in Brighton over recent years; however there was a substantial fall in the number of new cases seen at Brighton genitourinary medicine (GUM) clinic in 2008; this increased in 2009 but is still below 2004 levels (Figure 19).

Attendances at the main GUM clinic in Brighton and Hove remain very high and are increasing year on year. In March 2008 the national target of offering everyone an appointment to be seen within 48 hours of contacting the service was achieved locally and maintained in 2009.

In 2009 Brighton and Hove had the eighth highest HIV prevalence rate in England at 7.57 per 1,000 population aged 15-59 years (1,273 people), compared with 1.70 in England. Locally this was an increase from 7.16 per 100,000 in 2008 (1,216 people). The total figure for both sexes has been increasing rapidly: in December 2005 it was 1000, compared with 633 in 2001 (Health Protection Agency, 2010).[59]

In 2008, in 83% of cases in the city the probable route of transmission was sex between men. The increase in infections that were acquired through heterosexual sex between 2006 and 2007 was twice the increase that were acquired through sex between men but for the period 2004-2008 the rate of increase was similar.

It is estimated that one in four gay men with HIV are unaware of their infection.[60] This is important from a prevention perspective but also for ensuring correct monitoring to allow treatment to begin as soon as it is required.

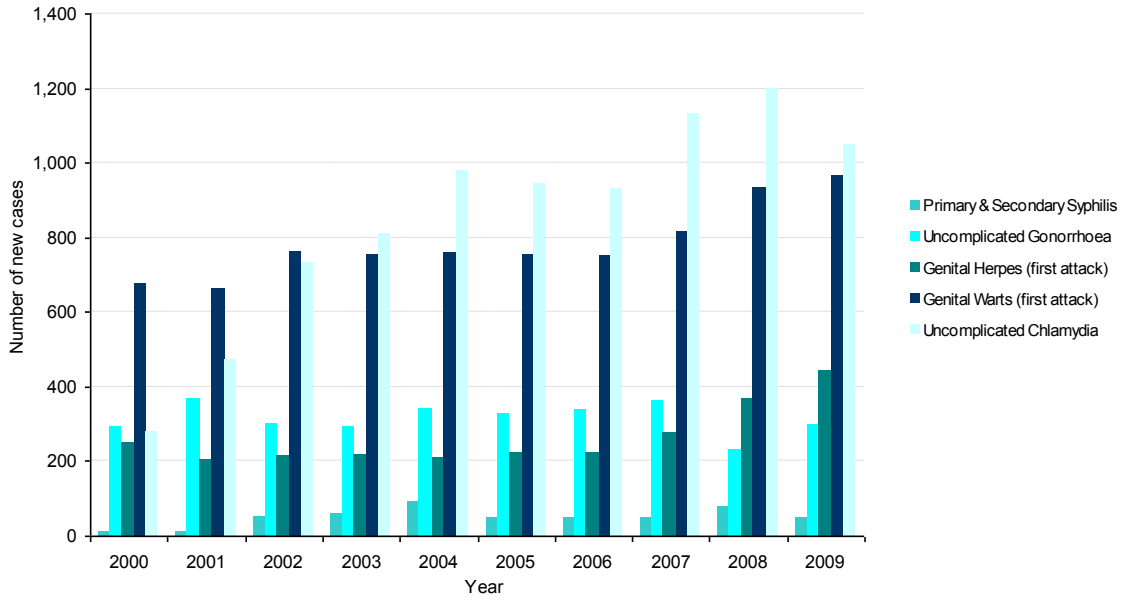
In 2008 in England 32% of HIV diagnoses were late diagnoses; this is considerably lower in Brighton and Hove at 22%.

During 2009/10, 22.6% of young people aged 15-24 years were screened for chlamydia (outside of GUM settings) against a target of 25%, an increase from 17% in 2008/09. The positivity rate for Brighton and Hove in 2009/10 (4.4%) was lower than England (6%).

Nearly one in ten Year 10 (14-15 years) pupils in the city who took part in the 2007 Health Related Behaviour Survey reported that they were in a sexual relationship, with the highest proportion in East Brighton (13%) and the lowest proportion in Central Brighton (6%): 45% of boys and 62% of girls reported knowing where to get free condoms.[55]

Brighton and Hove Sexual Health Needs Assessment 2010

Figure 19: Number of new cases of the top five STIs seen at the GUM clinic in Brighton and Hove, 2000 to 2009



Source: Brighton & Hove GUM clinic KC60 returns

Teenage conceptions

Teenage conception rates in Brighton and Hove are now below those in England for the first time, though they are still higher than across the South East. Rates in the city are the lowest among its comparator areas. The highest rates in the city are seen in the most disadvantaged areas and there is a clear association with educational achievement.

Whilst the rate of teenage conceptions in the city has fallen by 25.1% from the 1998 baseline to 2008 (Figure 20), to achieve the local 2010 target of a 45% reduction would require a significant sustained fall in the rate – equating to 40 fewer conceptions per year.[61]

Rates have fallen by 13.3% and 13.0% in England and the South East respectively. Among comparator areas, rates have fallen by between 4.5% and 27.1%.

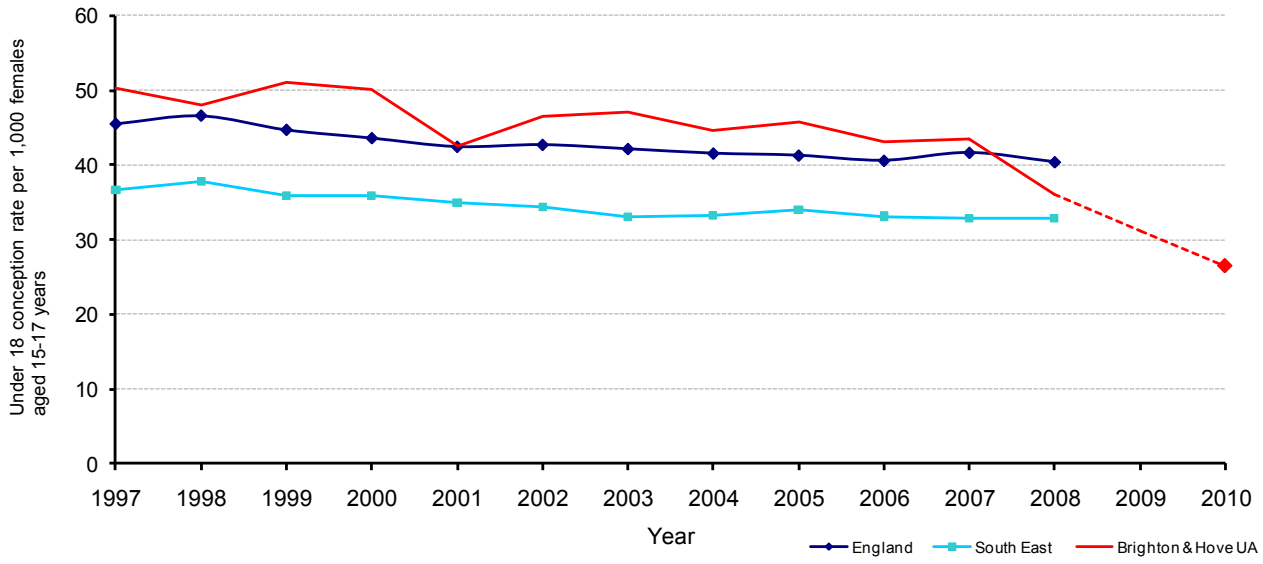
In 2008, 60% of teenage conceptions in the city resulted in a termination compared with 50% nationally, 51% in the South East and between 43% - 63% among statistical neighbours. The under 19 years repeat termination rate has fallen from 15% to 8% in Brighton and Hove between 2008 and 2009. In both years the under 19 years repeat termination rates in the South East and England were 11%.

Ward level data indicate that East Brighton has high conception rates; central Brighton and Hove has high birth rates, particularly in the coastal wards; in the west area there are high termination rates. Of particular concern is Moulsecoomb and Bevendean ward where the 3-year under 18 conception rate has slowly increased from 45.2 per 1000 (2004-2006) to 64.8 per 1000 (2006-2008).

The number of teenage mothers in Brighton and Hove has decreased from 184 in 2008 to 127 in 2009, with around 12% of teenage mothers having a second teenage birth. A local study into the profile of local young mothers highlighted that the majority have complex needs; around one in three were subject to domestic violence, two in five were suffering from postnatal depression, one in five had other mental health issues and one in three babies were subject to child protection proceedings.[62]

As at September 2010, 24% of teenage mothers aged 16-19 years in Brighton and Hove are in Education Employment or Training (EET), lower than England (26%) but the same as the South East (24%). We are currently off track for meeting the 60% EET target for 2010.

Figure 20: Teenage conception rate trend, Brighton and Hove, South East and England 1997-2008 with Brighton and Hove trajectory to meet the 2010 target



Source: Teenage Pregnancy Unit, Feb 2010. (Data for 2008 are provisional)

Mental health

Brighton and Hove has a high Mental Health Needs Index (MINI) score together with a large number of people at increased risk of mental health problems.[63] Based on national survey data it is estimated that 28,177 people in the city aged 18 to 64 years have a common mental disorder, most commonly anxiety and depression. There are estimated to be 2,000 people with bipolar disorder and 600 with schizophrenia, the most common cause of hospital admission for mental health problems, with the longest length of stay.

Count Me In Too found that 79% of the city's LGBT population reported some form of mental health difficulties (Count Me In Too Mental Health Additional Findings, 2008).[64]

An older people's needs assessment (2008) found the mental health problems affecting the most older people in the city are dementia and depression. Applying national prevalence to the local population suggests that there are around 3,000 people aged 65 years or over with dementia; projected to increase to around 3,900 by 2030. It also suggests around 3,100 with depression, and 1,000 with severe depression. This is projected to rise to 3,800 people with depression and 1,200 with severe depression by 2030.

There is growing demand for psychological therapies with more people expressing a preference for talking therapies over medication (Brighton and Hove Mental health needs assessment, 2007).

Women are more likely than men both to report and to be diagnosed with depression and anxiety, and more women are treated for these conditions.[4]

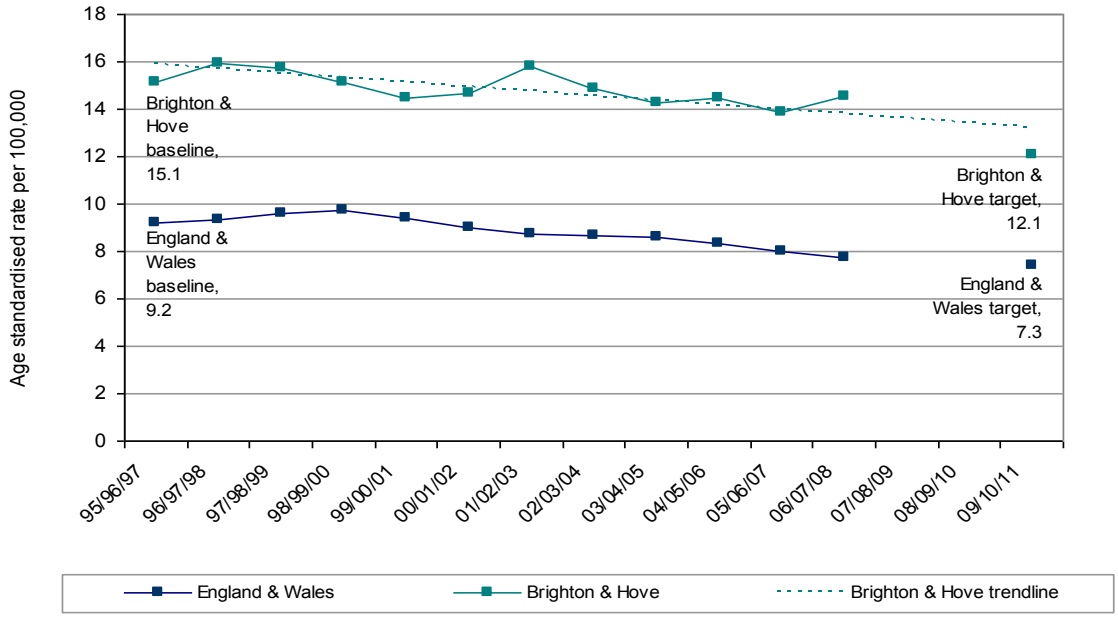
The number of children with mental health needs is significant. Around one in ten children aged 5-15 years has a clinically significant mental disorder[65]; based on this there are estimated to be 2,700 children in Brighton and Hove. Mental health issues are more likely amongst children who are looked after, adopted, on the child protection register, have learning difficulties, have suffered traumatic life events or are young offenders.

Suicide

Suicide is a devastating event; the consequences are felt by family, friends and the community. Suicide is the leading cause of death among men aged 35 years or under, and is the main cause of premature death in people with mental illness. Count Me In Too showed high rates of suicidal thoughts and attempts in the LGBT population.

Brighton and Hove had the second highest suicide and undetermined injury rate in England between 2006 and 2008 at 14.55 per 100,000 population, almost double the rate in England (7.76); although the trend is downwards (Figure 21).

Figure 21: Suicide and undetermined injury, Brighton and Hove and England and Wales 1995-97 to 2006-08 with trajectories to meet the 2010 target



Source: National Compendium for Clinical and Health Indicators, The NHS Information Centre for health and social care

Substance misuse

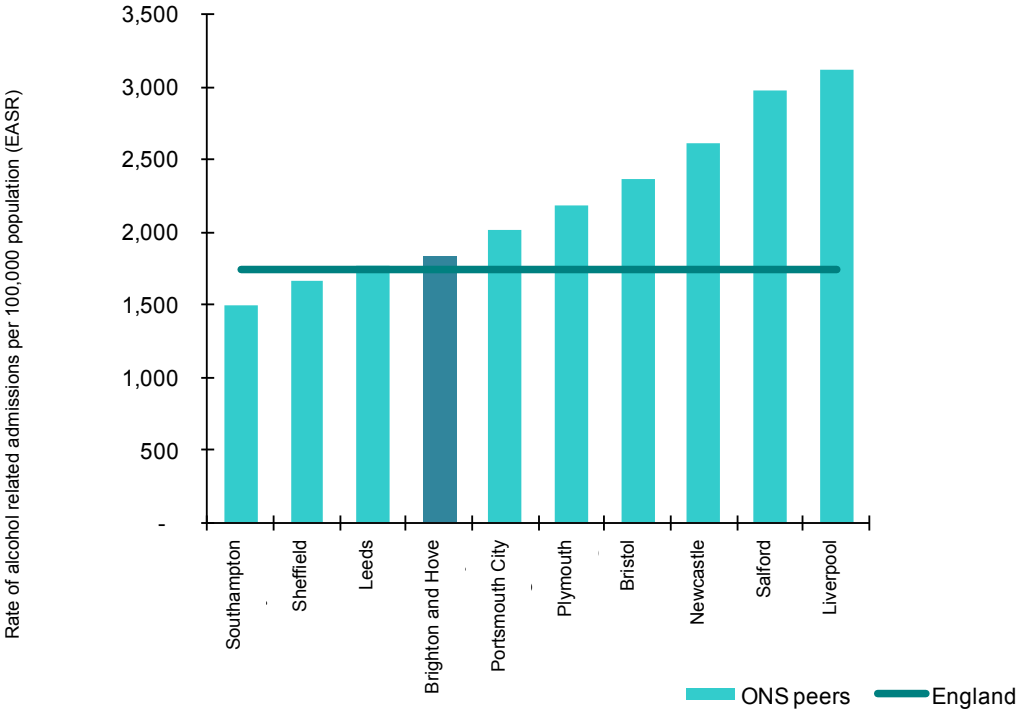
Alcohol

NHS Brighton and Hove and Brighton and Hove city council are working jointly on reducing alcohol related harm. As well as a review of the Alcohol Programme Board other actions have included a review of the alcohol JSNA, and a review of the alcohol prevention primary care pathway.

In Brighton and Hove it is estimated that almost 22.4% of adults engage in increasing risk drinking, defined as consumption of between 22 and 50 units of alcohol per week for males, and between 15 and 35 units of alcohol per week for females. A further 4.6% are estimated to engage in higher risk drinking, defined as consumption of more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females.[66]

In 2009/10 there were 5,029 hospital admissions of Brighton and Hove residents for alcohol related harm, a rate of 1,842 per 100,000 population compared with 1,743 in England. The comparison with comparator areas is given in Figure 22. The rate fell by 5% from the previous year; prior to that the rate of increase in the city was 15% per year, compared with 7% for comparator areas and 8% nationally.[66]

Figure 22: Rate of hospital admissions per 100,000 for alcohol related harm 2009/10



Source: Vital Signs from Hospital Episode Statistics

Findings from the Brighton and Hove Health Related Behaviour Surveys (HRBS) indicate that the percentage of people aged 14-15 years reporting drinking in the last week fell by 7%, from 56% in 1999 to 49% in 2007.[55] In 2009, 5% of 10-14 year old pupils in England said they had been drunk three or more times in the last four weeks compared with 9% in Brighton and Hove (Tellus4).[67]

The average reported consumption (units) of alcohol had also fallen. However, the proportion of young people reporting that they consumed more than 28 units in the past week increased by 3%.

Brighton and Hove has a higher male alcohol-specific mortality rate than its comparator areas, except for Bournemouth and Blackpool, and at 25.5 per 100,000 males the mortality rate is almost double that of England (13.1).[66]

ONS data indicate that alcohol related death rates are 45% higher in areas of deprivation. Alcohol related death rates are three times higher in areas of deprivation for women and five times higher for men.

A 2007 systematic review by the National Institute for Mental Health in England found an increased relative risk of alcohol dependence in lesbian, gay and bisexual groups of at least one and a half times higher than the heterosexual population. The relative risk for substance misuse was also increased.[68]

Alcohol attributable crime is significantly lower in Brighton and Hove than nationally.[66]

Drugs

Brighton and Hove local authority had the highest rate of drug related deaths in England in 2009 at 23.6 deaths per 100,000 aged 16 years or over. This was an increase from 21.2 per 100,000 in 2008. Table 6 shows the annual number and rate of drug related deaths in the city. Heroin or morphine and hypnotics/sedatives were implicated in the majority of the deaths.[69]

Table 6: Number of drug related deaths in Brighton and Hove 2000-2009

	Number of deaths	Rate per 100,000
2000	67	32.6
2001	59	28.5
2002	56	26.9
2003	53	25.3
2004	47	22.3
2005	51	24.2
2006	38	17.8
2007	44	20.7
2008	45	21.2
2009	50	23.6

Source: National Programme on Substance Abuse Deaths

In the 2008 Place Survey in Brighton and Hove 29.8% of residents thought that using or dealing drugs was a problem in their area, close to the South East average of 27.2%.[47]

Brighton and Hove has the third highest rate of problematic drug users (opiates and/or crack cocaine) in the South East with 1.17% of the population aged 15-64 years a problem drug user, or 2,109 individuals (Drug Treatment Monitoring Unit, 2008/09).[70] This was the 53rd highest prevalence of the 149 partnerships in England. During 2009/10 1,196 problematic drug users were in effective treatment (engaged with treatment services for 85 days or more), exceeding the treatment target of 1,175 people (National Drug Treatment Monitoring Service, 2010).[71]

It is estimated that 90% of those testing positive for Hepatitis C will have acquired the condition through injecting drug use. Figures from the Health Protection Agency indicate that 59% of injecting drug users in Brighton and Hove are positive for Hepatitis C compared with 47% in England, Wales and Northern Ireland.

There was a 12% increase in the number of current or previous injecting drug users who were offered and accepted a Hepatitis C test between 2007/08 and 2008/09.

Experimentation with drugs and alcohol is not uncommon amongst young people. Findings from the Health Related Behaviour Survey (1999-2007), indicate that 30% of those sampled (Year 10 pupils aged 14-15 years) had used cannabis in 2007 compared with 33% in 2004.[55]

However findings from the latest Tellus survey indicate that drug use amongst Year 8 and Year 10 pupils has risen: data from the 2009 Tellus4 survey[67] show an increase in the proportion of young people reporting that they had ever taken drugs of 13% to 24% of participants. Drug use amongst young people appears higher in the city than nationally: 9% of those sampled in England had ever taken drugs.

Data from the Tellus3 survey (2008) indicates that 13.7% of young people who participated in the survey in Brighton and Hove had either been drunk or taken drugs or solvents at least twice in the past four weeks, or had been drunk and experimented with drugs at least once in their lives. These findings place Brighton and Hove in the top quartile of local authorities, ranked 26 highest out of 150.

There were 163 young people in drug or alcohol treatment during 2009/10, the majority for either cannabis or alcohol, with fewer than eight classed as problem drug users (National Drug Treatment Monitoring Service, 2010).[71]

Some groups are more at risk of problematic use than others. Evidence exists that young people who have ever been excluded from school, are frequent truants, have ever been arrested, been homeless or in care are at greater risk of substance misuse. In Brighton and Hove it is estimated that 16% (2,957 people) of the population aged 10-16 years are vulnerable because of these reasons.

Domestic and sexual violence

Domestic violence is intentional, ongoing, controlling and coercive behaviours by one person, using emotional, financial, physical and sexual violence to ensure power and control over another, within an intimate or family relationship, regardless of gender or sexuality. This includes female genital mutilation and forced marriage. Sexual violence also covers a wide range of behaviours which can take place in a variety of contexts and circumstances, and can include rape, sexual assault, sexual harassment, trafficking and sexual exploitation.

Using national data it is estimated that in the last year in Brighton and Hove between 5,389 and 10,984 women experienced domestic violence; 2,763 women experienced sexual assault, and 6,682 women were victims of stalking. Furthermore, at some point as adults, over 27,000 women and nearly 2,000 men will experience repeat domestic violence locally, and up to half of all women will experience some form of interpersonal violence.

Domestic and sexual violence occurs in every socio-economic group, across all communities. However, most perpetrators are male and most victims female, and the gender of both victim and perpetrator influences behaviour, risk, and the severity of harm caused.

Whilst domestic and sexual violence impacts disproportionately on women and girls, a significant minority of men and boys also experience such violence, and it occurs across heterosexual and LGBT communities. Locally, data from Count Me In Too (2007)[72] suggests that 8,750 lesbians, gay men, bisexual and trans people in Brighton and Hove will experience abuse at some point in their lives, and in the last five years 3% of lesbians, 4% of gay men, 3% of bisexuals and 9% of trans people had experienced sexual assault.

Domestic and sexual violence also presents a risk of harm to children and young people. Locally, data indicates that domestic violence is the most common principal reason for children having a child protection plan in place: in March 2010 this was the case for 126 children (35% of children with plans).

Tipping the Iceberg, a 2007 study looked at sexual exploitation of young people across Sussex. They found evidence locally of sexual exploitation by family members, sexually exploitative relationships with older men or peers, and informal exchanges of sex for money, drugs, accommodation and other favours.[73]

Young people may also be experiencing domestic violence in their relationships. The first UK research on teenage partner violence (NSPCC, 2009) found that girls report greater incidence rates of teen relationship abuse, experience more severe abuse more frequently, and suffer more negative impacts on their welfare, compared with boys: of 88% of young people in an intimate relationship, 25% girls and 18% boys experienced physical abuse, 75% girls and 14% boys experienced emotional abuse and 33% girls and 16% boys experienced sexual abuse.

Both domestic and sexual violence is understood to be significantly under-reported to the police and other agencies. Victims of violence or abuse use all NHS services - in particular primary care, maternity care, GUM and mental health services. Women have much higher usage of general medical and mental health services, yet their disclosure to medical professionals remains low.

More women suffer rape or attempted rape than have a stroke each year, and the level of domestic violence in the population exceeds that of diabetes by many times.[74]

Physical and sexual violence have direct health consequences and are risk factors for a wide range of long term health problems, including physical injuries, self harm, eating disorders, suicide and attempted suicide, depression, anxiety and other mental health problems, alcohol misuse, unwanted pregnancy (including teenage pregnancy), abortion, sexually transmitted infections and risky sexual behaviour. Domestic violence can start or get worse during pregnancy, during which there is an increased risk of miscarriage, still or premature birth, foetal brain injury and fractures. It is less well recognised that a number of health problems such as obesity and dental neglect due to dental phobia can also be caused by sexual violence and abuse.

The NHS spends more time and money dealing with the impact of domestic and sexual violence than any other agency, and so action to tackle the causes and consequences of such violence is not only cost effective but contributes to the health and wellbeing of the population.[74] The 2011/12 NHS Operating Framework recommends health services should ensure that they properly identify individuals and have suitable care pathways in place to ensure sensitive, ongoing care.

Obesity

Obesity is an increasing concern both for adults and children. Being overweight or obese increases the risk of diabetes, hypertension, heart disease and cancer amongst other diseases.

Local forecasts of the direct financial cost to the NHS of diseases related to overweight and obesity have been published based on the national estimates produced as part of the Foresight report *Tackling Obesities: Future Choices*. The estimated annual costs to the NHS of diseases related to overweight and obesity in Brighton and Hove is £78.1 million in 2010 and £83.5 million by 2015.[75]

Childhood obesity

Applying estimates from the Health Survey for England 2008[76] to the local population, there would be almost 10,500 children and young people aged 2-15 years who are overweight or obese in Brighton and Hove.

As part of the National Child Measurement Programme (NCMP),[77] Reception (4-5 year olds) and Year 6 pupils (10-11 year olds) are weighed and measured each year. In the 2009/10 academic year the obesity prevalence Year 6 pupils was 15.5% (95% confidence interval 13.9%-17.1%) in Brighton and Hove, a lower prevalence than England (18.7%). The figure has fallen for the last two years from 17.7% in the 2007/08 academic year, but the difference is not statistically significant. Nationally, obesity prevalence is higher for boys than girls in both year groups.

Local data confirm there is a clear positive relationship between the prevalence of overweight and obesity and social deprivation (as defined by the Index of Multiple Deprivation (IMD), the Income Deprivation Affecting Children Index (IDACI) and the Child Well-being Index (CWI) as well as eligibility for free school meals).

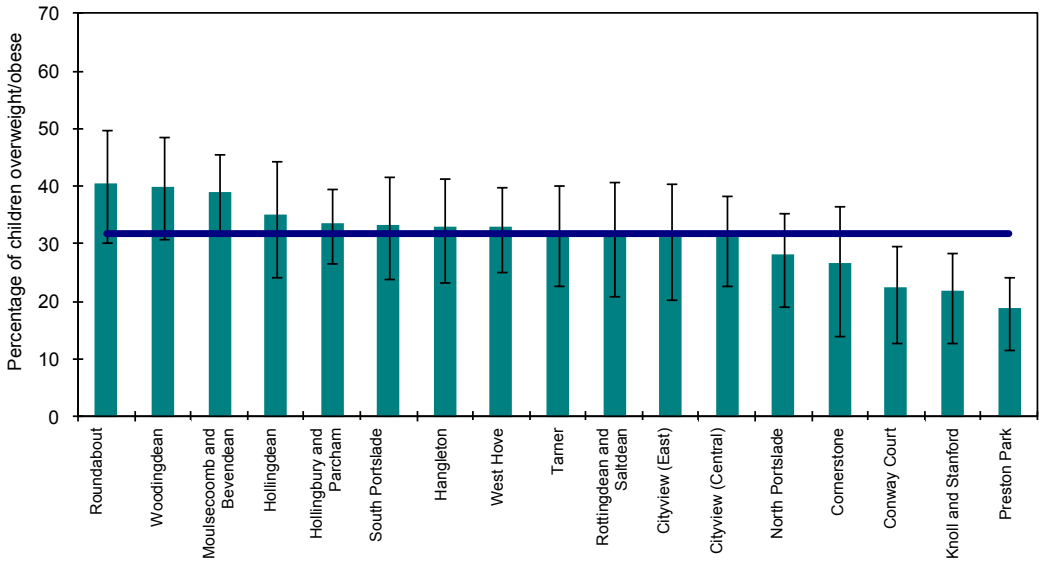
There is significant variation in the proportion of overweight or obese children across the city: Moulsecoomb, Bevendean & Coldean Children's Centre area have a statistically significant higher prevalence and Preston Park, and Knoll and Stanford Children's Centre areas have statistically significant lower prevalence (Figure 23).

Nationally, obesity prevalence is significantly higher for children in 'Asian or Asian British', 'Any Other Ethnic Group' and 'Black or Black British' ethnic groups . Obesity prevalence is significantly lower for 'Chinese' and 'White' children. Encouragingly the latest Health Related Behaviour Survey found that the eating habits of children aged 10-14 are improving, as are the levels of physical activity.[55]

Tackling obesity is being addressed locally by working with families on diet, nutrition and physical activity.

Childhood obesity needs assessment 2009

Figure 23: Percentage of children overweight or obese by Children's Centre area in Brighton and Hove, 2008/09



Source: National Child Measurement Programme

Physical inactivity

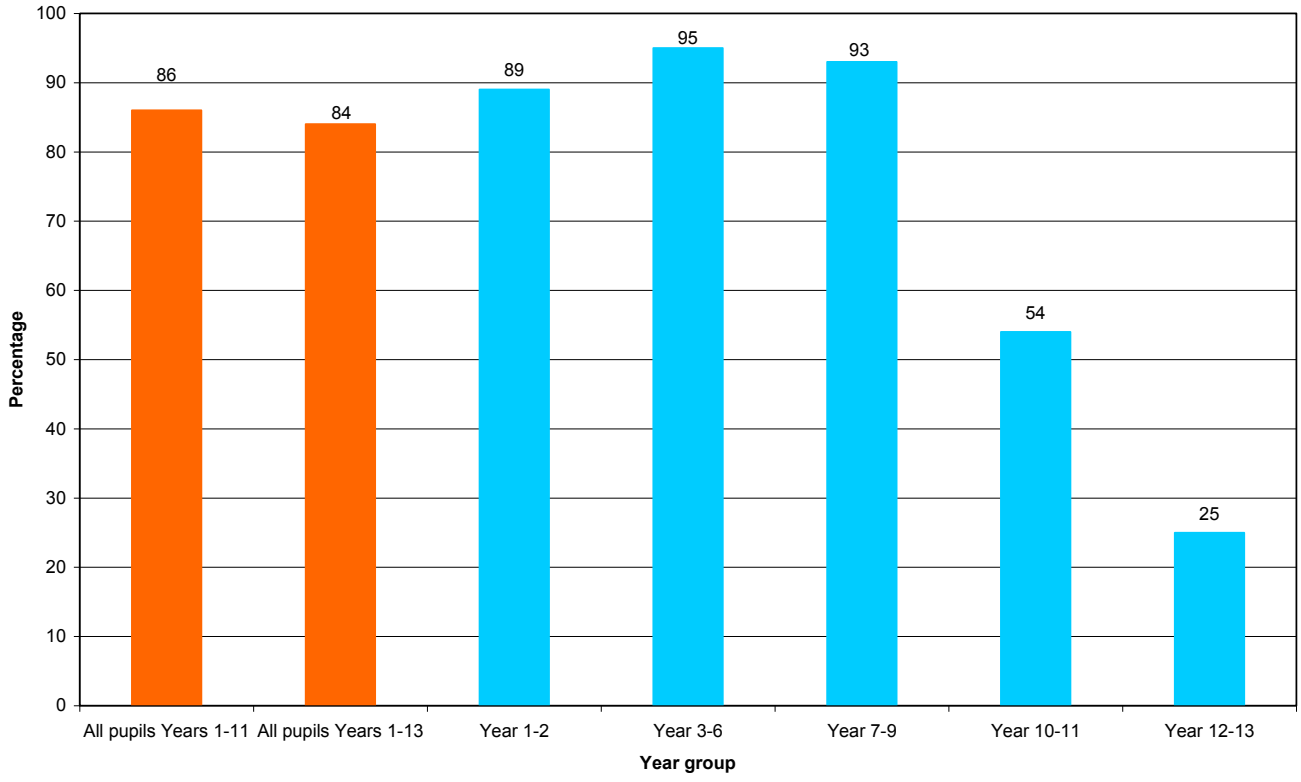
The British Heart Foundation Health Promotion Research Group at Oxford University produced estimates of the primary and secondary care costs attributable to physical inactivity for the NHS across England. Those costs relate to five diseases linked to physical inactivity (ischaemic heart disease, ischaemic stroke, breast cancer, colon/rectum cancer and diabetes mellitus). They estimated that physical inactivity cost the NHS in England more than £700 million in 2006/07 and Brighton and Hove £3.1million.[78]

Active travel and brief interventions in primary care have been shown to be highly cost effective in reducing physical inactivity.[78]

The 2009/10 PE and sport survey showed that across England 82% of pupils in Years 1-13 participated in at least two hours of curriculum PE compared with 77% in 2008/09. In Brighton and Hove, 84% of pupils participated in at least two hours of curriculum PE (83% of girls, 85% of boys). Participation is highest for years 3-6 pupils at 95% but reduces through secondary school from 93% of pupils in Years 7-9; 64% in Years 10-11, to 25% in Years 12-13 (Figure 24).[79]

Figures from the Sport England Active People Survey 2008/09 show that just 11.4% of adults aged 16 years or over in Brighton and Hove (11.2% in England) participated in moderate intensity sport and active recreation equivalent to 30 minutes on five or more days per week and 23.1% on three or more days (21.8% in England). The percentage doing no sessions was 43.0% (47.8% in England).[80]

Figure 24: Percentage of pupils who participated in at least two hours of curriculum PE a week by year group. Brighton and Hove 2009/10



Source: Department for Education

Long term conditions

Long term conditions include asthma, chronic obstructive pulmonary disease (COPD), diabetes, epilepsy and many others. Although these diseases are long lasting, they can be controlled by medication and other therapies; this includes patients taking an active role in their health and wellbeing.

These conditions, often identified as limiting long term illnesses, can result in frequent hospital admission. Managing patients with these conditions better will help to reduce the impact on the NHS.

A total of 14,326 (18.5%) people aged 50 and over thought that they were not in good health at the time of the 2001 Census.[81]

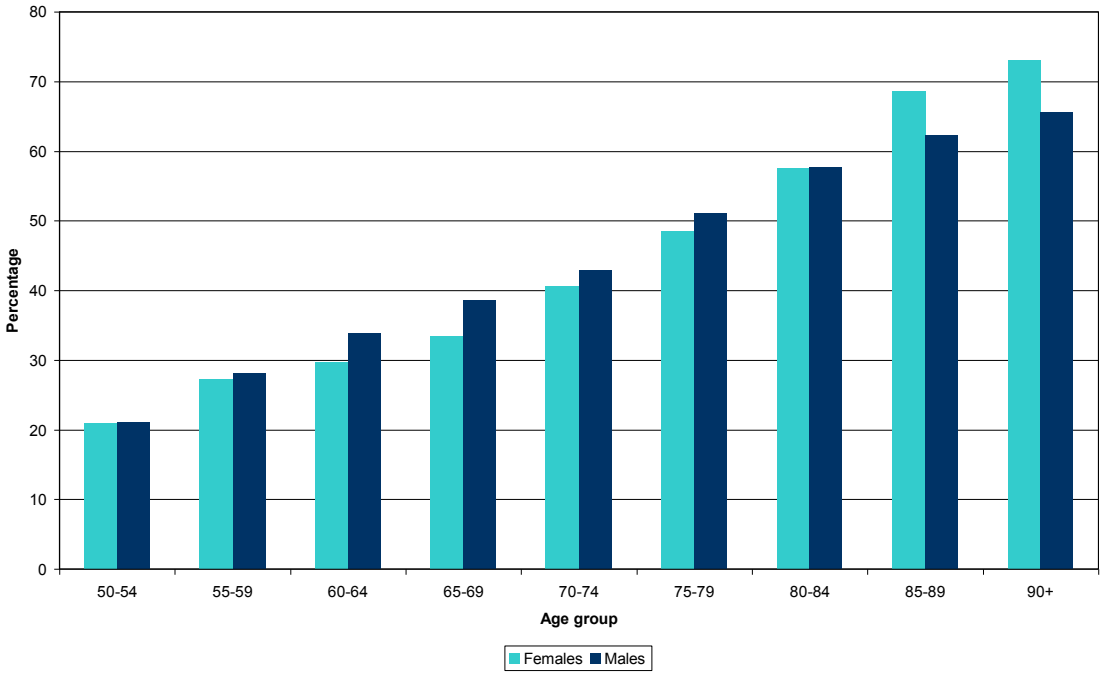
According to the 2001 Census, 18.0% of the total population of Brighton and Hove and 38.9% of older people reported having a limiting long term illness (Figure 25). In the more deprived areas of the city, the percentage of people living with a limiting long term illness increases to around 23%. From the age of 50 to 79 years men have higher reported rates than women but from 85 years the rates for women are higher.

A higher proportion of Brighton and Hove residents aged less than 65 years reported having a limiting long term illness compared with England and a higher percentage of residents aged 16 to 74 years reported that they were permanently unable to work.

Within Brighton and Hove long term conditions prevalence rates, modelled on population characteristics rather than actual prevalence, are generally much higher than the rates of diagnosed disease recorded on local GP disease registers.

According to GP practice registers, the proportion of people with long term conditions is lower in the central locality. The prevalence of hypertension, stroke/ transient ischaemic attack (TIA), dementia, depression and chronic kidney disease is highest in the west, perhaps due to the higher proportion of older people. The prevalence of coronary heart disease (CHD), diabetes, COPD, asthma and heart failure is highest in the east. The high prevalence of COPD, asthma and CHD in the east may be linked to the high smoking rates.

Figure 25: Limiting long term illness by age and gender, Brighton and Hove, 2001



Source: Census 2001, Office for National Statistics

In 2008, modelled estimates and projections of prevalence of a number of conditions based on data from the Health Survey for England were produced by the Eastern Region Public Health Observatory.[82]

For stroke, hypertension, CHD and COPD, whilst prevalence of the conditions is expected to change little in Brighton and Hove from 2008 to 2020, the numbers of people living with the conditions is expected to increase due to the changing population (Table 7).

There are projected to be almost 4,500 more people with hypertension by 2020. In addition there will be 266 more people with stroke; 715 more with COPD and 829 more with CHD by 2020 than in 2008.

In 2008/9 around 700 patients were admitted to hospital as an emergency four or more times - over 3,700 admissions. There were 538 admissions due to asthma and diabetes during the 2007/8 financial year (217 per 100,000 population), with many being potentially avoidable, as these conditions could be managed in primary care.[83]

Table 7: Modelled and projected prevalence of hypertension, CHD, stroke and COPD in Brighton and Hove, 2008, 2015 and 2020

	Hypertension		CHD		Stroke		COPD	
	n	%	n	%	n	%	n	%
2008	59,093	27.9%	11,192	5.3%	4,886	2.3%	9,543	4.5%
2015	61,024	27.9%	11,459	5.2%	4,961	2.3%	9,830	4.5%
2020	63,570	28.5%	12,021	5.4%	5,152	2.3%	10,259	4.6%
Increase 2008 to 2015	1,930		267		75		287	
Increase 2008 to 2020	4,476		829		266		715	

Source: Eastern Region Public Health Observatory, 2008

Physical disabilities

It is estimated that approximately 12,200 Brighton and Hove residents aged 18-64 years have a moderate physical disability, and 3,400 have a severe physical disability. The number of people with a moderate or severe physical disability (aged 18-64 years) is expected to increase by 7.4% between 2010 and 2020 (PANSI, Projecting Adult Needs and Service Information System).[84]

Approximately 5,700 local residents aged 18 to 64 years are estimated to have a moderate personal care disability, and 1,300 to have a severe personal care disability.

The World Health Organisation suggests two approaches to assessing the prevalence of disability within a city: sample surveys such as the Health Counts survey conducted in Brighton and Hove, and review of records of service utilisation which involves collation of routinely collected data.

The Health Counts survey (2003) had 748 respondents aged 55 years or over and collected information on behaviour, self-assessed morbidity and information on limiting illness or disability which may limit daily activities or work that the people may be able to undertake. In the survey 52.8% of respondents were reported as having a disability which prevented them from working or carrying out daily activities, 45.3% did not have any such disability and 1.9% did not respond.[85]

In May 2010, one in 12 adults aged 18 to 64 years in the city received Disability Living Allowance (DLA) (13,420 people), up from one in 20 in May 2008. The rate varies considerably across the city and is highest in East Brighton and Queens Park wards.[86]

Residents with a physical disability are more likely to live in a home in disrepair and be fuel poor. Since 2003 the number of people with physical disabilities helped to live at home by Brighton and Hove city council has increased considerably, and local performance is higher than the England average.

Homelessness in Brighton & Hove during 2009/10 due to physical disability is over two times higher than the England average, indicating a high level of need locally (BHCC Housing Statistical Bulletin, 2009/10).[36]

Learning disabilities

A needs assessment for adults with learning disabilities is part of the programme for 2010/11 and once complete will be available at www.bhlis.org.

It is estimated that nationally one in 50 adults will have a learning disability. This is forecast to increase over the next 10-20 years, with the highest increase being amongst older people and those with the most severe learning disabilities.

Applying national prevalence rates for learning disabilities to the population of the city suggests that there are approximately 5,000 people aged 18 years or over with learning disabilities (Table 8) with nearly one fifth having a severe learning disability.[87]

However, there were only 949 adults with learning disabilities recorded on GP practice registers in 2009/10 (a prevalence of 0.4% of adults compared to 2% in England).[88]

The Compass voluntary register for children and young people up to 19 years shows that there is a higher number of children and young people with learning disabilities in the more deprived areas of the city.[89]

Most people with learning disabilities will use mainstream services but there are 798 people in Brighton and Hove who use a learning disability service (2010).[90]

In addition there are 70 people supported by the specialist learning disability health team placed here by other councils. The number of people receiving a service has increased from 647 in 2007/08. This indicates that there might be under-recorded or un-diagnosed people with learning disabilities in the city. Some of the difference is likely to be due to large numbers of people with a learning disability who do not need additional support.

Table 8: Projected number of people aged 18-64 years and 65 years or over with learning disabilities in Brighton and Hove

	2010	2015	2020	2030
Total population aged 18-64 predicted to have a learning disability	4,320	4450	4536	4,729
Total population aged 65 and over predicted to have a learning disability	733	754	777	907

Source: PANSI, Projecting adult needs and service and POPPI, Projecting older people population information system.

National research suggests there could be 1,100 adults aged 18 years or over in the city with a moderate/high learning disability, more than the number currently getting services. Some of these people might have support from families now, but might need a learning disability service in the future.[87]

There will also be more people with higher needs requiring a service; more young people with learning disabilities will become adults over the next few years and are more likely to have complex and higher needs.

Employment increases inclusion and has been shown to improve health, wellbeing and independence and therefore reduce the need for other services. There is a need for more employment support for adults with learning disabilities in the city.

Applying prevalence rates to population projections gives estimated numbers of people with learning disabilities to 2030. Within Brighton and Hove the number aged 18 years or over is projected to increase from 5,053 in 2010 to 5,204 by 2015 and to 5,636 by 2030 (a 3% and 12% increase respectively).[87]

Adults with learning disabilities have a high prevalence of being overweight and of associated chronic diseases such as cardiovascular disease and diabetes (NHS Scotland, 2004) which would be likely to increase as a result of the increase in prevalence. People with learning disabilities are also more likely to develop early onset dementia (Emerson and Baines, 2010).[91]

Autistic Spectrum Conditions

A needs assessment for adults with autistic spectrum conditions is part of the programme for 2010/11 and once complete will be available at www.bhlis.org.

The first study looking at the prevalence of Autistic Spectrum Conditions (ASC) in adults was conducted recently and found prevalence to be around 1% in adults, a rate comparable to that found in children (NHS Information Centre for Health and Social Care, 2009).[92] The National Autistic Society also uses a 1% prevalence rate to estimate the number of people with an autistic spectrum condition.

As at 2010, there are an estimated 1,763 adults aged 18-64 years with ASC in Brighton and Hove (PANSI, Projecting Adult Needs and Service Information System). The largest numbers estimated in those aged 25-44 years. There is a far greater number of males estimated to have an ASC than females; 90% of the total at 1,589 males and 174 females.[84]

Children and young people with disabilities and complex health needs[93]

A disabled child's quality of life is not only determined by their impairment but also by poverty, unequal access to education, healthcare, leisure activities, transport and housing. Children with disabilities are more likely to experience social exclusion and are largely dependent on their families for emotional support.

Children are surviving longer with conditions they would previously have died from in childhood.

Recent estimates based on analysis of a number of studies suggest that the prevalence of child disability is between 4.5% and 16% in the UK as a whole, with suggestions that the lower estimates for England are due to differing definitions of disability. National estimates suggest that over 50% of children who have a disability live on or near the margins of poverty.

People with physical and learning disabilities are more likely to suffer discrimination, poor access to some health services and worse employment prospects as a result of their disabilities, and these factors all impact negatively on their health.

In addition to the needs of children and young people with disabilities there are wider implications for those caring for these individuals.

Estimates of the number of children and young people with a disability in Brighton and Hove range from 1,299 to 3,787, although these are likely to be underestimates.[94]

The Compass database, the voluntary city register for children and young people with disabilities and complex health needs, currently holds information on 1,606 children and young people. The greatest proportion of children and young people with disabilities and complex health needs in the city are aged 11-16 years. Boys are more than twice as likely as girls to have a disability or complex health need. There is a high proportion, and number, of children and young people with disabilities and complex health needs in more deprived areas of the city.[89]

Parent carers report that there is a lack of understanding and acceptance of disability within the wider community, and a lack of information for parents.

Children and Young People with disabilities and complex health needs - Needs assessment 2010

Carers

At the time of the 2001 Census, there were six million carers in the United Kingdom.[81]

Almost 22,000 people of all ages in Brighton and Hove said that they provided some informal care according to the 2001 Census, 9% of the population. Over 4,000 people (19% of unpaid carers) spent 50 hours or more a week caring. These are likely to be underestimates of the population of carers in the city.

More than half (52%) of carers in the city were aged 50 years or over. Of people aged 85 years or over, 5% provided some form of unpaid care, 50% of whom provided 50 hours or more.

The unpaid carer population saves the UK an estimated £87 billion a year. The economic value of the contribution made by carers is estimated at £223 million in Brighton and Hove.[95]

A carer's survey in the city in 2009 identified that the main reasons for caring needs were:

- long term conditions/illness
- physical disability
- care for older people

Carers most commonly identified the support they needed as being emergency back-up support, respite breaks, emotional and financial support, and information.

The highest proportion of carers were looking after their husband or wife or civil partner (42%) followed by adult son or daughter (26%) and parent or parent-in-law (20%), with carers of adult children more likely to be caring for someone with learning disabilities (Brighton and Hove Carer's Survey, 2009).[96]

There are almost 500 carers aged 8-17 years in the city according to the 2001 Census.[81] Young carers are children and young people under 18 years who provide (or intend to provide) care, assistance or support to another family member. They carry out, often on a regular basis, significant or substantial caring tasks and assume a level of responsibility which would usually be associated with an adult. The person receiving care is often a parent but may be a sibling, grandparent or other family member who is disabled or ill.

Young carers in the city identified the things most important to them as:

- Groups where you can talk about difficult feelings with young people in a similar situation
- Support to engage in new activities
- Not providing personal care
- Support to go out as a family
- Paid domestic help to reduce the impact of the caring role in the home
- 1:1 confidential support for information about choices and options
- Communication from people working and speaking up for young carers
- Young carers enjoy cooking to help at home
- Pre-prepared plan of action to follow in an emergency
- Raise awareness in schools in PSHE lessons.

(Brighton and Hove Carer's Strategy, 2010-2012).[97]

End of life care

End of life care services support those with advanced, progressive, incurable illness to live as well as possible until they die. The provision of end of life care services has become increasingly complex: people are living longer and the incidence of frailty and multiple conditions in older people is increasing.

As a result, people approaching the end of their life require a combination of health and social care services provided in the community, hospitals, care homes or hospices.

Surveys of the public have shown that the first preference for most people in the UK (56-74 per cent) would be to die at home, although as people become sicker and as they approach death this proportion may decline, as they want access to more extensive support, such as a hospice (Department of Health, 2010).[98]

Between 2006-08 21% of all deaths in Brighton and Hove occurred at home; this is significantly higher than England, the South East and for comparator areas.[99]

Healthcare associated infection

Healthcare associated infections (HCAI), and in particular Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.Diff), represent a genuine concern for patients and staff alike.

The profile of MRSA has been particularly high and in Brighton and Hove local rates have been among the highest in England and Wales.

During 2009/10 the steady progress in reducing HCAIs in Brighton and Hove continued. From a peak of 86 cases at Brighton and Sussex University Hospital Trust in 2006/07 MRSA bacteraemias fell to just 24 cases during 2009/10 (Figure 26).

Clostridium Difficile infections have also fallen steadily in Brighton and Hove in recent years, from a peak of 261 cases in 2007/08 to 148 infections in patients registered with a Brighton and Hove GP (against a target of 161 cases) (Figure 27).

For 2010/11, a PCT target of 119 has been set but there has been an increase in cases of C.Diff infections in the early part of 2010 both in the community but particularly in hospital patients and, as at the end of September, there have been 91 cases against a target-to-date of 61.

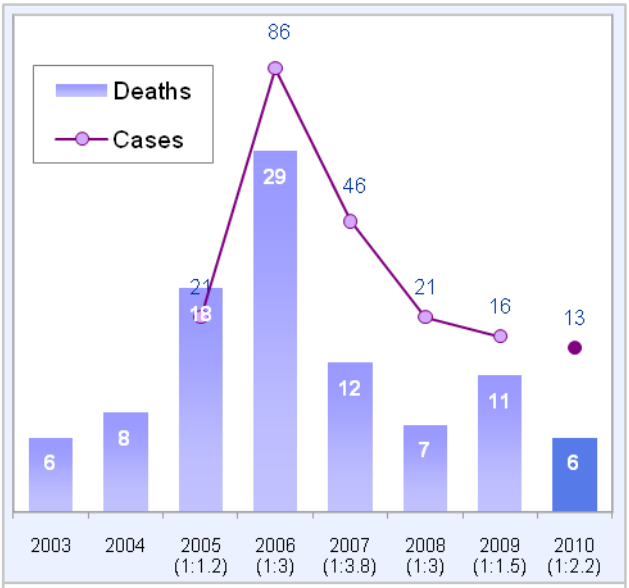
A rapid review is now undertaken on all community acquired HCAIs – these are mostly C.Diff infections, and a root cause analysis (RCA) is undertaken in all cases where there has been a death, where the case occurred in a residential home, where it appears two or more cases are connected or where, in consultation with the PCT Director of Infection Prevention and Control, it is felt that fuller investigation is required.

Deaths where an HCAI has been included in the death certificate peaked for C.Diff in the calendar year 2007, when there were 66 cases. For MRSA the peak was in 2006, when there were 29 cases. As at the end of October 2010, there have been six deaths where MRSA was mentioned on the death certificate. For C.Diff the number is 19, an increase compared to 12 for 2009.

From 2011 there will be a requirement for the PCT to monitor two additional HCAIs, Methicillin-Sensitive Staphylococcus Aureus (MSSA) from January, and Ecoli from April.

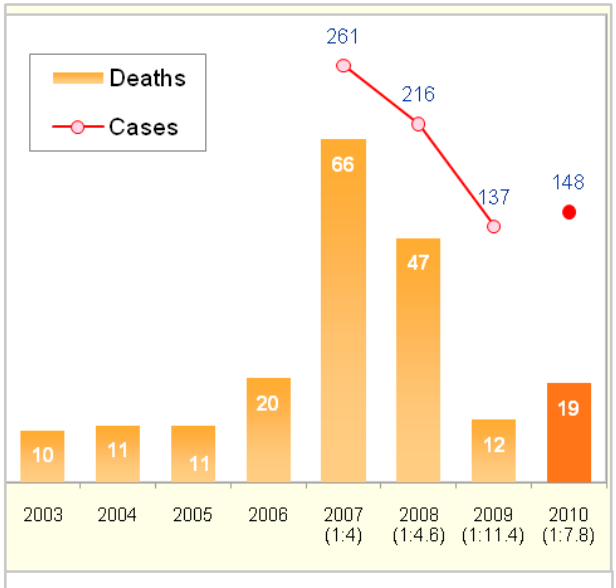
Figure 26 and 27: Brighton & Hove deaths (PCT registered patients) where MRSA and/or Cdiff was mentioned on the death certificate, and cases 2003 to October 2010

Figure 26: MRSA



Notes:
- Ratio (brackets) is no. of deaths to no. of cases.
- 2010 data is year to date.
- The 2 series do not use the same scale.

Figure 27: Clostridium Difficile



Notes:
- Ratio (brackets) is no. of deaths to no. of cases.
- 2010 data is year to date.
- The 2 series do not use the same scale.

Source: Monthly ONS Public Health Mortality Files and Health Protection Agency HCAI data capture system.

Public voice

Inclusion of "voice" in needs assessments

Individual needs assessments should reflect the views of service users, the public and professionals.

The new framework for needs assessments in the city includes specific "Voice" sections to ensure this evidence is considered in assessing needs.

So whilst voice is present elsewhere in the summary, this section of the summary looks at more general views gained from the NHS public satisfaction survey, the last Place Survey and the Community and Voluntary Sector in Brighton and Hove.

Community and Voluntary Sector

The Community and Voluntary Sector Forum (CVSF) position statement on health and well-being provides a summary of the views of the community and voluntary sector in the city. The views expressed in the position statement were gathered at a number of events held by the CVSF between 2006 and 2010.[100]

The statement gives the following priorities:

Preventative measures

Prevent people from becoming ill by providing counselling services, physiotherapy, family and carers support groups, befriending and medication services, and neighbourhood care schemes. Take into account socio-economic and environmental factors which have a major impact on residents' health, such as the impact of inequalities, poverty, and lack of access to fresh food shops.

Targeted interventions and measures

Provide support to all communities of interest who may have particular health needs, and target appropriate solutions to health issues to particular communities to prevent isolation and increase physical health. Recognise the barriers faced by particular individuals and groups to healthcare, and design services to address these.

Local health services and facilities

Improve access to local information and local services, particularly mental health services and local health facilities such as GPs, dentists, chemists and sports facilities. Provide community based services with good public transport links. Support older people to live safely at home. Improve the links between health professionals and community and voluntary groups.

Mental health

Promote good mental health in the workplace. Provide a range of activities to build confidence in those with mental health issues (e.g. steps towards education, training and volunteering opportunities). All agencies in the city should work together to ensure that the mental health services provided in the city are services which clients need and will use, and that service users have choice and control over the support they receive. There are severe gaps in mental health services at a neighbourhood level, particularly for conditions such as mild depression.

Public health issues

Important public health issues include: dementia; diabetes; substance misuse; mental health; sexual health; falls prevention for older people; use of alcohol by older people; health of refugee communities; inequalities in life expectancy; healthy living; cancer services; hospice services; maternity care; care for over 5s. The socio-economic and environmental factors which impact on health such as poverty, access to healthy food, education, housing, multiple disadvantages, and fear of crime are also serious public health issues. Other priorities include; young men and sexual health; pregnancy interventions; LGBT individuals and sexual health; STI reduction; respite care for all carers of all ages; use of art therapy as a form of health intervention.

Other issues

Issues such as health, housing and crime are inseparable and should not be considered in isolation. All service users and communities should be involved in setting the local health agenda and designing local services. Use existing structures to promote health and well-being and don't duplicate or produce new structures.

CVSF position statements can be found at www.cvsectorforum.org.uk

The Place Survey[47]

The Place Survey was last conducted in 2008 by each council in England and provides information on the local public's satisfaction with the local area as a place to live. This incorporates services delivered by various local partners.[47]

Residents in Brighton and Hove are generally happy with their local area as a place to live and we compare well to other local authorities on this score.

However residents in deprived areas, council housing tenants, those renting from a Housing Association, and Lesbian, Gay, Bisexual and Transgender (LGBT) residents are less likely to be satisfied.

The picture of whether residents feel their concerns are listened to and acted upon is mixed. White Other groups and local authority housing tenants are more likely to feel that they can influence decisions in their local area.

Residents in more deprived areas are more likely to feel that their interests are promoted.

Council tenants, women, and BME groups also feel that local services act on the concerns of local residents.

BME groups and local authority housing tenants are more likely to feel that local public services do not treat all people fairly and that these services do not treat them with respect.

LGBT communities are more likely than heterosexual residents to feel that public services treat all people fairly.

Overall:

- 77% of respondents were satisfied with their GP
- 67% with their local hospital
- 66% with their local dentist

Brighton and Hove were in the fifth quintile (lowest satisfaction) of local authorities for satisfaction with GP and local hospital, and fourth quintile for dentists.

Brighton and Hove was ranked 14th of all local authorities in England for the percentage of residents very or fairly satisfied with parks and open spaces at 82.1% compared with 72.6% in the South East and 68.5% in England.

Brighton and Hove Place Survey reports

NHS Public Satisfaction Survey[101]

Results from the 2009 NHS Public Satisfaction Survey for Brighton and Hove[101] showed that four in five (81%) Brighton and Hove residents agree that the local NHS provides them with a good service – this is a significant increase since the 2008 survey.

One in three (32%) residents say health services in the area have improved over the last few years with half (49%) saying they have stayed about the same.

Three in ten (31%) also think health services are likely to improve in the coming years, twice the percentage who expect them to get worse (15%).

Positively, over four in five (83%) residents agree that their local NHS helps improve the health and wellbeing of themselves and their families, a significant increase on 2008.

The percentage who agree local NHS and social services work well to provide a "joined-up" service remains the same (51%).

More people than in the previous survey agree that they can influence decisions affecting their local NHS than in 2008, but this remains the majority (54%).

Three in five (58%) agree their local NHS is giving people more choice about their treatment and care.

There has been an increase in the proportion of residents who agree that their local NHS is improving services for people like them – up to two in three (65%).

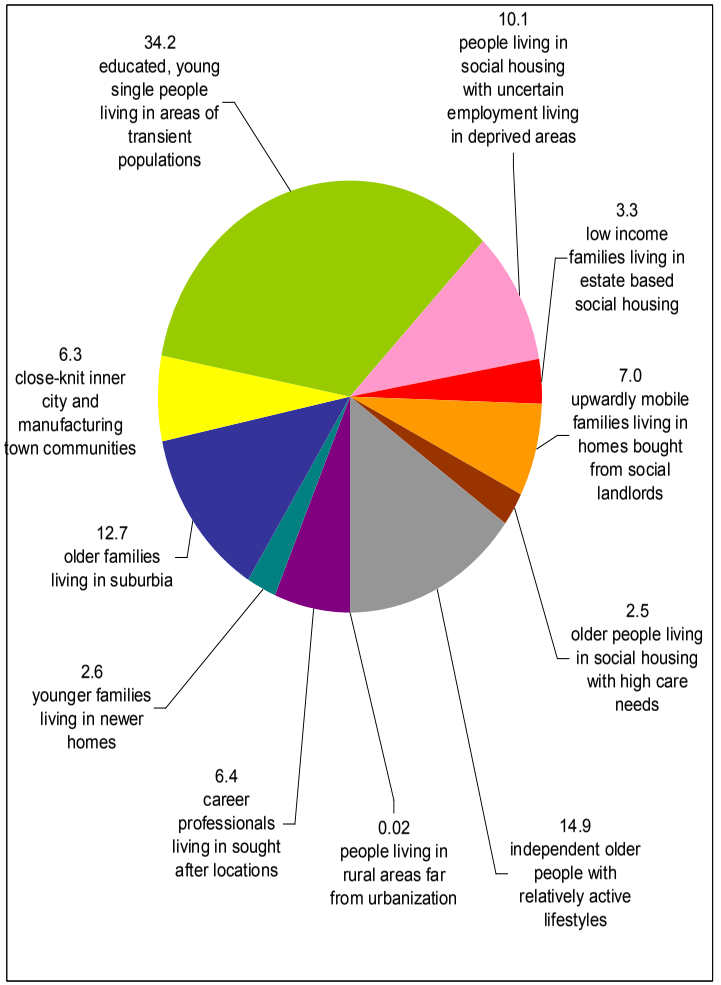
NHS Public Satisfaction Survey, 2009

Glossary

ASC	**Autistic Spectrum Condition**
BME	**Black and Minority Ethnic**
CHD	**Coronary Heart Disease**
COPD	**Chronic Obstructive Pulmonary Disease**
CWI	**Child Wellbeing Index** The Child Well-being Index (CWI) is produced at Lower Super Output Area level (LSOAs) and is made up of seven domains. Summary measures of the CWI are presented at local authority district and county council levels. The CWI is based on the approach, structure and methodology that were used in the construction of the IMD 2007. The seven domains included in the CWI are: • Material well-being • Health • Education • Crime • Housing • Environment • Children in need.
DAT	**Drug Action Team**
DCLG	**Department for Communities and Local Government**
DCSF	**Department for Children Schools and Families**
ERPHO	**Eastern Region Public Health Observatory**
ESA	**Employment and Support Allowance**
HCAI	**Healthcare Associated Infection**
HRBS	**Health Related Behaviour Survey**
IDACI	**Income Deprivation Affecting Children Index** IMD 2007 Income Deprivation Affecting Children supplementary index is the proportion of children in households in receipt of means tested low income benefits
IDAOPI	**Income Deprivation Affecting Older People Index** The IDAOPI is a supplementary index that has accompanied the Index of Multiple Deprivation in 2004 and 2007. It shows the proportion of older people in a small area that are living in pension credit (guarantee) households.

IMD	**Index of Multiple Deprivation** The new Index of Multiple Deprivation 2007 (IMD 2007) is a Lower layer Super Output Area (LSOA) level measure of multiple deprivation, and is made up of seven LSOA level domain indices. There are also two supplementary indices (Income Deprivation Affecting Children and Income Deprivation Affecting Older People). The seven domains of the IMD are (weighting in the index): Income Deprivation (22.5%), Employment Deprivation (22.5%), Health Deprivation and Disability (13.5%), Education, Skills and Training Deprivation (13.5%), Barriers to Housing and Services (9.3%), Crime (9.3%) and Living Environment Deprivation (9.3%)
JSA	**Job Seekers Allowance**
JSNA	**Joint Strategic Needs Assessment**
LGBT	**Lesbian, Gay, Bisexual and Transgender**
LSOA	**Lower Super Output Area** (See SOA)
NCMP	**National Child Measurement Programme**
NEET	**Not in Education, Employment or Training**
ONS	**Office for National Statistics**
OSCI	**Oxford Consultants for Social Inclusion**
PANSI	**Projecting Adult Needs and Service Information System**
PCT	**Primary Care Trust**
POPPI	**Projecting Older People Population Information System**
QALY	**Quality Adjusted Life Years**
QOF	**Quality and Outcomes Framework**
SEPHO	**South East Public Health Observatory**
SOA	**Super Output Area** Super Output Areas (SOAs) are a set of geographical areas developed after the 2001 census. The aim was to produce a set of areas of consistent size, whose boundaries would not change (unlike electoral wards). They are an aggregation areas with similar social characteristics. Lower Layer SOAs typically have a population of around 1500. Middle Layer SOAs on average have a population of 7,200.
STI	**Sexually Transmitted Infection**
TIA	**Transient Ischaemic Attack**
WHO	**World Health Organisation**

Group	Group description	percentage of households	key features
a	career professionals living in sought after locations	6.4	Middle-aged; successful; rewarding careers; high incomes; high net worth; choicest housing; good diet; drink alcohol daily; concern for the environment
b	younger families living in newer homes	2.6	Young couples; good education; corporate careers; low unemployment; good prospects; modern homes; internet; enjoy exercise; care for environment
c	older families living in suburbia	12.7	Married Couples; Older Children; white collar workers; hardworking; self-reliant; comfortable homes; plan for retirement; good place to live; environmental charities
d	close-knit inner city and manufacturing town communities	6.3	Young couples; children; family close by; older houses; small industrial towns; traditional; close knit communities; working family tax credit ; inactive lifestyles
e	educated, young single people living in areas of transient populations	34.2	Young singles; few children; well educated; full time students; professionals; open-minded; cosmopolitan tastes; good diet and health; cultural variety
f	people living in social housing with uncertain employment living in deprived areas	10.1	Families; many young children; low incomes; free school meals; high deprivation; council housing; public transport; heavy watchers of TV; Heavy drinkers / smokers
g	low income families living in estate based social housing	3.3	Families; low incomes; income support; free school meals; terraces and semis; large council estates; outer suburbs; bad place to live; heavy TV viewers
h	upwardly mobile families living in homes bought from social landlords	7.0	middle aged couples; mostly poorly educated; council estates; small towns; exercised right to buy; self reliant and capable; poor diet; heavy smokers; heavy viewers of TV
i	older people living in social housing with high care needs	2.5	Older people; low incomes; low savings; pension credit; some small bungalows; some sheltered homes; TV popular; Bingo; dominoes; cards; HESS emergencies
j	independent older people with relatively active lifestyles	14.9	Pensioners; relocated on retirement; own their homes; index linked pensions; significant capital; active; good health and diet; HES emergencies; prefer face to face service
k	people living in rural areas far from urbanization	0.02	Older people; small communities; neighbourly; distinct rural life; farming; agro-tourism; good diet and lifestyle; work long hours; cars important



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