

Brighton & Hove Joint Strategic Needs Assessment

2013

NHS
Brighton and Hove


Brighton & Hove
City Council

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The JSNA is an ongoing process that provides a comprehensive analysis of current and future needs of local people to inform commissioning of services that will improve outcomes and reduce inequalities. To do this, needs assessments gather together local data, evidence from the public, patients, service users and professionals, plus a review of research and best practice.

In Brighton & Hove there are three elements to the needs assessment resources available:

- An annual JSNA summary, which gives a high level overview of Brighton & Hove's population, and its health and wellbeing needs;
- A rolling programme of comprehensive needs assessments for the city;
- Brighton & Hove Local Information Service (BHLIS), which is a health data and information resource for those living and working in Brighton & Hove.

This section gives some key information on the City from the JSNA – with more information available at www.bhlis.org/jsna2013

The population of Brighton & Hove

The latest mid year population estimates for 2011 show there are 273,000 people resident in the city and this is predicted to increase to 291,000 by 2030. Our population differs in distinctive ways to that of the South East and England. There is a much higher proportion of people aged 16-64 years, with lower proportions of children and older people aged 65-74. However, a similar proportion of the population are aged 85 years or over in Brighton & Hove as in England (2.2% of the population) and this group is likely to need more services.

Some key population groups within the city include:

- **Gender** – The 2011 Census indicated a fairly even proportion of male and female residents. However, the Census did not quantify the trans population and the 2013 Brighton & Hove Trans Equality Scrutiny Panel concluded that there is not a reliable local or national estimate of the size of the trans population.
- **Black and Minority Ethnic (BME) groups** - The most recent population estimates (2011) show that 80.5% of the city's population are White British and 19.5% are from a BME group. This is a lower proportion than England (20.2%), but higher than the South East (14.8%).
- **LGB** - Estimates suggest that there may be 40,000 people from Lesbian, Gay, Bisexual (LGB) communities living in Brighton & Hove, around 15% of the city's population.
- **Carers** - 9% of the population (approximately 24,000 people) identify themselves as carers.
- **Migrants** - the city is a common destination for migrants from outside the UK, 2010 figures show that 15% of the city's population was born abroad.

- **Students** - there has been an increase in the numbers of students in the city to more than 35,200 in 2011/12. This is approximately 13% of the total population. Many students choose to stay on after university.
- **Military veterans** – an estimated 17,400 military veterans live in the city. A veteran is anyone who has served in Her Majesty’s Armed Forces at any time, irrespective of length of service.

Life expectancy, healthy life expectancy and inequalities

Life expectancy in Brighton & Hove is 77.7 years for males and 83.2 for females. Whilst females in the city can expect to live on average six months longer than nationally, life expectancy for males is almost one year lower. Healthy life expectancy is 67.9 years for males and 72.9 years for females meaning that, on average, around 10 years of life is spent in ill health.

As has been seen nationally, whilst mortality rates in the city are falling in all groups, they are falling at a faster rate in the wealthiest 20% of the population meaning inequalities are widening. The gap in life expectancy between the most and least deprived people in the city is now over 10 years for males and over six years for females and similar inequalities also exist in healthy life expectancy.

Highest impact health and wellbeing issues

For the 2012 JSNA we aimed to systematically identify the impact of different factors on the health and wellbeing of the city’s population. This fed into the prioritisation process for the Joint Health and Wellbeing Strategy. The issues with the greatest impact on health and wellbeing in the city, mapped across the life course, are:

Wider determinants which have the greatest impact on health & wellbeing

	Children & young people	Adults	Older people
Child poverty			
Education			
Employment & unemployment	Youth unemployment	Unemployment & long term unemployment	
Housing			
Fuel poverty			

High impact social issues

	Children & young people	Adults	Older people
Alcohol	Alcohol & substance misuse – children & young people	Alcohol (adults & older people)	
Healthy weight & good nutrition	Healthy weight (children & young people)	Healthy weight (adults & older people)	
	Good nutrition & food poverty		
Domestic & sexual violence			
Emotional health & wellbeing – including mental health	Emotional health & wellbeing & mental health		
Smoking	Smoking (children & young people)	Smoking (adults & older people)	
Disability	Children & young people with a disability or complex health need	Adults with a physical disability, sensory impairment & adults with a learning disability	

Specific conditions

	Children & young people	Adults	Older people
Cancer & access to cancer screening			
HIV & AIDS			
Musculoskeletal conditions			
Diabetes			
Coronary heart disease			
Flu immunisation			
Dementia			

Wider determinants of health

The health and wellbeing of our population is greatly influenced by a wide variety of social, economic and environmental factors and action to address these wider determinants is the most effective way to make improvements in health outcomes. This section sets out some of the issues that are considered key to Brighton & Hove.

Child poverty: National data for 2010 suggests that approximately one in five children in Brighton & Hove live in poverty which is similar to the national average and to levels in some other nearby cities. However, it is significantly higher than the South East Coast average which has the lowest regional rate in the country.

Employment and unemployment: In 2012 the employment rate in the city was 71% of people of working age, which is similar to the national rate but lower than the South East Coast. In total there are estimated to be 11,800 unemployed people in the city.

Education: In 2012 56.4% of pupils achieved 5 A*-C grades including English and Maths in Brighton & Hove (compared with 59.4% for England). However, provisional figures for 2013 suggest that

local performance improved to 62% (final confirmed local data and comparative data for England will be published in 2014).

Housing and homelessness: Housing pressures have seen homelessness increase by nearly 40% over the last three years with the most common reasons being eviction by parents, family or friends (38%) and loss of private rented accommodation (30%). A third of the city's housing stock (up to 40,000 homes) is considered to be non-decent with the vast majority (92%) being in the private sector; 42.5% of all vulnerable households in the private sector are living in non-decent accommodation

Fuel poverty: In 2011, 12.2% (14,500) of households in the city were estimated to be fuel poor (defined as a household needing to spend more than 10% of its income to maintain an adequate level of warmth). People living in cold homes during the winter months are at increased risk of ill health and death. In Brighton & Hove from 2008-11 there was an average of 135 'excess winter deaths' per year (equivalent to a similar rate to the South East but slightly higher than England).

Improving health

This section summarises the key health and wellbeing issues currently facing Brighton & Hove including health related behaviours and specific conditions that contribute to both early mortality and reduced quality of life.

Alcohol: 18% of adults in the city are believed to engage in increasing or higher risk drinking. Rates of alcohol-related A&E attendance and hospital admissions have increased in recent years, and in the recent Big Alcohol Debate, 36% of respondents were worried about the effect alcohol has on people in the city. In addition, the city faces challenges from substance misuse and there were 1,582 clients in drug treatment during 2012. A third of this client group had been in treatment for over four years.

Healthy weight: Overweight and obesity are major risk factors for diseases such as Type 2 diabetes, cancer and coronary heart disease. In terms of children in the city, in 2011/12, 15% of Year 6 pupils in the city were obese which is lower than England at 19% while almost 8% of reception children were obese which is also lower than England at 9.5%. For adults, data suggest that in Brighton & Hove, 20% of adults are obese compared to 24% nationally, and an estimated 3% are morbidly obese which is similar to national levels.

In terms of healthy eating, the 2012 Health Profile for Brighton & Hove indicates that 30% of adults are eating a healthy diet, which is similar to the England average of 29% and between 2003 and 2012 there was a significant increase in the proportion of residents eating 5 portions of fruit and vegetables a day – from 43% to 52%.

Domestic and sexual violence: In 2012/13, almost three and a half thousand domestic violence incidents were reported to the police in Brighton & Hove, a slight increase from the previous year. There were also 373 police recorded sexual offences, an increase of 12% compared with the previous year although these figures are likely to be underestimates since many people do not report such violence to the police.

Emotional health and wellbeing: Nationally one in ten children aged 5-16 years are thought to have a mental health problem which would equate to nearly 4,000 children in Brighton & Hove. In adults, 13% have a common mental health disorder while 1% have a more severe disorder. Both of these figures are higher than across the country as a whole. Despite this, local surveys have suggested that a large proportion of people are emotionally well with over 70% of adults indicating that they are happy with their lives and feel that the things they do are worthwhile.

Smoking: In Brighton & Hove, prevalence of smoking is 23% which is higher than the national figure of 20%. On average there are 381 smoking related deaths per year in Brighton & Hove, which again is higher than the national average. However, the city did have a significantly higher rate of successful quitters in NHS Stop Smoking Services than the England average.

Disability: People with physical and sensory disabilities are more likely to suffer discrimination, poor access to some health services and worse employment prospects, each of which can impact negatively on health. It is estimated that in Brighton & Hove in 2012 there were almost 17,000 people aged 18-64 with a moderate or severe physical disability, approximately 3,500 people with a moderate or severe visual impairment and approximately 23,000 people with a hearing impairment.

Specific health issues

Cancer and screening access: Mortality from all cancers in people under 75 years of age is significantly higher in Brighton & Hove than England and the South East. There are three NHS cancer screening programmes in England: breast, cervical and bowel. In Brighton & Hove, screening uptake rates are generally lower than both regional and national figures.

HIV/AIDS: In 2011 Brighton & Hove had the ninth highest HIV prevalence in England at 7.6 per 1,000 15-59 year olds compared with 1.7 in England as a whole. This was the highest prevalence anywhere outside of London. Brighton & Hove also has the highest rates of common sexually transmitted infections outside London.

Diabetes: The prevalence of diabetes is increasing nationally due to increased obesity, an aging population and increasing numbers of South Asian people, who are at greater risk of developing diabetes. In Brighton & Hove numbers have also increased with 3.3% of people aged 17 years or over registered with GPs having diabetes in 2012 compared with 2.9% in 2008.

Coronary heart disease: In 2011/12 2.3% of all patients registered with GPs in the City had coronary heart disease. Despite reductions over recent decades, it remains the most common cause of death nationally and in Brighton & Hove. It was the main cause of death for 218 people in Brighton & Hove in 2011 which was approximately 10% of all deaths with rates higher in the most deprived areas.

Influenza immunisation: Influenza is a highly contagious viral infection that can cause serious illness and death, especially in vulnerable groups including very young and elderly people. Immunisation is available for people in these groups including everyone over the age of 65. In 2012/13, uptake in Brighton & Hove among those eligible was just under 70%, which is a slight decrease from the previous year and lower than England as a whole and the national target of 75%.

Dementia: It is estimated that there are currently almost three thousand people aged 65 years or over with dementia in Brighton & Hove and in 2011 it was the main cause of death for 112 people, approximately 5% of all deaths.

Musculoskeletal conditions: Musculoskeletal conditions include a range of conditions including back pain, shoulder pain, hip and knee pain which can limit mobility in older people and make them vulnerable to falls. In each year it is estimated that about 40% of the adult population have low back pain, 5% have hip pain and 60% of over 65s severe knee pain.

Health services

Primary care: Primary care is a focal point for prevention of ill-health, treatment and support of illness in all its forms for the people of Brighton & Hove.

According to the City Tracker Survey, public satisfaction with General Practice and local community pharmacist is high (at 86% and 93% respectively). Satisfaction with dentists was somewhat lower for NHS dentists at 61% of all respondents.

Every General Practice can reduce will health and save lives by identifying patients with risk, recording them on disease registers and managing their care effectively. The Quality & Outcomes Framework (QOF) rewards GP practices for how well they care for patients. There remains variation in achievement of quality outcomes for patients in general practice and on average local QOF scores are also lower than the national average.

End of life care: These services support those with advanced, progressive, incurable illness to live as well as possible until they die including enabling people to choose their preferred place of death. Between 2008 and 2010, 41% of people in Brighton & Hove died in their usual place of residence, compared to 38% nationally. However the local figure is still considerably lower than the target of 70%.

What is needs assessment?

The needs assessment process aims to provide a comprehensive analysis of current and future needs of local people to inform commissioning of services that will improve outcomes and reduce inequalities.

To do this, needs assessments should gather together local data, evidence from the public, patients, service users and professionals, plus a review of research and best practice. Needs assessments bring these elements together to look at unmet needs, inequalities and overprovision of services. They also point those who commission or provide services towards how they can improve outcomes for local people.

The common name for these needs assessments is **Joint Strategic Needs Assessment (JSNA)**. Joint reflects that they should be carried out jointly by the NHS and councils as a requirement, but in terms of good practice should also include others locally with expertise to offer. Strategic reflects that they should be about providing the 'big picture' in terms of identifying local needs.

National policy and guidance

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.¹

The 2012 Health and Social Care Bill set out changes, with the transfer of Public Health to councils, new Clinical Commissioning Groups (CCGs) and the creation of Health and Wellbeing Boards from April 2013. Department of Health guidance states that councils and CCGs have equal and explicit obligations to prepare a JSNA; this duty discharged by Health and Wellbeing Boards.²

The guidance signals an enhanced role for JSNAs to support effective commissioning for health, care and public health as well as influencing the wider determinants that influence health and wellbeing, such as housing and education.

¹ Department of Health. Guidance on Joint Strategic Needs Assessment. 2007. Available at:

www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081267.pdf [Accessed 23/04/2012]

² Department of Health. Statutory guidance published on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. 2013. Available at: <http://healthandcare.dh.gov.uk/jsnas-jhws-guidance-published/> [Accessed 18/07/2013]

Our local approach

In Brighton & Hove there are three elements to the needs assessment resources available:

Overarching documents: The JSNA summary, the State of the City Report and Annual Reports of the Director of Public Health

The JSNA summary gives a high level overview of Brighton & Hove's population and its health and wellbeing needs. 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 Sustainable Community Strategy. The JSNA summary is also used for the State of the City Report which provides high level facts and figures about the city.

Rolling programme of needs assessments on a specific theme or population group

A rolling programme of comprehensive needs assessments forms part of a portfolio of 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 publicly available and include recommendations to inform commissioning.

BHLIS - the information resource for the city, supported by the city Analysis and Intelligence Network

BHLIS (Brighton and Hove Local Information Service – www.bhlis.org) is the Strategic Partnership data and information resource for those living and working in Brighton & Hove. It provides local data on the population of the city. This data underpins needs assessments across the city. BHLIS is the home for needs assessments and their supporting data and evidence.

City needs assessment steering group

Since August 2009, a steering group has overseen the programme of needs assessments. This

includes the JSNA, but is broader and encompasses needs assessments typically outside of health and wellbeing.

In 2011 the group broadened its membership to reflect this and now includes the Community and Voluntary Sector Forum (CVSF), Sussex Police and the two universities, in addition to the existing members from the city council, Clinical Commissioning Group and Local Involvement Network (LINK) – now HealthWatch.

Local consultation

Each year the JSNA summary develops from feedback and consultation. 2012 in particular saw changes to the way it was produced. These changes were informed by the new guidance, Outcomes Frameworks for Public Health, Adult Social Care and the NHS,³ but also from consultation with local partners and the community and voluntary sector. In particular:

- The CVSF conducted a gap analysis of the JSNA summary in January 2012.
- In March 2012 we held a seminar for thematic partnership chairs, councillors, commissioners, community and voluntary sector representatives and providers on plans for the JSNA and Joint Health and Wellbeing Strategy.
- In July 2012, the draft summary was consulted on and the JSNA informed by the responses. The consultation report is available at www.bhlis.org/jsna2012.
- The 2013 update includes evidence gathered from a call to evidence from the community and voluntary sector.

Inequalities and protected groups

Over the last two years the summary has more systematically identified local inequalities in terms of equalities groups, geography and socio-economic status. Each report section has inequalities clearly evidenced. The 2011 Census and 2012 Health Counts Survey have added considerably to this evidence for the 2013

summaries. In addition, there are sections which bring together the key needs of protected groups.

Joint Strategic Assets Assessment

JSNAs should not focus solely on needs but also identify assets of local communities. Our approach to building assets into needs assessments is given in section 6.5.4. This was informed by the March 2012 event. The 2010 Annual Report of the Director of Public Health mapped community resilience⁴ and is an important resource for JSNA.

Voice

The voice of professionals, patients, service users and the public provides important evidence for the JSNA. This is embedded throughout this summary, and where we do not currently have this evidence it is included in 'what we don't know'.

What we don't know

Throughout the summary, where there is a lack of local data, if possible other studies and evidence have been used to produce estimates for the city. Where this is the case it is clearly identified.

Assessing impact

In previous years we have listed the health and wellbeing issues for the city. In 2012 we tried to identify more systematically the impact on the city's population. The approach is set out in Section 3 along with the highest impact issues for the city. This fed into the prioritisation process for the Joint Health and Wellbeing Strategy and will be repeated to inform the next Strategy/refresh.

Joint Health and Wellbeing Strategy

The Health and Wellbeing Board have jointly agreed what the greatest issues are for local people based on the evidence in the JSNA. The Strategy sets these out along with what the Board will do to address them and what outcomes it intends to achieve. It does not include everything, but focuses on the key issues that make the biggest difference by partners working together.

Further information

³ There is not at present a Children's Services Outcomes Framework but the Department of Health has provided advice to local areas on the Children and Young People's Outcomes Strategy due out later in 2012

⁴ NHS Brighton and Hove and Brighton & Hove City Council. Resilience: Annual Report of the Director of Public Health 2010. www.bhlis.org/needsassessments/publichealthreports

2. Our approach to needs assessment

Brighton & Hove JSNA 2013

This summary, along with the portfolio of needs assessments and local data on health and wellbeing is available at: www.bhlis.org/jsna2013

Figure 1: JSNA Summary 2012 – issues with the greatest impact on the health and wellbeing of the population of Brighton & Hove

Wider determinants which have the greatest impact on health and wellbeing

	Children & young people	Adults	Older people
Child poverty			
Education			
Employment & unemployment	Youth unemployment	Unemployment & long-term unemployment	
Housing (inc. rough sleepers)			
Fuel poverty			

High impact social issues

	Children & young people	Adults	Older people
Alcohol	Alcohol & substance misuse (children & young people)	Alcohol (adults & older people)	
Healthy weight & good nutrition	Healthy weight (children & young people)	Healthy weight (adults & older people) Good nutrition & food poverty	
Domestic & sexual violence			
Emotional health & wellbeing – including mental health	Emotional health & wellbeing & mental health		
Smoking	Smoking (children & young people)	Smoking (adults & older people)	
Disability	Children & young people with a disability or complex health need	Adults with a physical disability, sensory impairment & adults with a learning disability	

Specific conditions

	Children & young people	Adults	Older people
Cancer & access to cancer screening			
HIV & AIDS			
Musculoskeletal conditions			
Diabetes			
Coronary heart disease			
Flu immunisation			
Dementia			

3. Impact

What do we mean by impact?

In previous summaries we have simply listed the health and wellbeing issues for the city. For the first time in we attempted to measure the relative impact of the issues identified within this summary in a systematic way and present this as an impact matrix.

As JSNAs are about the health, care and public health of the population as well as the wider determinants that influence health and wellbeing, such as housing and education, wider determinants were also included in the process.

How we developed the impact matrix

In developing the matrix we have looked at methods used elsewhere, particularly in areas which have had shadow Health and Wellbeing Boards for some time.

The measures we have used in the matrix include:

- ***Number of people affected***
- ***Impact on life expectancy gap***
- ***Impact on wellbeing (including healthy life expectancy)***
- ***Impact on equalities groups***
- ***Comparison to national data***
- ***A specific target not being met***
- ***Direction of trend***

Impact on equalities groups is included as an element of the grid rather than considering equalities groups as distinct issues. This was done since it was felt that it was not appropriate to rate the needs of different equality groups against each other and because some groups are small in number and would be likely to rate low impact across many of the measures. The impact on equalities groups measure was on population groups and not geographical inequalities.

We scored each element on a three-point scale as indicated in Table 1. For some elements we were able to quantify the classification used (for example the number of people affected, or comparison to national data), but others were a more subjective assessment.

It is worth noting that there were other measures we would have liked to include, such as cost impact, but the evidence was not available systematically to be included this year. This will be developed over the coming years.

How we completed the matrix

Two impact sessions were held in order to complete the matrix. Those invited included members of the City Needs Assessment Steering Group;¹ further representatives from Public Health, Children's Services and Adult Social Care; and Community and Voluntary Sector Health and Wellbeing elected representatives. At the start of the first session the purpose of the sessions was outlined along with guidance on the measures to ensure a shared understanding of how to categorise.

Participants were then split into four groups with between three and five people in each group. Each group had between 14 and 19 sections to assess. To do this, individuals each took a JSNA section and completed a grid with the evidence as presented in the JSNA. As a group, the evidence put forward was then considered for each measure and consensus on the rating was reached.

At the end of the first session each group then considered which issues had the greatest impact of those they had covered.

In the second session, a few remaining sections were completed. However, the main focus of the second session was reconciling and checking consistency of the methods used by each of the four groups. This was done as one group and meant some small changes were made to ratings and the issues with greatest impact.

The high impact issues were assessed as those with three or more measures with a high rating. Although this created 27 high impact issues, it was clear that many were the same across different parts of the life course and so could be combined.

¹ The Steering Group membership includes the Community and Voluntary Sector Forum (CVSF), Sussex Police, the two universities, and members from the city council, Clinical Commissioning Group and LINKs

Table 1: Impact measures and categories used				
Measure	Low	Medium	High	Comment
Number of people affected	Low Below 1% of population at risk	Medium 1%-10% of population at risk	High 10% or more of population at risk	Could be of total population/ children & young people/ working age/ older people
Impact on life expectancy gap	Low	Medium	High	Population level
Impact on wellbeing (including healthy life expectancy)	Low	Medium	High	Medium- to long-term impact
Impact on equalities groups	Low	Medium	High	Current impact
Comparison	Better	Similar	Worse	Compared to England average (based upon significance where available)
Target	Better	Similar	Worse	Where a specific national/local improvement target/ standard exists
Trend direction	Improving	Stable	Worsening	Medium- to long-term trend

It must be understood that whilst those involved had a great deal of expertise and knowledge, this was not a perfect process. Whilst part of the session involved a reconciliation of the methods used, judgements made by one group may have differed from those which another would have made.

As this was the first time this had been attempted it was a learning process. An important next step will be to get feedback on these issues through the consultation process and build in wider engagement for the next time this is done.

In 2012 the shadow Health and Wellbeing Board used this list of issues to identify its initial priorities. The impact assessment will be run again in line with the next Health and Wellbeing Strategy

The issues ranking most highly

Issues with three or more ratings of high impact were:

Six

- Cancer
- Mental health (adults and older people)

Five

- Alcohol (adults and older people)
- Flu immunisation (older people)

Four

- Healthy weight (adults and older people)
- Good nutrition and food poverty
- Smoking (adults and older people)
- Domestic and sexual violence
- Employment and unemployment
- Housing (inc. rough sleepers)
- Education
- Alcohol and substance misuse (children and young people)

3. Impact

- Physical disability and sensory impairment (adults and older people)
- Musculoskeletal conditions

Three

- Access to cancer screening
- Fuel poverty
- Emotional health and wellbeing (adults and older people)
- Emotional health and wellbeing (children and young people)
- Child poverty
- Healthy weight (children and young people)
- Disability and complex health needs (children and young people)
- Diabetes
- Dementia
- HIV and AIDS
- Coronary heart disease
- Smoking (children and young people)

Grouping the issues

For some of the issues identified there were clear natural groupings, for example healthy weight in children and young people; healthy weight in adults and older people; and good nutrition and food poverty.

Once issues were grouped in this way they were categorised into the following:

- High impact social issues
- Wider determinants which have the greatest impact on health and wellbeing in the city
- Specific conditions

All issues were considered across the life course. Figure 1 sets out the key issues and indicates which stages of the life course they were identified as particular issues for in Brighton & Hove.

Where we don't have information on impact

There were elements where we did not have enough evidence upon which to make informed judgements about the impact on the population.

Brighton & Hove JSNA 2013

The full impact grid, available on BHLIS (Brighton & Hove Local Information Service), highlights where this is the case and the City Needs Assessment Steering Group will be looking at how to best fill some of these gaps in the future. This may not be possible in all cases.

Joint Health and Wellbeing Strategy

From these issues highlighted as having the greatest impact on the city the Health and Wellbeing Board jointly agreed what issues it will prioritise to work on in partnership.

The five priorities within the Joint Health and Wellbeing Strategy are:

- Smoking
- Healthy weight and good nutrition
- Cancer and access to cancer screening
- Emotional health and wellbeing (including mental health) and
- Dementia

The Joint Health and Wellbeing Strategy sets these out along with what the Board will do to address them and what outcomes it intends to achieve. It does not include everything, but focus on the key issues that make the biggest difference by partners working together.

Further information

The full impact grid is available at: www.bhlis.org/jsna2012

Last updated

July 2013

4.1 Our population

Why is this issue important?

Population size, structure and composition are crucial elements in any attempt to identify, measure and understand health and wellbeing. It is important to know how many people live in an area and their demographic characteristics such as age and gender.

Here we consider Brighton & Hove's population and how social factors impact on the city's population. We also consider estimated future population changes. How these demographic features, together with social and environmental factors, impact on the health and wellbeing of our residents and influence need and demand for health and social care services is looked at throughout the summary.

Population groups in Brighton & Hove

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 & Hove is one of the most deprived areas in the South East and has a population with significant health needs and inequalities.

This section of the report describes the key population trends for the city and further sections show the important health and wellbeing issues for the key population groups in the city.

Impact in Brighton & Hove

Brighton & Hove has an unusual population compared to the South East and England. There is a much higher proportion of people aged 16-64 years, with lower proportions of children and older people. However, there is the same percentage of people aged 85 years or over in Brighton & Hove as in England (2.2% of the population) – this is 3% for females in both areas.

Total population – 2011 Mid Year Estimate

According to the Office for National Statistics (ONS) the resident population of Brighton & Hove has increased by just over 10,000 people since 2002 when the population was 249,700 people.¹ The

¹ Office for National Statistics. Population Estimates for England and Wales, Mid-2002 to Mid-2010 Revised (Subnational). Released: 30 April 2013. Available at <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-280885> [Accessed 17/07/2013]

latest mid year population estimates (2011) show there are 273,000 people resident in the city² (an increase of 9%).

The 2011 ONS Mid Year Estimates show that Brighton & Hove has 16% of the population aged 0-15 years, 71% aged 16-64 years and 13% aged 65 years or over. This compares to 19%, 64% and 17% in the South East and England figures of 19%, 65% and 16% (Table 1). So whilst there is a lower proportion of children in the city, there is also a lower proportion of older people, giving the city a different age-structure compared to England and the South East.²

Table 1: Population by age and gender as a % of total population (number of people in brackets) - Mid Year Estimate 2011

	Brighton & Hove	England	South East
All people	273,000	53,107,000	8,652,800
Females	50% (136,800)	51%	51%
Males	50% (136,200)	49%	49%
0-15	16% (44,500)	19%	19%
16-64	71% (192,700)	65%	64%
65+	13% (35,800)	16%	17%
Working age	69% (187,300)	62%	61%
Pensionable age	15% (41,200)	19%	20%

Source: Office for National Statistics (ONS) Mid Year Estimates 2011 available from <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-262039>

Migrants

The city is a destination for migrants from outside the UK, the latest figures are for 2010 and show that 15% of the city's population is born outside the UK, higher than the South East (11%) and England (13%). For the year ending June 2010 there were estimated to be 4,000 migrants to the city from outside of the UK, and 2,400 people leaving

² Office for National Statistics. Population Estimates for England and Wales, Mid-2011 (2011 Census-based). Released: 25 September 2012. Available at <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-262039> [Accessed 17/07/2013]

4.1 Our population

the city to go outside of the UK – a net inward migration of 1,600 people.³

In the year ending June 2012, 18,800 people moved to Brighton & Hove from elsewhere in the UK and 19,800 moved from Brighton & Hove to another part of the UK. So the net effect of internal migration is 1,000 fewer people in that year.⁴ Only in those aged 16-24 years was there a net inward migration from other parts of the UK with 1,500 more 16-24 year olds arriving than leaving the city (Table 2).

	Inflow	Outflow	Net internal migration
All ages	18,800	19,800	-1,000
0-15	1,400	2,100	-700
16-24	8,000	6,500	1,500
25-44	7,100	8,200	-1,100
45-64	1,700	2,100	-400
65+	600	900	-300

The largest numbers move to and from London,⁵ although the largest numbers by local authority move to and from Lewes. Figures 1 and 2 show internal migration to and from Brighton & Hove respectively.

Brighton & Hove JSNA 2013

Figure 1: UK internal migration to Brighton & Hove in the year ending June 2012



Source: Office for National Statistics (Available at <http://www.neighbourhood.statistics.gov.uk/HTMLDocs/dvc25/index.html#00ML,nat,to>)

Figure 2: UK internal migration from Brighton & Hove in the year ending June 2012



Source: Office for National Statistics (Available at <http://www.neighbourhood.statistics.gov.uk/HTMLDocs/dvc25/index.html#00ML,nat,from>)

³ Office for National Statistics. Migration Indicators Tool. Available from <http://www.ons.gov.uk/ons/rel/migration1/migration-statistics-quarterly-report/may-2013/index.html-2013/index.html> [Accessed 17/07/2013]

⁴ Office for National Statistics. Internal Migration by Local Authorities in England and Wales, Year Ending June 2012. Released 26 June 2013. Available at <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-314026> [Accessed 17/07/2013]

⁵ Office for National Statistics. Migration Statistics Quarterly Report, August 2011. <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-222711> [Accessed 26/07/2012]

Students

There has been a sustained increase in the numbers of students at the two universities in the city from around 26,000 in 1995/96 to 35,205 in 2011/12, with many students staying on after university.⁶ Recent increases in numbers have been lower than in previous years.

Ward level population

The population breakdown by ward is given in Table 3. Ward level figures are available only available by five year age band so figures are for 0-14 year olds and not 0-15 as for the city level figures in Table 1.

Wish and Hangleton and Knoll are the wards with the highest percentage of children and young people aged 0-14 years in Brighton & Hove (both 20% of the total population), whereas Regency has the lowest percentage of children and young people (7%), followed by Brunswick and Adelaide (8%), and Central Hove (9%).⁷

In Regency, Brunswick and Adelaide, and St Peters and North Laine more than four in five people are aged 15-64 years (all 84%). Woodingdean and Hangleton and Knoll have the lowest proportion at 62%.

Older people (65 years or over) live across all areas of the city. However, the largest percentages are in Rottingdean Coastal (22% of the population) and Woodingdean (19%). In six of the city's 21 wards, fewer than one in ten people are aged 65 years or over with the lowest percentage in St Peters and North Laine (6%) followed by Hanover and Elm Grove, and Brunswick and Adelaide (both 7%).

Predicted future need

Changes in the population age structure affect the need for health and social care services. Therefore, population projections 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.

⁶ Higher Education Statistics Agency. Statistics by Institution. Available at http://www.hesa.ac.uk/index.php?option=com_content&task=view&id=1897&Itemid=239 [Accessed on 21/08/2012].

⁷ Office for National Statistics. Ward Level mid-year population estimates for England and Wales. <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-301951> [Accessed 12/06/2013]

The resident population is predicted to increase to 289,900 by 2021 (a 6.2% increase from the current 2011 Mid Year Estimate).⁸

The greatest projected increase will be seen in the 25-34 and 50-59 year age groups (Figure 3). There are also projected to be higher numbers of children under 15 years. The number of people aged 75 years or over is expected to increase by 10% from 18,272 in 2011 to 20,085 in 2021.

As in the recent past, the main determinants of future changes in the total population of the city are house building, international migration and the number of university students.

A recent Housing Duty to Co-Operate Study for Brighton & Hove City Council⁹ found that a realistic assessment of housing need/demand for the city would be between 800 and 1,000 homes per year to 2030 (between 16,000 and 20,000 homes over twenty years). However that need/demand has to be considered alongside the availability of suitable land for residential development, amongst other factors. On the basis of a number of assumptions, a housing trajectory scenario considers capacity to 2030 and suggests a capacity for around 11,528 dwellings.¹⁰

Before 2006-07 the net effect of international migration was relatively small, with as many people leaving the city to live outside the UK as were moving to the city. Since this time, there have been larger inflows than outflows.¹¹ We can therefore anticipate that the number of international residents in the city will continue to grow if this pattern continues.

⁸ Office for National Statistics. Interim 2011 based sub national population projections. <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-274527> [Accessed 12/06/2013]

⁹ Hearn GL. Housing Duty to Co-Operate Study. May 2013. Available at <http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/Duty%20To%20Cooperate%20Housing%20Study%20Final.pdf> [Accessed 17/07/2013]

¹⁰ Brighton & Hove City Council. Strategic Housing Land Availability Assessment 2012. December 2012. Available at http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/downloads/ldf/SHLAA_Update_2012.pdf [Accessed 17/07/2013]

¹¹ Office for National Statistics. Migration Indicators Tool. Available from <http://www.ons.gov.uk/ons/rel/migration1/migration-statistics-quarterly-report/may-2013/index.html> -2013/index.html [Accessed 17/07/2013]

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Table 3: Office for National Statistics Mid Year Estimates of population for wards in Brighton & Hove , 2011

	All people	People aged 0-14	People aged 0-14 (%)	People aged 15-64	People aged 15-64 (%)	People aged 65 or over	People aged 65 or over (%)
Brunswick and Adelaide	10,080	840	8%	8,517	84%	723	7%
Central Hove	9,276	874	9%	7,061	76%	1,341	14%
East Brighton	14,085	2,439	17%	9,842	70%	1,804	13%
Goldsmid	15,644	2,120	14%	11,464	73%	2,060	13%
Hangleton and Knoll	14,745	2,960	20%	9,140	62%	2,645	18%
Hanover and Elm Grove	16,014	2,294	14%	12,632	79%	1,088	7%
Hollingdean and Stanmer	15,690	2,376	15%	11,726	75%	1,588	10%
Moulsecoomb & Bevendean	17,489	2,696	15%	13,181	75%	1,612	9%
North Portslade	10,053	1,912	19%	6,606	66%	1,535	15%
Patcham	14,261	2,664	19%	9,017	63%	2,580	18%
Preston Park	14,881	2,636	18%	10,982	74%	1,263	8%
Queens Park	14,957	1,666	11%	11,199	75%	2,092	14%
Regency	9,925	717	7%	8,364	84%	844	9%
Rottingdean Coastal	13,581	1,829	13%	8,706	64%	3,046	22%
St Peters and North Laine	18,275	1,783	10%	15,400	84%	1,092	6%
South Portslade	9,545	1,859	19%	6,310	66%	1,376	14%
Hove Park	10,576	2,024	19%	6,674	63%	1,878	18%
Westbourne	10,043	1,716	17%	6,732	67%	1,595	16%
Wish	9,627	1,954	20%	6,201	64%	1,472	15%
Withdean	14,440	2,589	18%	9,533	66%	2,318	16%
Woodingdean	9,765	1,851	19%	6,017	62%	1,897	19%
Brighton & Hove	273,000	41,800	15%	195,400	72%	35,900	13%

4.1 Our population

Understanding changes in birth rates is important in population change and is explored in the pregnancy and maternity section. The number of births per year in the city is projected to increase by 5% from 2011 to 2021 – to around 3,500 births per year. This compares with a projected increase of 5% in England and 2% in the South East.¹²

What we don't know

All projections are based upon assumptions of how the population will change. There could well be unknown factors which mean that these patterns change in unforeseen ways and so projections will always have a degree of uncertainty around them.

Key evidence and policy

The Office for National Statistics Population Hub gives the methods used for population estimates and projections, along with the estimates:

<http://www.statistics.gov.uk/hub/population>

Key links to other sections

- Population groups
- Pregnancy and maternity
- Life expectancy and healthy life expectancy
- Main causes of death

Further information

Office for National Statistics Population Estimates
<http://www.statistics.gov.uk/hub/population>

Office for National Statistics Census 2011 data
<http://www.ons.gov.uk/ons/guide-method/census/2011/index.html>

Population page on BHLIS (Brighton and Hove Local Information Service) www.bhlis.org/population

Last updated

July 2013

Total population note

A census is a count of people and households undertaken every decade, and is used to set policies and estimate resources required to provide services for the population. It is the most complete source of

information about the population that we have. The latest census was held on 27 March 2011.

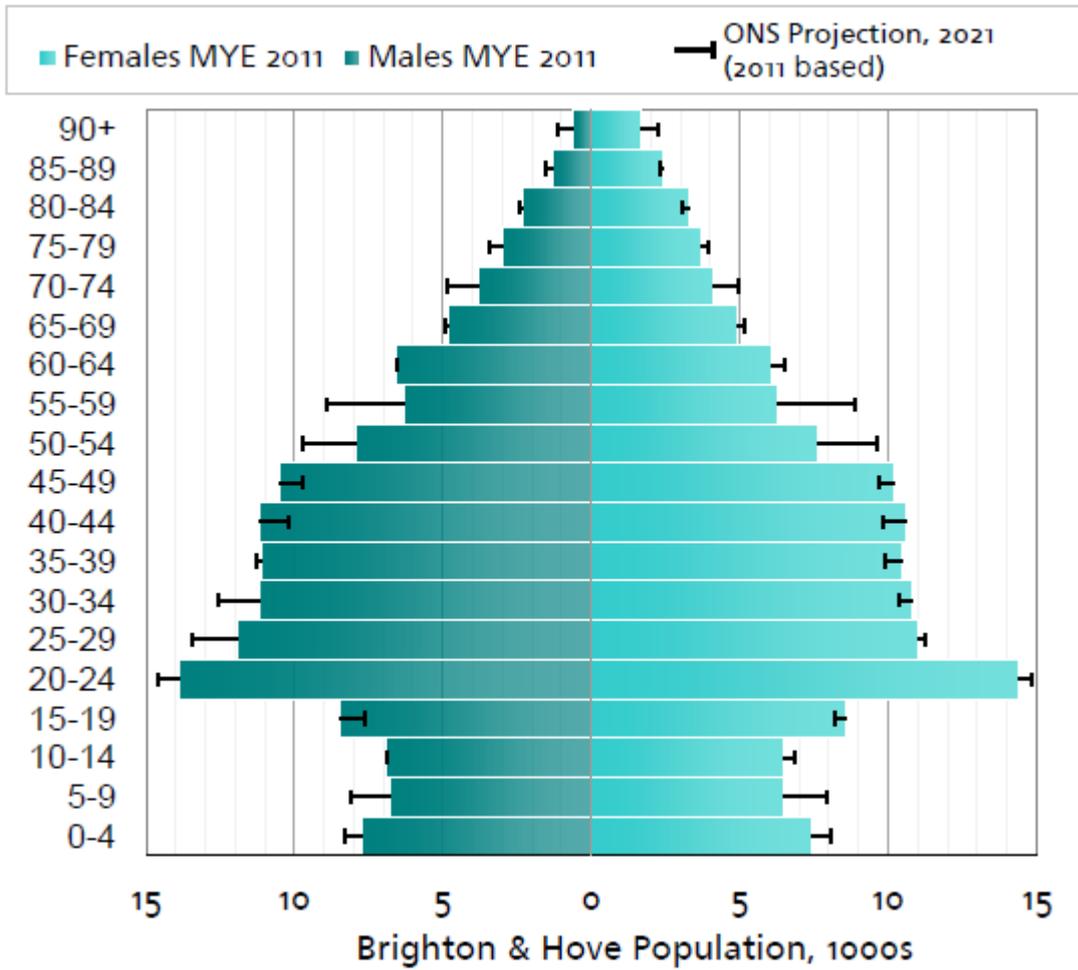
Each year the Office for National Statistics (ONS) produces Mid Year Estimates of the population. These use the Census as their base and adjust for births, deaths and migration between years.

Population data from the 2011 Census give a total population of 273,400 – 14,600 more people than the 2010 Mid Year Estimate. Population estimates have seen been rebased for 2002-2010 because of these changes. However, it should be noted that not all trend data presented within the JSNA is available yet using rebased population estimates.

¹² Office for National Statistics 2011 births data and Subnational Population Projections, Interim 2011-based. Published September 2012. Available at: <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-274527> [Accessed 08/07/2013]

4.1 Our population

Figure 3: Population pyramid, 2011 Mid Year Estimate and 2021 projection, Brighton & Hove



Source: Office for National Statistics

4.2.1 Gender

Why is this issue important?

Gender-based inequalities in health have been consistently documented.^{1,2,3,4} Since gender is a measure of both biological/genetic and social differences, inequalities are likely to be a result of a combination of behavioural/environmental and biological/genetic factors.^{5,6,7}

Many men are reluctant users of traditional health services, such as GPs and pharmacies, and do not always respond to mainstream health awareness campaigns to the same extent as women.⁸ However, most men care about their health and do respond to messages when the information is presented in formats that appeal to them: men are enthusiastic users of a wide range of new technologies – online systems, mobile phone applications, social networking, gaming, etc. Harnessing this interest in new technologies to develop health services, information and products that engage men could help them to take action to improve their health.⁹

Health is affected by socio-economic status. Socio-economic factors also help to mediate the relationship between gender and health. The different experiences of men and women in terms of employment, financial independence and domestic responsibilities, amongst other factors, contribute to gender differences in health status through life.

Key outcomes

None of the indicators in the Public Health, NHS or Adult Social Care Outcomes Frameworks are specifically focused on gender. However gender is a

¹ Nathanson C. Illness and the feminine role: A theoretical review. *Social Science and Medicine*. 1975;9:57-62.

² Verbrugge L. Females and illness: Recent trends in sex differences in the United States. *Journal of Health and Social Behavior*. 1976;17:387-403.

³ Nathanson C. Sex, illness, and medical care: A review of data, theory and method. *Social Science and Medicine*. 1977;11:13-25.

⁴ Macintyre S, Hunt K, Sweeting H. Gender differences in health: Are things really as simple as they seem? *Social Science and Medicine*. 1996;42:617-624.

⁵ Verbrugge L. Female illness rates and illness behavior: Testing hypotheses about sex differences in health. *Women and Health*. 1979;4:61-79.

⁶ Verbrugge L. The twain meet: Empirical explanations of sex differences in health and mortality. *Journal of Health and Social Behavior*. 1989;30:282-304.

⁷ Bird C, Rieker P. Gender matters: An integrated model for understanding men's and women's health. *Social Science and Medicine*. 1999;48:745-755.

⁸ <http://www.independent.co.uk/life-style/health-and-families/features/why-do-men-die-younger-843401.html> [Accessed 17/08/2012]

⁹ Prus SG, Gee E. Gender differences in the influence of economic, lifestyle, and psychosocial factors on later-life health. *Canadian Journal of Public Health*. 2003 Jul-Aug;94(4):306-9

‘protected characteristic’ in the Equality Act 2010 and public sector organisations are required to have due regard to the need to advance equality of opportunity and eliminate discrimination faced by people based on their gender.¹⁰

Impact in Brighton & Hove

Brighton & Hove has an even population split by gender with 50% of the population being female and 50% male.¹¹ There is a younger age structure for men in the city, which is also seen nationally, mainly due to lower life expectancy for men.

Where we are doing well

The gap in life expectancy between men and women is narrowing, but men still tend to develop and die from conditions much sooner than women.

Local inequalities

As evidenced in other sections of the report, we know that there are the following gender inequalities in the city:

Life expectancy:

- Life expectancy in Brighton & Hove is 78.5 years for males and 82.6 for females (2009-11).
- The main causes of death (for all ages) are similar for males and females. The main difference is the higher proportion of deaths in males from external causes (mainly accidents, suicide and drug or alcohol poisoning).
- For males, the proportion of deaths from circulatory diseases and cancer are similar, but for females a higher proportion of deaths are due to circulatory diseases than cancer.
- The premature death rate is much higher among men (17 deaths per 100,000 men under 75) than among women (nine deaths per 100,000).
- Hospital emergency admission rates are significantly higher in men than women.

¹⁰ Equality and Human Rights Commission.

<http://www.equalityhumanrights.com/advice-and-guidance/new-equality-act-guidance/protected-characteristics-definitions/> [Accessed 20/08/2012]

¹¹ Office for National Statistics. Population Estimates for England and Wales, Mid-2011 (2011 Census-based). Released: 25 September 2012. Available at <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tc%3A77-262039> [Accessed 17/07/2013]

4.2.1 Gender

Wider determinants of health

Parenting: Within the Triple P parenting programme in Brighton & Hove, 15% of parents are male and 85% female.

Children in need: There are more males allocated to Advice, Contact and Assessment Service (ACAS), Children in Need (CIN), and looked after children (LAC). In all categories except for children who are the subject of a Child Protection Plan (CPP) where 52% are female and 45% male (3% unborn or unknown gender). This is in contrast to the England average where 50% of children who are the subject of a CPP as at 31st March 2012 are male and 48% are female (2% unborn or unknown gender). Half (50%) of children looked after in the City were male compared with 56% in England.

Education:

- In 2011, 57% of girls in the city achieved five or more A*-C grades at GCSE compared with 49% of boys, a gap which has widened by 4% from the previous year.
- Students at the University of Brighton have an older age structure and a greater proportion is female than at the University of Sussex. Nationally a higher proportion of higher education students are female (56%) than male (44%) in the UK. This imbalance is more pronounced among part-time students of whom 61% are female.

Employment and work:

- The majority of young people aged 16-18 years in the city who are not in education, employment or training (NEET) are male (52%). However, of the NEET young people not available to the labour market, young women make up 86%, mainly because they are either young mothers or pregnant.
- The employment rate gap between men and women (6%) is much lower in Brighton & Hove than the South East and nationally (both with gaps of 10%).
- There is a gender divide in average weekly earnings with full-time female earners averaging lower earnings than males in the city. However, the differential is much lower in

Brighton & Hove than across Great Britain or the South East.

- Nationally, sickness absence is consistently higher for women than for men.

Community safety and crime reduction:

- Young men account for 75% of the population supervised by Brighton & Hove Youth Offending Service which is in line with national figures.
- National research has suggested that death rates of male community offenders aged 15 to 44 years were found to be four times that of the rate in the general population.
- Research has showed that female offenders have higher levels of mental health and relationship problems; while male offenders have higher levels of alcohol problems
- Assaults, particularly alcohol-related assaults, disproportionately involve young men, both as perpetrators and as victims.
- Women are more likely to report feeling less safe in the city.

Sustainable communities and places:

- Around 30% of asylum seekers are young men.
- Around 90% of rough sleepers in the City are male and 84% of hostel residents.
- 55% of people attending hospital following a road traffic collision are female.

Wellbeing and community resilience

- Nationally 58% of carers are women and 42% men, and this is mirrored in Brighton & Hove.
- 66% of volunteers in Brighton & Hove are women and 34% men, in contrast with national data which shows no significant difference between men and women who volunteer.
- The 2012 Health Counts survey showed that females are significantly more likely to have to have medium to high satisfaction with life and to feel the things they do are worthwhile. Males however are significantly more likely to have had very low or low levels of anxiety on the previous day. There was little difference in how happy people felt on the previous day by gender.

4.2.1 Gender

Developing well

- Young females are more likely than males to present to A&E with serious self harm. Of the young people under 18 presenting to A&E with serious self harm in 2012, 88% were female.
- Boys are considerably more likely to do more physical activity or sport, both within or outside school, than girls.
- Locally, and nationally, a higher proportion of boys are obese than girls.
- Older girls (14-16 years) are significantly more likely to smoke than boys.
- Whilst having tried alcohol is similar for boys (52%) and girls (50%) for 11-16 year olds, girls (42%) aged 14-16 years are more likely than boys (33%) to report 'drinking to get drunk' either often or every time they drink.¹¹
- More males access alcohol and drug treatment services than females: in 2012/13, 61% of young people in treatment were male and 39% were female.
- Having tried drugs is similar for boys (22%) and girls (24%). However, young males are more likely than young females to have tried drugs other than cannabis.
- Young men are also more likely not to be sexually active: 81% of young men compared to 78% young women said that they have not had sex (14-16 year olds).
- Over two thirds of children and young people recorded as having a disability are male.

Living well

- Men are significantly less likely to be a healthy weight than women. Nationally, women are more likely to be morbidly obese, although the rate of increase of morbid obesity is higher for men.
- Eating five a day is significantly more common in females (59%) than males (46%).
- Males are more likely than females to meet the recommendations for physical activity (27% for males and 22% for females). Males were more likely to meet the recommended physical

activity level in all age groups with the exception of 55-64 year olds.

- The burden of sexual ill-health is not shared equally; younger people (under 25 years old) and men who have sex with men (MSM) are disproportionately affected. Rates of STIs in these groups far exceed those of the general population locally and nationally.
- The uptake of Chlamydia testing for 15-24 year olds is higher in females than males.
- There is no significant difference in smoking prevalence between males and females (males 25%, females 22%).
- According to the 2012 Health Counts survey, having ever taken drugs is higher for males than females but drinking at increasing/higher risk levels is similar for males and females.
- Men aged 35-54 years have the highest rate of long term alcohol-related health problems. Young men aged 19-29 years old were the most frequent group attending A&E for alcohol or assault reasons.
- Women now make up 29% of the substance misuse treatment population.

Table 1: Needs assessed for women clients accessing the Brighton Women's Centre Counselling Services, 2013

Issues	Application	Assessment	Counselling
Relationship	70%	85%	96%
Depression	20%	22%	22%
Anxiety	17%	25%	30%
Physical Illness	8%	9%	12%
Sexual Violence	22%	36%	38%
Domestic Abuse	21%	32%	42%
Low Self Esteem/ Confidence	55%	60%	74%
Substance Misuse	11%	15%	17%
Self Harm	5%	8%	12%
Bereavement	3%	3%	6%
Eating Issues	2%	4%	5%
Childhood Abuse	5%	11%	29%

Source: Brighton Women's Centre. Women's Counselling Service data and feedback. June 2013. Based upon 180 women.

4.2.1 Gender

- Of the 180 women receiving counselling from the Brighton Women's Centre in 2011/12, 96% had experienced relationship issues, 74% low self esteem/confidence, 38% had experienced sexual abuse, 42% domestic abuse and 29% childhood abuse (See Table 1).¹²
- Although domestic and sexual violence and abuse and associated crime types are predominately experienced by women and girls, they also affect men and boys.
- Healthy life expectancy and disability free life expectancy at age 65 years is similar for males in Brighton & Hove and in England, but longer for females.
- Nationally, falls are more common amongst older women than older men.

Preventing ill-health

- Men have lower awareness of cancer screening programmes than women.
- Men have twice as many decayed teeth as women and women have more filled teeth than men.
- Self-harm is significantly higher in females (13%) than males (8%).
- 81% of suicide deaths in 2010 were men.

Improving health and promoting independence

- Nationally men are more likely than women to have a mild or severe learning disability. In Brighton & Hove 59% of those with learning disabilities known to the City Council are male.
- There were an estimated 1,618 men and 172 women with Autistic Spectrum Conditions in Brighton & Hove in 2012. Nationally, prevalence is estimated to be 1.8% in men and 0.2% in women.
- From the age of 40, a higher proportion of men than women develop hearing loss.
- Diabetes is more common in men.
- Male coronary heart disease emergency admission rates to hospital are 2.9 times greater than for females.

- Emergency admission rates for stroke are significantly higher than for men than women. Deaths from stroke are also higher for men.
- Nationally, prevalence rates of respiratory diseases appear to be increasing in women and to have reached a plateau for men.
- Cancer incidence and mortality is higher in men than women but, due to women's longer life expectancy, more women than men are living with or beyond a diagnosis of cancer.
- Women are more likely than men both to report and to be diagnosed with depression and anxiety, and more women are treated.
- More men than women are admitted to the mental health trust overall for mental illness: 64% of people admitted are men.
- There are more men than women in housing commissioned to support mental health by the local authority, though there is one female-only house.
- Around 90% of people living with HIV in the city are male.
- Women living with HIV locally are on average younger than men living with HIV.
- Nationally, dementia is more common in women and two thirds of people with dementia are women. Research suggests early onset dementia is more common in men.

End of life care:

- A higher proportion of men die at home or elsewhere than women (35%) and slightly more men die in hospital (45%). A higher proportion of women die in a care or nursing home (24%) than men. This is likely to be a result of women living longer than men.

What we don't know

Gaps in local knowledge about the health and wellbeing of the city's population by gender are highlighted in the individual sections of the JSNA.

Key evidence and policy

NHS services have to be designed differently to meet the needs of men and women. For example

¹² Brighton Women's Centre. Inspire and Women's Counselling Service data and feedback. June 2013.

4.2.1 Gender

men tend not to use primary care as effectively as women.¹³

Recommended future local priorities

1. The JSNA has systematically looked at whether there are local inequalities by gender. Where gaps in information have been identified, efforts should be made for this to be gathered. Where inequalities are evidenced, these should be considered by those commissioning and delivering local services.
2. Continue to record the difference in experience and outcome of health services for men and women.
3. Ensure that commissioning and activity focus on addressing gender differences and reduce inequalities.
4. Find ways to encourage men to access health services sooner.
5. Identify stakeholder groups, and support and engage with them to identify ways to address inequalities.
6. Special attention should be paid to the mental health needs of men and young people who are at high risk of suicide.

Key links to other sections

Gender is one of the equalities groups considered throughout the JSNA and so relates to every section

Further information

<http://www.bhlis.org/gender/>

WHO Gender Equality, Work and Health: A review of evidence (2006).

<http://www.who.int/gender/documents/Genderworkhealth.pdf>

Last updated

September 2013

¹³ Wilkins D et al. The Gender and Access to Health Services Study (final report), November 2008. Available at http://www.insidegovernment.co.uk/health/mens_health/

Why is this issue important?

*“Ethnicity results from many aspects of difference which are socially and politically important in the UK. These include race, culture, religion and nationality, which impact on a person’s identity and how they are seen by others. People identify with ethnic groups at many different levels. They may see themselves as British, Asian, Indian, Punjabi and [Brightonian] at different times and in different circumstances”.*¹

Black and Minority Ethnic (BME) groups in the UK, including Gypsies and Travellers, share many of the same health and wellbeing risks and needs as the rest of the population. However, there are some key differences in risk and protective factors, incidence and prevalence of certain diseases, access to services and the resulting health and wellbeing outcomes.

Given the variations both within and between groups, caution needs to be used if considering ethnicity as the main explanation for these differences. Other influences include:²

- Racism and discrimination
- Socio-economic status
- Long-term effect of migration
- Lack of cultural awareness in service delivery
- Lower uptake of services
- Differences in culture and lifestyle choices
- The importance of seeing the person, not the stereotype

National evidence highlights that some groups are at increased risk of some conditions:³ South Asians have higher levels of stroke, coronary heart disease and diabetes; Black African, Black Caribbean and Black British people have higher levels of hypertension and stroke.⁴

There are also strong associations between ethnic group and specific health conditions e.g. raised risk of sickle cell disease in Black African, Black Caribbean and Black British groups.⁵

Overall, cancer rates tend to be lower in BME groups. For lung cancer, mortality rates are lower in people of South Asian, Caribbean and African, backgrounds (related to lower levels of smoking).⁵

Ethnic differences in mental health are controversial since most of the data are based on treatment rates, which show that individuals from BME groups are much more likely to receive a diagnosis of mental illness than those who are White British.⁵ Studies show that the rate of new diagnoses of psychosis is up to seven times higher among Black Caribbean than White British groups.⁶ However, surveys on the prevalence of mental illness in the community show smaller ethnic differences.

There is evidence of ethnic differences in risk factors that operate before people come into contact with health services, such as discrimination, social exclusion and urban living.⁵

Nationally, almost half of all children from ethnic minorities live in low-income households compared with a quarter of White British children, with 66% of Bangladeshi and Pakistani children and 50% of Black and Black British children living in poverty.^{7,8}

The health status of Gypsies and Travellers is much poorer than that of the general population,⁹ with life expectancy being 15-25 years less than for the general population; an infant mortality rate of one in 20; and 38% of Gypsies and Travellers having a long-term illness. Poor access to, and uptake of, health services is a major factor in Gypsy and Traveller health. There are an estimated 300,000

¹ Parliamentary Office of Science and Technology. Ethnicity and Health. January 2007. Postnote Number 276.

² Barnard H, Turner C. Poverty and ethnicity; a review of evidence. York: Joseph Rowntree Foundation. 2011.

³ Diseases and different ethnic groups [Online]. 2011 Available from URL : <http://www.patient.co.uk/doctor/Diseases-and-Different-Ethnic-Groups.htm>. [Accessed April 2012].

⁴ Stansbury JP, Jia H, Williams LS, et al. Ethnic disparities in stroke: epidemiology, acute care, and postacute outcomes. Stroke. 2005 Feb;36(2):374-86. Epub 2005 Jan 6. [abstract].

⁵ Information Centre for Health & Social Care. Health Survey for England 2004: The health of minority ethnic groups - headline tables. 2005.

⁶ Raleigh VS, Irons R, Hawe E, et al. Ethnic variations in the experiences of mental health service users in England: results of a national patient survey programme. Br J Psychiatry. 2007;191:304-312.

⁷ Low income and ethnicity. Available from URL <http://www.poverty.org.uk/06/index.shtml> [Accessed April 2012].

⁸ Kenway P, Palmer G. Poverty among ethnic groups how and why does it differ? JRF New Policy Institute. York. 2007.

⁹ EHRC. Inequalities Experienced by Gypsy and Traveller Communities: a review: EHRC: 2009.

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Gypsies and Travellers in the UK of whom two thirds live in settled housing.¹⁰

Key outcomes

None of the indicators in the Public Health, NHS or Adult Social Care Outcomes Frameworks are specifically focused on ethnicity. However ethnicity is a 'protected characteristic' in the Equality Act 2010 and public sector organisations are required to have due regard to the need to advance equality of opportunity and eliminate discrimination faced by people based on their ethnicity.¹¹

Impact in Brighton & Hove

The most recent population estimates (2011) show that 80.5% of the city's population are White British and 19.5% are from a BME group (compared to 12% in 2001). This is now a lower proportion than England (20.2%), but higher than the South East (14.8%).¹²

Table 1: Population by ethnic group as a % of total population, 2011 (number of people in brackets)

	Brighton & Hove 2011	Brighton & Hove 2001	England
White	89.1% (243,512)	94.3%	85.4%
White British	80.5% (220,018)	88.0%	79.8%
White Irish	1.4% (3,772)	1.6%	1.0%
Other White	7.1% (19,524)	4.6%	4.7%
Mixed/Multiple Ethnic Group	3.8% (10,408)	1.9%	2.3%
Asian or Asian British	4.1% (11,278)	2.4%	7.8%
Black or Black British	1.5% (4,188)	0.8%	3.5%
Chinese	1.1% (2,999)	0.5%	0.7%
Other non-White ethnic group	0.7% (1,799)	0.6%	0.6%

Source: Office for National Statistics (ONS)

Table 1 gives the total population by ethnic group. The largest BME community is Other White with 19,524 people, over a third (36.6%) of the BME population. Numerically, the Other White community has seen the largest increase since 2001 (8,041 people).

All BME groups (apart from Irish) have seen a significant increase in their population since the 2001 census. The Other Asian community has seen the biggest increase, increasing two and a half times (255.9%) from just 918 people in 2001 to 3,267 people in 2011. All mixed / multiple ethnic groups have also seen their populations double and increase by more than 1,000 people as have the Chinese and the Black African communities.

Of the city's population who are aged over three years, 8.3% do not have English as their preferred or first language, compared to 5.8% in the South East and 8% in England. Arabic is the most widely spoken language in the city besides English (0.8%), followed by Polish (0.8%) and Chinese (0.7%).¹³

In 2012-13, Sussex Interpreting Services (SIS) provided 10,751 community interpreting sessions for 2,518 different service users in 47 different languages – over 80% of sessions and service users relate to Brighton & Hove. The most frequently required languages were: Arabic (34%), Polish (10%) and Farsi (7%). Across Sussex there has been an annual increase of 183% in Hungarian, 17% in use of Mandarin, 13% in Turkish, 7% in Polish.¹⁴

Over the last three years 30% of Brighton and Sussex University Hospital Trust's (BSUHT) use of interpreting services has related to maternity care, with services in the Trevor Mann baby Unit rising by 274% from 0.26% of all BSUHT interpreting services in 2011-12 to 2.1% in 2012-13.¹⁵

A cross-sector event looking at engaging people who use interpreting services in relation to health needs highlighted a lack of knowledge of urgent care services outside of GPs and Accident and Emergency. Continuity of service, face-to-face interpreting, confidentiality and information giving were identified as building confidence, broadening

¹⁰ Cemlyn S, Greenfield M, Whitwell C, Matthews Z, Burnett S. Inequalities experienced by gypsy and traveller communities, a literature review. London: Equalities and Human Rights Commission. 2009.

¹¹ <http://www.equalityhumanrights.com/legal-and-policy/equality-act/>

¹² ONS Neighbourhood statistics Ethnic Group (KS201EW) Census 2011 13th Jan 2013

¹³ ONS Neighbourhood statistics Census 2011 [accessed 11th June 2013]

¹⁴ Sussex Interpreting Services 2013

http://sussexinterpreting.org.uk/annualreview/AR2013/SIS_AnnualReview_2012-13_LowRes.pdf

¹⁵ Sussex Interpreting Service (2013)

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opportunity and increasing service accessibility for this cohort.¹⁶

In the 2012 Safe and Well at School survey 76% of students stated their ethnicity as White British, 6% were Other White, 14% were from other BME groups and 4% either did not know or did not say. This reflects the younger age profile of the BME population in the city compared to the White UK population.

The Black and Minority Ethnic Young Peoples Project (BMEYPP) works with Black and Minority Ethnic (BME) Young People aged 11-25, specifically 'Black' people including people who have heritage of; African, Asian (including East Asian), Arab, Iranian, Persian, and the Indigenous peoples of the Australasia and the Americas. Data from 237 youth work sessions between January and December 2012 highlighted the top 5 issues of concern for young people as: Relationships (229), Racism (177), Culture (141), Discrimination (123) and Education (116).¹⁷

Qualitative data from a 2012 needs assessment on the health and wellbeing needs of the gypsy and traveller community in the city identified the following determinants on Traveller health: stress; isolation; stigma; adaptability; gender roles; literacy; education and employment access; physical environment; high rates of smoking; poor diet and low breastfeeding rates. Specific health priorities identified include, amongst others, obesity, oral health, mental health, and health care accessibility.

Where we are doing well

The BME community partnership (BMECP) is a gateway organisation funded by the PCT to enable participation by BME communities in health-related developments. The partnership comprises 45 BME community groups with membership size ranging from 10 to 3,000 members.

The Friends, Families and Travellers group is based in Brighton and works closely with Gypsy and Traveller communities, providing an important opportunity to engage with these communities.

Public sector services fund interpretation and translation through the Sussex Interpreting Service (SIS). The majority of interpreting services in 2012-13 were provided in relation to healthcare, council, or housing services. Since March 2011 SIS has also provided a bilingual health advocacy service, providing 371 advocacy sessions for 93 service users in 2011. Of this number those registered at a GP or dentist increased from 70% before to 100% after the sessions.¹⁴

A health needs assessment of Gypsies and Travellers was undertaken in 2012 which helped to address a paucity of local information about this group.

Both the City Council and the Clinical Commissioning Group have a clear commitment to developing further work with BME communities.

The 2014-17 Brighton and Hove Commissioning Prospectus outlines the intention to commission a service providing psychosocial support to improve the mental health management and well-being of BME communities, particularly those who have limited knowledge of, or access to, community mental healthcare services.

Local inequalities

The proportion of the population that are from BME groups varies by age: 21% of children and young people aged 0-15 years are from BME groups; 21% of people of working age; and just 8% of people of retirement age or older.¹⁸ So the BME population of the city is considerably younger than the White British population.¹⁷

According to the 2011 Census there were 198 Gypsies and Travellers living in Brighton and Hove which amounts to 0.1% of the city's population. This amounts to fewer travellers per capita than would be expected for the population, yet according to local research the lack of suitable stopping places means Travellers are four times more likely than the national average to be on an unauthorised site.¹⁹ Since the publication of the Traveller Commissioning Strategy in the city, a site

¹⁶ A partnership between the Brighton & Hove Clinical Commissioning Group, Sussex Interpreting Services and the Black and Minority Ethnic Community Partnership.

¹⁷ The Black and Minority Ethnic Young Peoples Project (2013) Sessional recording Sheets

¹⁸ ONS Neighbourhood statistics Ethnic group by sex by age (DC2101EW) Census 2011 [accessed 11th June 2013]

¹⁹ NHS Sussex (2012) Brighton & Hove Gypsy & Traveller Rapid Health Needs Assessment December 2012

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has been agreed for a 16 pitch permanent traveller site.²⁰

Brighton & Hove's BME communities live throughout the city, but just under half of the Bangladeshi population and just under a third of the Black African population live in the 10% most deprived areas of the city.²¹

Population groups

Pregnancy and maternity: 26% of births are to mothers born outside of the UK which is the same as the across England.²² The greatest proportion of non-UK born mothers in the city are mothers born in the EU (9.3%) and Africa (4.6%). Until 2003 the most common country of birth outside of the UK was Bangladesh, but in more recent years those born in Poland outnumber the Bangladeshi population in the city.

Carers: The Brighton and Hove Carers Survey 2012-13 was sent out to a sample of Carers who had received a carers assessment, either separately or jointly with the person they care for, between August 2011-August 2012. Of the 565 carers whose ethnicity was recorded, 8% were from BME groups.

Nationally, caring roles vary between ethnic groups. Bangladeshi and Pakistani men and women are three times more likely to provide care compared with their White British counterparts.²³

In the latest annual City Tracker survey (2012) almost a third (32%) of Other White respondents said that they provided some help at least once a month, compared to 27% of White UK respondents and 26% of BME respondents.²⁴

Military veterans: There is no specific data on ethnicity of military veterans but at national level an estimated 99% are White.²⁵

Students: The full time 16 year and over student population in Brighton accounts for 14.1% of the city's population. This is significantly higher than

the average for the South East (7.5%) and England (8.2%).²⁶ 25% of the student population of the University of Brighton not of a White background in 2012 (including White, White British and Other White), and 67% at the University of Sussex. Students of Asian or Black backgrounds have much higher representation than the city average, although not all registered at the universities will live in the city and about a fifth will be part time.²⁷

Wider determinants of health

Children, young people and families

Children in need and looked after children: In 2013, 21% of Looked After Children were not White British, which is as expected in relation to the City's ethnic profile at the time of the 2011 Census of 21% of children under 17 years being not White British. 29% of those subject to a Child Protection Plan in February 2013 were from BME groups (9% more than in July 2012). This is a larger percentage than expected in relation to the 2011 Census. However, factors such as the small cohort size, improvements in recording and scrutiny, and revised population figures from the 2011 Census could all influence this to some degree.

Education: The percentage of pupils of all ethnicities achieving five or more A*-C grades at GCSE (71%) is below national (81%) and South East (79%) averages. Pupils from Mixed Ethnic Groups (80%) are achieving at similar levels to national attainment (81%), while Chinese pupils (70%) are achieving below the national average for this cohort (93%)²⁸ School Census data (2012) indicates that those who have lower GCSE attainment locally are pupils who are Other Black or Black African, whilst the highest performing at GCSE level are White and Asian pupils.²⁹ Pupils from the following ethnic groups have lower GCSE attainment nationally: Travellers of Irish Heritage (38%) and Gypsy/Roma (38%), although attainment has

²⁰ Brighton and Hove City Council, (2013) Travellers Service Update [June 2013] <http://www.brighton-hove.gov.uk/content/housing/travellers>

²¹ Brighton & Hove City Council. State of the City Report: Summary. June 2011. Available from http://www.brighton-hove.gov.uk/index.cfm?request=b1149084&action=show_pr&id=261445 [Accessed 20/08/2012].

²² ONS. Vital Stats 2010 Data

²³ Carers UK. Who Cares Wins Statistical Analysis of the Census. 2001.

²⁴ Brighton and Hove City Council (2012) Annual City Tracker Survey

²⁵ Royal British Legion. Profile and Needs of the Ex-Service Community 2005-2020. Royal British Legion. 2006.

²⁶ ONS Census 2011

²⁷ (accessed 1st May 2013)

<http://staffcentral.brighton.ac.uk/xpedio/groups/Public/documents/staffcentral/doc013928.pdf>

<http://www.sussex.ac.uk/ogs/policies/equalityduty/students/data>

²⁸ ONS. Overall pupil attainment by ethnic group. Census 2011. Available from: <http://www.bhlls.org/profiles/profile?profileid=232&geoTypeId=> [Accessed 10/06/2013].

²⁹ Brighton and Hove City Council (2012) School Census data

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increased from 18% and 16% respectively in 2007/08.³⁰

Physical activity: There is no significant difference in physical activity levels between those who are White British and BME groups. However, White Irish women are the most likely cohort of all ethnic groups to participate in the recommended level of physical activity for 5 or more days of the week (44%), followed by White Gypsy/Traveller males (40%). People of Black or Black British ethnicity are least likely to do the recommended levels of physical activity 5 or more days a week (4%).³¹

There is little difference in secondary school physical activity participation within schools by ethnic group, yet BME pupils more likely to have done less than an hour of physical activity out of school in the last week (16%) than White British pupils (13%).³²

NEET: At the end of April 2013 there were 467 young people who were not in education, employment or training (NEET), and a higher proportion were White UK/British than we might expect, all other things being equal. Around 3% of the total population of young people in the city were NEET in April 2013. (It's not possible to be more accurate as the NEET count is based on young people in academic years 12 to 14 as required by the Department for Education and our best population data is based on age so we can't work out exactly what proportion of our young people are NEET).

Comparing the NEET population's ethnic profile to the ethnic profile of the city shows that White UK/British young people were over-represented in the NEET group, by 10.8%. The only other ethnic group that is over-represented is "Other Mixed" background. Chinese and Other White young people were the most under-represented groups by 4.3 and 3.0% respectively.³³ In total BME groups were under-represented in the NEET population by 14.4%.

Employment and work: Information on economic activity is based on 2011 Census data about people aged 16-74 years, and thus includes people of retirement age. Overall, for all BME groups, Brighton and Hove (55%) slightly higher proportion of economically active adults compared with UK average (52%). This is particularly true of: White Gypsy or Irish Travellers (56%) compared with 32% nationally; and Other Black people (60%) compared with 42% nationally. Lower levels of economic activity compared with the UK are found among Mixed, Black African and Chinese groups in the city.³⁴

Community safety and crime reduction: The police recorded 164 racist or religiously motivated incidents and crimes in the city in 2012/13, 16% more than in 2011/12, although numbers in preceding years have shown a declining trend, but remain of particular concern to ethnic communities.

Reports to the police of hate incidents which are targeted at people because of who they are, such as racist or religiously-motivated crimes or incidents against lesbian, gay, bi, or trans people, have been declining over recent years, but remain of particular concern to these communities.

During 2012/13 the Anti-social Behaviour and Hate Crime Casework Team started to operate a duty line for receiving reports, and in its first year of operation (May 2012 to April 2013) 613 incidents have been recorded on the duty system, of which 386 related to ASB, 86 to race, 30 to disability, 16 to sexual orientation, three to trans gender, one to religion and 91 others. Over that 12 month period there were 126 new cases for the team.

In 2011/12 BME males had a higher offending rate than White UK/British males at 47.9 per 1,000 of the population compared to 40.7 per 1,000. Conversely, BME women had a low offending rate compared with White UK/British women and all men. There were 8.9 offenders per 1,000 members of the population who were from a BME background compared to 11.1 per 1,000 for White UK/British women.

³⁰ Department for Education. GCSE and equivalent attainment by Pupil Characteristics in England, [Online] 2011/12. Available from <https://www.gov.uk/government/publications/gcse-and-equivalent-attainment-by-pupil-characteristics-in-england> [Accessed June 2013].

³¹ NHS Brighton and Hove (2012) Health Counts: A survey of people in Brighton and Hove. University of Kent Centre for Health Services Studies

³² Brighton and Hove City Council. Safe and Well at School Survey 2011

³³ National Client Caseload Information System – End April 2013

³⁴ ONS Neighbourhood statistics DC6201EW - Economic activity by ethnic group by sex by age Census 2011 [accessed 11th June 2013]

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In Brighton & Hove, the BME population of young offenders is proportionate to that of the city as a whole, although it has been found that BME young men are more likely to remain in the youth justice system.³⁵

Sustainable communities and places

Services: Locally, BME groups are less likely to feel that services treat them with respect. A local survey has shown that 50% of BME respondents thought services treated them with respect compared with 76% of White British respondents. However, BME respondents were also more likely to report that local services act on the concerns of residents (52% compared with 43% overall).^{36,37} Local consultations highlight the need for greater cultural awareness amongst services to improve suitability and sensitivity.³⁸

Housing and homelessness:

BME people are more likely to experience housing need in the city.³⁹

In 2011/12, 84% of those in hostels in Brighton and Hove were White British.

Good nutrition and food poverty: Nationally it has been identified that members of BME communities are amongst the groups most likely to experience food poverty.⁴⁰ Local evidence suggests that White Irish people are the most likely ethnic group to eat 5 or more portions of fruit and vegetables a day, and men of Mixed/Multiple ethnicity are least likely.⁴¹

Wellbeing and community resilience

Happiness and wellbeing: Analysis of results from the ONS Annual Population Survey across the UK for April to September 2011 showed that Mixed and Black or Black British groups reported lower

ratings for 'life satisfaction'.⁴² In contrast, findings from Health Counts data (2012) indicate that Black or Black British men are most likely of all ethnic cohorts to report higher levels of life satisfaction in Brighton & Hove, and those of mixed/multiple ethnicities were least likely of all ethnic groups to report medium/high levels of life satisfaction, with two thirds of males in this cohort reporting they have low or very low life satisfaction.³⁷

With the exception of people of Asian/Asian British or Mixed Multiple ethnicity, between 70% and 75% of all ethnic groups reported that they feel happy and that the things they do are worthwhile. People from a White Gypsy/Traveller or Other ethnic background are more likely to report higher levels of anxiety.⁴³

Children and young people of Asian, Asian British or 'other' ethnic groups and those eligible for free school meals are less likely to participate in group activities, with non-participation linked to higher levels of vulnerability and to risk taking.⁴⁴

BME pupils (6%) are twice as likely as White British students (3%) not to feel safe at school, and are slightly less likely to feel like they have one or more good friends at school. "Other" ethnic groups are more likely to be bullied than any other ethnic group.⁴⁵

Children and Young people of Asian, Asian British and "other" ethnic groups were found to be less likely to participate in group activities, with this non-participation linked to higher levels of vulnerability and risk-taking.⁴⁶

³⁵ Youth Justice Statistics 2010/11 England and Wales. Youth Justice Board/Ministry of Justice Statistics Bulletin.

³⁶ Black P. Brighton & Hove Place Survey 2008. Brighton & Hove City Council. 2009.

³⁷ BMECP Health Forum event July 2011. Available on request from http://bmeccp.org.uk/bme_health.html.

³⁸ South Downs Health NHS Trust. Equal to the challenge. Brighton 2004.

³⁹ Homelessness by ethnicity census data[online] 2001. Available at <http://www.bhlis.org/profiles/profile?profileid=194&geoTypeid=> [Accessed March 2012]

⁴⁰ National Heart Forum. Nutrition and food poverty: a toolkit. 2004.

⁴¹ NHS Brighton and Hove (2012) Health Counts: A survey of people in Brighton & Hove 2012. University of Kent centre for Health Services Studies.

⁴² ONS. Analysis of experimental subjective wellbeing data from the Annual Population Survey, April to September 2011. February 2012.

⁴³ NHS Brighton and Hove (2012) Health Counts: A survey of people in Brighton & Hove 2012. University of Kent centre for Health Services Studies.

⁴⁴ NHS Brighton and Hove & Brighton & Hove City Council. Annual Report of the Director of Public Health – Resilience. 2010.

⁴⁵ <http://www.bhlis.org/needsassessments/publichealthreports> [Accessed 20/08/2012].

⁴⁶ Brighton and Hove Safe and Well at School survey 2011

⁴⁶ Brighton & Hove City Council Children's Services. Youth Service commissioning joint strategic needs assessment. May 2011.

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Improving health

Starting well

Antenatal and newborn screening: Based on national data, one baby every seven months will be born with Sickle Cell Disease in Brighton & Hove.⁴⁷

Maternal and infant health: Maternal smoking prevalence is significantly higher in White British mothers (10%) and significantly lower for Other White (4%), Black or Black British (2%), Asian or Asian British (0.7%) and Chinese (0%) groups.

Breastfeeding rates are highest among Other White mothers (95%), Black or Black British mothers (90%) and Asian or Asian British mothers (92%).⁴⁸

Developing well (children and young people)

Healthy weight: Local data on childhood weight for some ethnic groups are based on small numbers, but data indicates that Black or Black British (30%) aged 4-5 and 10-11, and Asian or Asian British (22%) children aged 10-11 years are significantly more likely to be obese than other ethnic groups.⁴⁹

Across England, obesity prevalence is significantly higher for Asian or Asian British, Any Other Ethnic Group and Black or Black British children and significantly lower for Chinese and White children.⁵⁰

Smoking: There is little difference in smoking prevalence by ethnic group in school pupils.

Alcohol and substance misuse: The younger population is more ethnically diverse than their older counterparts. However, BME groups make up a lower proportion of people in substance misuse and alcohol treatment services, with only 13% of the treatment population being from BME

communities compared with 21% of the city's 0-15 year olds being from BME groups.⁵¹

Local data indicates that pupils from BME groups are significantly less likely to have ever tried an alcoholic drink (45%) than white British pupils (57%) or Other White pupils (62%). However, of those 14-16 year olds that do drink alcohol, BME pupils were found to be more likely to drink more regularly than White British pupils⁵².

Sexual health: The sexual health needs assessment reported that Chlamydia detection rates were highest in Asian or Asian British young people.⁵³

Local data for 14-16 year olds indicates that White British girls (26%) were more likely to have had sex than BME girls (17%), and BME young people were less likely to know about Contraception and Sexual Health services.⁴⁷ 85% of under 18 year olds in the city who had a termination of pregnancy between 2010 and 2012 were White British⁵⁴.

Living well (adults and older people)

Healthy weight: Nationally there is a correlation between obesity and ethnicity, with Black African and Black Caribbean populations exhibiting the highest obesity rates amongst all ethnic minority populations, and Chinese and Bangladeshi populations the lowest. Women have a higher prevalence of obesity in every ethnic group; the gender difference is significant amongst Pakistani, Bangladeshi, and Black African populations.⁵⁵

Similarly to the national picture, local data⁵⁶ indicates that a higher proportion of Black or Black British (54%) or White Irish (57%) people are overweight or obese than other ethnic group. People of White Gypsy/Traveller or Other descent (32%) and of Mixed/Multiple ethnicity (33%) have lower levels of overweight or obese, but the latter has the highest level of underweight people (9%).

⁴⁷ Foetal anomaly screening programme –standards and policies <http://fetalanomaly.screening.nhs.uk/standardsandpolicies> [Accessed 20/08/2012].

⁴⁸ Public Health Directorate 2011.

⁴⁹ National Child Measurement Programme results, Information Centre for Health and Social Care [Accessed on 25/08/2012].

<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/obesity>

⁵⁰ National Child Measurement Programme results, Information Centre for Health and Social Care <http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/obesity> [Accessed 20/08/2012].

⁵¹ ONS Neighbourhood statistics Ethnic group by sex by age (DC2101EW) Census 2011 [accessed 11th June 2013]

⁵² Brighton and Hove City Council. Safe and Well at School Survey 2011

⁵³ Brighton and Hove Sexual Health Needs Assessment 2010 available at <http://www.bhlis.org/needsassessments> [Accessed 20/08/2012].

⁵⁴ British Pregnancy Advisory Services (2012) Monthly monitoring data

⁵⁵ National Obesity Observatory 2010. Demography and Health Inequalities of Obesity.

http://www.noo.org.uk/NOO_about_obesity/adult_obesity/demography_in_equalities [Accessed 20/08/2012].

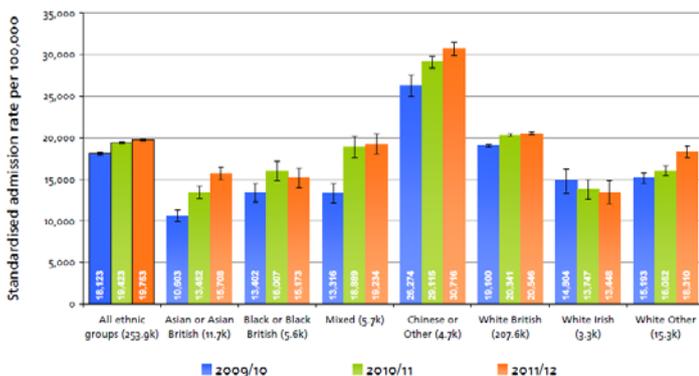
⁵⁶ NHS Brighton and Hove (2012) Health Counts: A survey of people in Brighton & Hove 2012. University of Kent centre for Health Services Studies.

Physical activity: Local research has found that BME groups lack targeted sports and physical activity provision, especially for Muslim women; those who are disabled and those prone to clinical obesity; and in cases where language is the key barrier to participation.⁵⁷

Local data⁴⁵ indicates that within this sample, White Irish women are the most likely cohort to participate in the recommended level of physical activity for 5 or more days of the week (44%), followed by White Gypsy/Traveller males (40%). People of Black or Black British ethnicity are least likely to do the recommended levels (4%) with low levels also reported by people from Other ethnic groups (13%) and Asian or Asian British people (14%).

Hospital admissions: Between 2009/10 and 2011/12, age standardised admission rates to hospital have shown significant year-on-year increases for Asian or Asian British, and Chinese or Other populations in Brighton and Hove (Figure 1).

Figure 1: Admissions to hospital by ethnic group, Brighton & Hove, 2009/10 to 2011/12



Source: Hospital Episode Statistics

Substance misuse: There is an under representation in the substance misuse treatment population from the BME community groups, particularly members of the Other White, White Asian, Indian, Pakistani, Bangladeshi, Caribbean, African and Chinese Communities⁵⁸. Local research⁵¹ indicates that people of Mixed/Multiple ethnicity are most likely of all BME groups to have tried non-prescription/over the counter drugs, and Asian or Asian British people least likely.

⁵⁷ Brighton and Hove needs assessment stakeholder interviews 2011.

⁵⁸ Brighton and Hove Drug and Alcohol Action Team (2012) Substance Misuse (Drugs) Needs Assessment 2012-13

Alcohol: Ethnicity was not shown to be a significant factor in assaults recorded by A&E or the police, or in all alcohol related attendances at A&E.⁵⁹

Between January 2012 and December 2012, 91% of people in alcohol treatment in the city were White British. Of the 9% BME cohort of Alcohol Clients in this period, 3% were Other White ethnicity⁶⁰.

Local data⁶¹ suggests that people of White Irish ethnicity are significantly more likely than any other ethnic group to be at increasing/high risk of alcohol related harm (25% compared to 18% across all ethnic groups in the city). Other Ethnic, Asian or Asian British and Black or Black British groups are more likely not to drink alcohol. These findings correspond to national research⁶².

Smoking: Local data⁶³ indicates that Black or Black British people are significantly more likely to be ex-smokers or non-smokers (96%) than any other ethnic group.

Preventing ill-health

Preventable sight loss: National evidence shows that there is a higher rate of glaucoma and age-related macular degeneration in Black ethnic groups, and a higher rate of diabetic retinopathy in South Asian populations.⁶⁴

Suicide: Of the deaths included in the local suicide audit 2007-2010, 87% were for people of White British origin, with 13% being of White Other or Asian ethnicity.⁶⁵ This is slightly higher than 2011 ONS estimates of 12.2% for Brighton and Hove⁶⁶

Migration does not appear to increase risk of suicide, with suicide rates among migrants in England and Wales generally reflecting patterns in the country of origin⁶⁷.

Improving health and promoting independence

⁵⁹ Brighton and Hove Citizens Panel, Community Safety Survey 2010.

⁶⁰ Brighton and Hove Drug and Alcohol Action Team (February 2013)

⁶¹ NHS Brighton and Hove (2012) Health Counts: A survey of people in Brighton & Hove 2012. University of Kent centre for Health Services Studies.

⁶² Hurcombe, R., Bayley, M., and Goodman, A (July 2010) Ethnicity and Alcohol: A review of the UK literature. Joseph Rowntree Foundation.

⁶³ NHS Brighton and Hove (2012) Health Counts: A survey of people in Brighton & Hove 2012. University of Kent centre for Health Services Studies.

⁶⁴ Access Economics. Future Sight Loss UK 1: Economic Impact of Partial Sight and Blindness in the UK Adult population. 2009.

⁶⁵ Scanlon T, Memon A, Dorling C, Walker A. 100 years of suicide in Brighton and Hove. J Epidemiol Community Health. 2011.Aug;65(Suppl1):A158.

⁶⁶ ONS Neighbourhood statistics Ethnic group by sex by age (DC2101EW) Census 2011 [accessed 11th June 2013]

⁶⁷ Gill P.S., Kai J., Bhopal R.S. and Wild S. (2007) Black and Minority Ethnic Needs Assessment

Mental health: The 2007 mental health needs assessment for working age adults in Brighton & Hove identified higher risks among BME populations.⁶⁸ There is evidence that Brighton & Hove follows the national trend for twice the rate of mental health hospital admissions among people from a BME background and lower uptake of primary care mental health services.⁶⁹

Qualitative research into BME mental health has been conducted with the University of Brighton and found that the identified obstacles to maintaining good mental health in Brighton and Hove, namely: experience of racism; poverty; poor education; and acculturation difficulties are prevalent throughout BME populations in the UK. 81% of respondents in this study reported experiencing barriers to getting help, most commonly stigma which was particularly prevalent amongst less acculturated members of BME communities.⁷⁰ The most popular sources of support locally were mental health and wellbeing services (61%), and complementary services and peer support groups were viewed as more satisfactory than GP and specialist mental health services.⁵³

Adults with learning disabilities: The overall prevalence estimate of learning disability in BME communities in the UK is not known⁷¹, but research indicates that there is an increased prevalence of severe learning disability in the UK's south Asian community.⁷²

Diabetes: Diabetes is more common in certain ethnic groups: it is up to six times more common in people of South Asian descent and up to three times more common in those of African and African-Caribbean descent.⁷³

Coronary heart disease: South Asian men are more likely to develop coronary heart disease at a younger age, and have higher rates of heart attacks.⁷⁴

Stroke: Nationally, there is known to be higher prevalence of stroke in some BME groups.⁷⁵ In Brighton and Hove Black people have the highest stroke mortality rates.⁶⁸

Chronic Obstructive Pulmonary Disease (COPD): Modelled prevalence of COPD by ethnic group indicates that in Brighton & Hove 5% of adult White and Mixed groups had COPD (compared with 4% in England) and 4% of the Black population and 2% of the Asian population had COPD (compared with similar rates in England).⁷⁶

HIV and AIDS: Of the 1,528 people accessing NHS HIV treatment services in the city in 2011, 88% were White British and around 56% of HIV infected females are Black African.⁷⁷

Musculoskeletal conditions: Research conducted in Manchester found that disability prevalence due to musculoskeletal pain is higher for Indian and Bangladeshi people than White people.⁷⁸

Predicted future need

Brighton and Hove's Black and Minority Ethnic communities are growing. At the time of the 2001 census 12% of the city's population (29,683 people) were from a BME background. By the 2011 census this reached 20.5% (53,351 people).⁷⁹ The population of the city, and older people in particular, is expected to become more ethnically diverse with implications for services.

What we don't know

⁶⁸ Government Office for Science. Mental capital and wellbeing: making the most of ourselves in the 21st century - Foresight Report. 2008.

⁶⁹ Brighton and Hove City PCT. Black and minority ethnic health needs analysis. 2008.

⁷⁰ NHS Brighton and Hove (2012) A Qualitative Study of BME Mental Health and Wellbeing in Brighton and Hove. University of Brighton

⁷¹ Raghu Raghavan (2009) Improving Access to Services for Minority Ethnic Communities. September 2009, Volume 12, Number 7. Learning Disability Practice

⁷² Emerson E, Azmi S, Hatton C et al (1997) Is there an increased prevalence of severe learning disabilities among British asians? Ethnicity and Health. 2, 4, 317-321.

⁷³ Department of Health. Who gets diabetes - Health Inequalities http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4899972 [Accessed 20/08/2012].

⁷⁴ SEPHO. Cardiovascular disease PCT health profile. Brighton & Hove City PCT 2013.

⁷⁵ Primatesta and Brookes. Health Survey for England: the health of minority ethnic groups: Cardiovascular disease. Information Centre for Health and Social Care. 1999

⁷⁶ East of England Public Health Observatory. COPD prevalence estimates. December 2011.

⁷⁷ Health Protection Agency, HIV prevalence by Local Authority in England 2011. Available at

http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1228207184991

⁷⁸ Allison T et al. Musculoskeletal pain is more generalised among people from ethnic minorities than among white people in Greater Manchester. Ann Rheum Dis. 2002;61:151-156. doi:10.1136/ard.61.2.151.

⁷⁹ A census is a count of people & households undertaken every decade, & is used to set policies & estimate resources required to provide services for the population. It is the most complete source of information about the population that we have. The latest census was held on 27 March 2011.

4.2.2 Ethnicity

Whilst some ethnicity data is available it does not provide a full picture of service uptake or suitability. Ethnicity is incompletely monitored in primary care.⁸⁰ A 2012 BME mental health needs assessment has gone some way to pulling together the available ethnicity data.

Ethnicity is not recorded on death certificates. Country of origin is recorded but this only provides partial information on first generation immigrants and misses out subsequent generations.

Key evidence and policy

Tackling Health Inequalities: A Programme for Action 2003. The Acheson Inquiry made three recommendations for reducing ethnic health inequalities:

- Policies to reduce socio-economic inequalities should consider the needs of BME groups.
- Services should be sensitive to the needs of BME groups and promote awareness of their health risks.
- The needs of BME groups should be specifically considered in planning and providing health care.

Delivering racial equality (DRE) in mental health care 2005.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773

The Equality Act 2010 expands and clarifies anti-discriminatory legislation and creates a duty on statutory organisations to evidence that they have considered the impact of their functions on excluded communities (including BME communities) and that they are actively removing disadvantage, discrimination and barriers to services.

In 2008, the Department of Health published 'No Patient Left Behind: how can we ensure world class primary care for BME people?' which identified barriers and proposed recommendations:

- Supporting patient 'choice and voice'
- Commission for diverse communities
- Routine ethnicity data collection
- Training of primary care staff

- Nurturing diverse workforce
- Leadership and commitment
- Focus of a National Improvement Team project http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084971

Health Inequalities: a guide for general practitioners; Royal College of General Practice Health Inequalities standing group; London 2008. <http://www.rcgp.org.uk/pdf/Health%20Inequalities%20Text%20FINAL.pdf>

Recommended future local priorities

1. Continue to work with Community and Voluntary sector representatives and gateway organisations, and ensure communities' 'voices' are present in service development and evaluation.
2. Take forward the recommendations in the Brighton & Hove City Council Traveller Commissioning Strategy 2012 and the 2012 needs assessment of the health and wellbeing issues for Gypsy and travelling communities.
3. Continue cultural awareness training for all services.

Key links to other sections

Ethnicity is considered throughout the JSNA.

Further information

http://www.bhlis.org/race_ethnicity/

Last updated

August 2013

⁸⁰ Alves B. Health and health service usage of BME populations in Brighton & Hove. Brighton & Hove City PCT. 2006.

Why is this issue important?

Sexual orientation is defined as whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.¹

Lesbian, gay and bisexual (LGB) people are at higher risk than heterosexual people of bullying, abuse, discrimination and exclusion.^{2,3,4} LGB people are also at greater risk of mental disorder, substance misuse and dependence, self-harm and suicidal behaviour/ideation than heterosexual people. Socially isolated LGB people and those on a low income are more susceptible than others.^{5,6} Some LGB people are more resilient than others despite these higher risks. E.g. the higher risk of mental health issues, suicidal ideation or substance abuse relating to sexual orientation may be mitigated by protective factors that promote resilience such as 'family (and friend) connectedness'.^{7,8,9}

Key outcomes

None of the indicators in the Outcomes Frameworks are specifically focused on sexual orientation, but cover all people. However sexual orientation is a 'protected characteristic' in the Equality Act 2010 and public sector organisations are required to have due regard to the need to advance equality of opportunity and eliminate discrimination faced by people based on their sexual orientation.¹⁰

¹ Equality and Human Rights Commission. <http://www.equalityhumanrights.com/advice-and-guidance/new-equality-act-guidance/protected-characteristics-definitions/> [Accessed 20/08/2012].

² Hernandez GG. LGBT Resilience Toolbox. www.lgbtyouthnorthwest.org.uk/wp-content/uploads/2011/02/Resilience-toolbox-by-Gloria-Gil-Hernandez-31.10.071.pdf (Accessed 21/08/2011).

³ Csikszentmihalyi M. Flow: The Psychology of Optimal Experience. New York: Harper and Row; 1990.

⁴ Browne K. Count Me In Too. LGBT lives in Brighton & Hove initial findings: Academic report. University of Brighton and Spectrum LGBT Community Forum; 2007.

⁵ NIMHE. Mental disorders, suicide, and deliberate self harm in lesbian, gay and bisexual people: a systematic review; 2007.

⁶ Browne K and Lim J. Count Me In Too: Mental Health Additional Findings Report; 2008.

⁷ Eisenberg ME, Resnick, MD. Suicidality among Gay, Lesbian and Bisexual Youth: The Role of Protective Factors. Journal of Adolescent Health; 2006; 39(5): 662-668.

⁸ Fenaughty J, Harré N. Life on the seesaw: a qualitative study of suicide resiliency factors for young gay men. Journal of Homosexuality; 2003; 45(1):1-22.

⁹ Johnson K, Faulkner P, Jones H, Welsh E. Understanding Suicidal Distress and Promoting Survival in the LGBT Communities. Brighton & Sussex Community Knowledge Exchange Project; 2007.

¹⁰ <http://www.equalityhumanrights.com/legal-and-policy/equality-act/>

Impact in Brighton & Hove

There is no definitive research into the number of lesbian, gay, bisexual (LGB) people who live in the city and the recent 2011 Census did not include a question on sexual orientation. However, it did include civil partnership within the marital status question and 1% of residents aged 16 or over (2,346 people) are registered in a same-sex civil partnership; four or five times more than in the South East (0.2%) and England (0.2%).¹¹

Local estimates suggest that there may be 40,000 LGBT people living in Brighton & Hove, around 15-16% of the city's population and the largest concentration of LGBT people in England outside London.^{12,13}

Information is presented for LGB communities where available in this section. However, in some information sources trans and gender reassignment are included with LGB communities and this is presented here where information is not available separately for LGB.

Wider determinants of health

Parenting: 16% of the CMIT sample were parents with lesbians/gay women (26%) and bisexuals (24%) parenting more often than gay men (8%). Deaf (33%) and disabled people (24%) were also more likely to be parents. 28% of parents described their child as bullied or taunted because of their sexuality. School was also the place most cited for problems related to sexuality.

Education: Local survey results suggest that the LGBT population is highly educated even in comparison to the high qualification levels of the general population of Brighton & Hove.¹⁴ In 2007, the largest UK Survey of LGBT people reported that almost two thirds of young lesbian, gay and bisexual people had experienced homophobic bullying, and that bullying was more common in faith schools where it was also less likely to be reported.

¹¹ Office for National Statistics. Census 2011.

¹² Oxford Consultants for Social Inclusion (OCSI). Developing Appropriate Strategies for Reducing Inequality in Brighton and Hove; 2007.

¹³ Webb D, Wright D. Count Me In: Findings from the lesbian, gay, bisexual and transgender community needs assessment 2000. University of Southampton, Southampton; 2001.

¹⁴ Browne K, Lim J. Count Me In Too: General Health Additional Findings Report: University of Brighton and Spectrum; 2008. http://www.countmeintoo.co.uk/general_health.php [Accessed 20/08/2012].

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Housing and homelessness: A quarter of LGBT CMIT respondents said they had experienced difficulties in obtaining accommodation and 22% reported that they had been homeless at some point in their lives. A third of those who defined themselves as bisexual, queer and other had experienced homelessness, compared with 22% for lesbians / gay women and 19% for gay men. Those more likely to have experienced homelessness also include LGBT disabled people, people who were HIV positive, people on low incomes and people with mental health difficulties.¹⁵ A specialist LGBT Housing Options Officer ensures the needs of these groups are more effectively supported with their housing needs.

Material wellbeing: CMIT indicates that employment levels of LGBT people in the city appear to be high compared with all working age adults. Gay men were more likely to have higher incomes than those in the other sexuality categories: the majority of respondents identifying as gay (58%) had an income of over £20,000 whilst most lesbians / gay women in the sample had an income of less than £20,000 (54%). Those identifying as bisexual were more likely to have an income less than £20,000 (68%) whilst only 22% of those in the other sexuality categories had an income of over £20,000 a year. However, a statistically significant relationship was only found for the younger age groups (under 46), whilst this is not the case for those 46 or over.⁴

Crime and antisocial behaviour: Hate crime is experienced by some members of LGB communities and there is a lack of perceived safety, particularly on estates on the outskirts of the city where hate crime is perceived to be more common.¹⁶ Many LGB people are 'normalising' abuse as an expected part of daily life as a coping strategy.¹⁷ Reports to the police of hate incidents which are targeted at people because of who they are, such as racist or religiously-motivated crimes or incidents against lesbian, gay, bi, or trans

people, have been declining over recent years, but remain of particular concern to these communities.

During 2012/13 the Anti-social Behaviour and Hate Crime Casework Team started to operate a duty line for receiving reports, and in its first year of operation (May 2012 to April 2013) 613 incidents have been recorded on the duty system, of which 386 related to ASB, 16 to sexual orientation.

Good nutrition: In the 2012 Health Counts Survey there was little difference in eating the recommended five or more portions of fruits or vegetables per day LGB and unsure respondents (50%) and heterosexuals (53%).

Public services: LGBT residents are more likely to be out to their GP than a decade ago; perception of police services is improving; and the majority of LGBT people are comfortable accessing mainstream services. However, some gay men still do not feel "safe" being open about their sexual identity with their GP.¹⁴ LGBT people are the least likely of all communities of interest to be satisfied with public services run by the City Council.¹⁶

Wellbeing and community resilience

Happiness: In the 2012 Health Counts survey heterosexual respondents were more likely to be more satisfied with their life, feel the things they do are worthwhile, have higher levels of happiness and be less anxious than LGB and unsure respondents, however none of these differences were significant. There were also no significant difference results for any LGBU group.

Life satisfaction: In Brighton & Hove 86% of people were very or quite satisfied with their local area, higher than England (80%) and the South East (83%). For heterosexual residents 87% were very or quite satisfied but this was lower for LGBT residents at 77%. The majority of LGBT people living in Brighton & Hove (over 80%) are happy with where they live and many people live in Brighton & Hove because of its LGBT friendliness.¹⁴

Belonging: The vast majority of LGBT people report that it is easy/very easy to live in the city as an LGBT person. Over a third of those with a disability/long-term health impairment found living in Brighton & Hove easy/very easy. A quarter found

¹⁵ Browne K, Lim J. Count Me In Too: Housing Report: University of Brighton and Spectrum; 2008. <http://www.countmeintoo.co.uk/housing.php> [Accessed 20/08/2012].

¹⁶ Brighton & Hove City Council. The Place Survey 2008. <http://consult.brighton-hove.gov.uk/portal/lsp/place/place08> [Accessed 20/08/2012].

¹⁷ Brighton & Hove Partnership Community Safety Team. LGBT hate crimes and incidents strategic assessment extract; 2010.

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it difficult/very difficult.¹⁸ 25% of deaf respondents said they found it easy or very easy to be an LGBT deaf person in Brighton & Hove compared with 76% of the overall sample. LGBT deaf people experienced difficulties with services, health, safety and housing. Some LGBT people feel marginalised and isolated even within LGBT communities.¹⁹

However, heterosexual people in the city were more likely than LGBT residents to believe their local area to be a place where people from different backgrounds get on (87% versus 76%).¹⁶

LGBT people are more likely than heterosexual people in the city to volunteer.¹⁶

Social connectedness: There are high levels of reported friend and partner support for LGBT people in Brighton & Hove. LGBT groups experiencing significant levels of marginalisation and isolation and feeling that their local area is not inclusive for people from different backgrounds include LGBT BME people, those with hearing impairments and those who are HIV positive.⁴

Developing well

In the 2012 Safe and Well at School Survey (SAWSS) conducted in secondary schools across the city:

- 93% of pupils aged 11-16 years stated their sexual orientation as heterosexual; 3% as LGB and 3% as unsure.

LGB and unsure 11-16 year old pupils are:

- Less likely to enjoy coming to school; feel safe at school; or have good friends in or out of school; less likely to be happy and more likely to have been bullied, truanted (LGB only) or excluded (LGB only) than heterosexual pupils.
- Less likely to participate in physical activity.
- LGB pupils were much more likely to have tried cigarettes than heterosexual pupils.
- LGB pupils were much more likely to have drunk alcohol in the last week; to have drunk

on more days; and LGB and Unsure pupils to drink with the intention of getting drunk or to have used non-prescription drugs than heterosexual pupils.

- LGB pupils aged 14-16 are more likely to have ever had sex (41%) compared with heterosexual pupils (19%) and pupils unsure about their sexual orientation (29%).²⁰

Surveys undertaken by Allsorts, a local support project for LGBT young people, reflect the increased vulnerability of this group to mental health issues: Of the 42 LGBT young people surveyed, over the last three months:

- 55% had experienced mental health problems (e.g. depression and anxiety that had left them feeling unable to cope)
- 79% had felt low and had been troubled by fears, obsessive thoughts or habits
- 55% said they had suffered some form of homophobic/biphobic/transphobic incident/discrimination/harassment or bullying
- 50% had done something to injure or harm themselves
- 50% had contemplated suicide and 17% had attempted suicide²¹

Living well

General health: In the Health Counts 2012 survey LGB and unsure respondents (79%) were less likely to say that they were in good or better health than heterosexuals (85%), though the difference is not statistically significant.

82% of lesbian and bisexual women resident in the city reported their health as excellent or good (compared with 81% in Britain).¹⁴ For men 78% of gay or bisexual men in the city reported very good or good health compared with 76% in England.

Some groups were less likely to rate their health as good or very good, including those who identified as deaf, disabled/long-term health impaired or HIV positive; those who were older; those on low incomes; those in temporary/council housing; and those who had mental health difficulties.¹⁵

¹⁸ Browne K, Lim J. Count Me In Too: Disability & LGBT Lives: University of Brighton and Spectrum; 2009. http://www.countmeintoo.co.uk/deaf_and_disabled.php [Accessed 20/08/2012].

¹⁹ Browne K and Lim J. Count Me In Too: Deaf LGBT lives: University of Brighton and Spectrum; 2009. http://www.countmeintoo.co.uk/deaf_and_disabled.php [Accessed 20/08/2012].

²⁰ Brighton & Hove City Council. Safe and Well at School Survey. 2012. Summary briefing available at www.bhlis.org/surveys

²¹ Allsorts Youth Project. Allsorts Survey Report, Quarter 4 Jan - March 2013

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Emotional health and wellbeing: Almost one in five CMIT respondents described their mental and emotional health as poor or very poor over the last year, and only one fifth of respondents had not experienced difficulties with one or more of these issues in the past five years. Lesbians / gay women (65%) and gay men (64%) were far more likely to describe their emotional and mental wellbeing as good/very good compared with those identifying as bisexual (57%) and queer (48%).⁶

Physical activity: In the 2012 Health Counts Survey there was little difference in meeting the recommended physical activity levels between LGB and unsure respondents (22%) and heterosexuals (26%).

The LGBT community and young LGBT men were identified as having specific physical activity needs by key stakeholders taking part in semi-structured interviews during 2011 (see section 7.3.3).

Nationally, a quarter of gay and bisexual men meet recommendations for 30 minutes or more of exercise five times or more per week, 21% in Brighton & Hove, compared with 39% of men in general.¹²

Healthy weight: In the 2012 Health Counts survey Heterosexual respondents (45%) and LGB, unsure and other respondents (47%) were as likely to be of healthy weight, the small difference was not statistically significant.

In Brighton & Hove 47% of gay and bisexual men are overweight or obese compared with 44% of gay and bisexual men across England (70% of men in general).¹² 45% of lesbian and bisexual women in Brighton & Hove are overweight or obese (compared with 47% in Britain).¹³

Nationally, almost half of gay and bisexual men worry about the way they look and wish they could think about it less; in Brighton & Hove 17.5% (England 13%) had been told they had a problem with their weight or eating in the last year compared with 4% of men in general.¹²

23% of lesbian and bisexual women in Brighton & Hove had ever been told they had an eating disorder, the same proportion as in Britain.¹³

Smoking: In the 2012 Health Counts survey LGB and unsure respondents (30%) are more likely to say that they smoke than heterosexuals (22%) –

though neither group was significantly different to all respondents. The highest smoking prevalence is seen amongst bisexuals (40%) – significantly higher than for all respondents.

A third of LGBT CMIT respondents said that they smoked cigarettes.¹⁴

Nationally, a quarter of gay and bisexual men say they currently smoke and in Brighton & Hove this is 22%.¹²

In Brighton & Hove 20% of lesbian and bisexual women smoke (compared with 26% in Britain).¹³

Alcohol and drugs: In the 2012 Health Counts Survey there was a small difference in drinking at increasing or higher risk drinking between LGB and unsure respondents (17%) and heterosexuals (23%). LGB and unsure respondents (63%) are statistically significantly more likely to have ever taken drugs than all respondents (40%), the figure for heterosexual respondents was 38%.

The alcohol needs analysis²² indicates that Lesbian, gay, bisexual and transgender people living in St. James Street and Kemp Town were more likely to drink alcohol than those in other areas; those who lived in rented and privately owned property were more likely to drink than those in social housing; and those who were frequently concerned about their use of alcohol or amount they drank had experienced problems in getting accommodation.

There is an under-representation of the lesbian, gay, bisexual and transgender (LGBT) community within the substance misuse treatment population (8%) in treatment compared with an estimate of 13% within the City).²³ Use of substances within this community may not be problematic, however given evidence of higher levels of use and under-representation within treatment it is possible that a gap in provision exists. The LGBT community are over represented in respect of use of “Club Drugs” 40% (n=19) of the 48 people in treatment who were being supported for use of these substances come from this community.

In Brighton & Hove 50% (of gay and bisexual men report drinking alcohol on three or more days a week – higher than England (42%) and 35% of men

²² Brighton & Hove Community Safety Partnership. Alcohol Needs Assessment. 2010. Available at: www.bhlis.org/needsassessments

²³ Brighton & Hove Drug and Alcohol Action Team. Substance Misuse (drugs) Needs Assessment 2013-14 draft.

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in general across England. Half of gay and bisexual men in England report taking drugs in the last year compared with one in eight men in general, in the city 56% of gay and bisexual men report having taken drugs in the last year.¹²

In Brighton & Hove, 21% of lesbian and bisexual women say they drank on five or more days in the last week (compared with 19% in Britain) and 45% of lesbian and bisexual women had used drugs in the last year (compared with 35% in Britain).¹³

Domestic abuse: Locally, CMIT suggests that in the last five years, 3% of lesbians, 4% of gay men and 3% of bisexuals had experienced sexual assault.

In Brighton & Hove 9% of lesbian and bisexual women had experienced domestic violence (20% from a female and 9% from a male) compared with 28% in Britain).¹³

Nationally half of gay and bisexual men have experienced at least one incident of domestic abuse from a family member or partner since the age of 16 compared with 17% of men in general, in Brighton & Hove 59% of gay and bisexual men reported this; more than a third of gay and bisexual men have experienced at least one incident of domestic abuse in a relationship with a man and this is nearly half in Brighton & Hove (46%); 26% of gay and bisexual male respondents in Brighton & Hove have experienced domestic abuse from a family member since the age of 16; four in five gay and bisexual men in the national survey who have experienced domestic abuse have never reported incidents to the police; of those who did report, more than half were not happy with how the police dealt with the situation – this information is not available at city level.¹²

Sexual health: In the 2012 Health Counts survey LGB and Unsure respondents (35%) were significantly more likely to have had a common sexually transmitted infection (STI) compared with heterosexual respondents (14%).

A quarter of CMIT LGBT respondents had never had a sexual health check-up, but those who are most sexually active are most likely to have had one.¹⁴

In Brighton & Hove 49% of lesbian and bisexual women had ever tested for a sexually transmitted infection (compared with 43% in Britain).¹³

Rates of testing for STIs and HIV are higher in the city than across England according to the Stonewall research. Nationally 24% of gay and bisexual men have never been tested for any sexually transmitted infection compared with 16% in Brighton & Hove.¹²

Men who have sex with men (MSM) are over-represented in people with sexually transmitted infections: rates in this group far exceed those of the general population locally and nationally.

One in ten CMIT respondents had taken part in sex work at some point, and over the past five years 4% have made themselves available for sex in order to have somewhere to stay.¹⁴

Preventing ill-health

Cancer screening: Many lesbian women and their health professionals are unaware of their need for cervical screening.²⁴ A Brighton & Hove survey showed that a quarter of 130 lesbian and bisexual respondents had never been screened or were screened more than five years ago (26% Britain) and only 21% regularly checked their breasts (26% Britain).²⁵

Suicide and self-harm: In the Health Counts survey 2012 LGB and unsure respondents (20%) were more likely to say that they had ever self harmed than heterosexuals (9%), and the difference was statistically significant. The highest percentages were for lesbian/gay women (39%) and bisexuals (41%) – both significantly higher than for all respondents. The figure for gay men was 9%.

Almost a quarter of CMIT respondents say that they have had serious suicidal thoughts, with 7% attempting suicide in the past five years.⁶ Identity groups that are more likely to have had suicidal thoughts and attempted suicide include bisexual and queer people, disabled LGBT people and those living with a long-term health impairment.⁶

In the last year, 4% of gay and bisexual men from Brighton & Hove in the Stonewall survey said that they had deliberately harmed themselves

²⁴ Fish J. Cervical screening in lesbian and bisexual women: a review of the worldwide literature using systematic methods. Leicester: DeMontfort University. June 2009. Available at: <http://www.cancerscreening.nhs.uk/cervical/publications/screening-lesbians-bisexual-women.pdf> [Accessed 08/05/2012]

²⁵ Prescription for Change: Lesbian and bisexual women's health check 2008. http://www.stonewall.org.uk/what_we_do/research_and_policy/3101.asp [Accessed on 26/08/2012]

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compared to 6.5% across England and 2% had tried to take their life in the last year compared with 3% across England.¹²

In Brighton & Hove 5% of lesbian and bisexual women say they tried to take their life in the last year (compared with 6% in Britain) and 17% say that they intentionally harmed themselves (without intending to take their life) (compared with 19% in Britain).¹³

Improving health and promoting independence

Physical disability and sensory impairment: In the 2012 Health Counts survey LGB and unsure respondents (29%) were more likely to say that they have a limiting long-term illness than heterosexuals (26%), though the difference is not statistically significant. According to CMIT 15% of LGBT people identified themselves as having a long-term health impairment or physical disability.

Mental health: In the 2012 Health Counts survey LGB and unsure respondents (46%) were more likely to be at risk of major depression than heterosexuals (37%), though the difference to all respondents is not statistically significant.

In the Stonewall survey 11% of gay and bisexual men in the city had both moderate to severe anxiety and moderate to severe depression compared with 13% across England; 7.6% had moderate to severe depression with mild or no anxiety in Brighton & Hove, 8.5% in England.

The 2007 mental health needs assessment for working age adults in the city identified higher risks among the LGB population. CMIT found that 79% of the city's LGBT population reported some form of mental health difficulties. Bisexual, queer and BME LGBT people more frequently reported experiencing mental health difficulties, as did those who feel isolated and those on a low income.⁶

Bisexual people have high rates of mental health problems, including depression, anxiety, self harm and suicidal thoughts. This has been strongly linked to experiences of biphobia and bisexual invisibility.²⁶

HIV: 7% of CMIT respondents were HIV positive.¹⁴ The Gay Men's Sex Survey (2010) reports that of 289 respondents resident in Brighton & Hove: 19% had never taken an HIV test; 21% last tested negative more than a year ago; and of those who had ever tested, 25% tested HIV positive.

In England 29% of gay and bisexual men have never had an HIV test compared with 21% locally. Of those who had never been tested for HIV in the Brighton & Hove sample 66% said it was because they did not think that they had put themselves at risk and 16% because they had never been offered a test (lower than England at 27%).¹²

In 2011, in 83% of patients in the city, the probable route of transmission was sex between men. The rise in infections acquired through heterosexual sex between 2006 and 2007 was twice the increase through sex between men, but the rate of increase was similar for 2004-2008. It is estimated that one in four gay men with HIV are unaware of their infection²⁷ which is important from a prevention perspective and to ensure correct monitoring to allow treatment to begin as soon as required.

Specific health services

In Brighton & Hove, a survey of lesbian and bisexual women showed that 42% had disclosed their sexuality to almost all GPs or healthcare professionals (compared with 36% in Britain); 57% had no negative experiences of healthcare in the last year (compared with 51% in Britain); 63% had positive experiences (compared with 57% in Britain); and 17% felt there was no opportunity to discuss sexual orientation in a healthcare setting (compared with 22% in Britain).¹³

Nationally and locally 35% of gay and bisexual men who have accessed healthcare services in the last year have had a negative experience related to their sexual orientation. In England a third are not out to their GP or healthcare professionals (out to few or none) but this is lower in Brighton & Hove at 26%. Nationally more than a quarter of gay and bisexual men said their healthcare professional acknowledged they were gay/bisexual after they had come out; a quarter said that healthcare

²⁶ Barker M, Richards C, Jones R, Bowes-Catton H, Plowman T. The Bisexuality Report: Bisexual inclusion in LGBT equality and diversity. The Open University; 2012. Available at <http://www.bisexualindex.org.uk/uploads/Main/TheBisexualityReport.pdf>

²⁷ Health Protection Agency, Sexually Transmitted Infections in Men who have Sex with Men in the UK, 2011 report. http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1317131680627 [Accessed on 26/08/2012]

4.2.3 Sexual orientation

workers had given them information relevant to their sexual orientation; one in five said that their GP surgery displayed a policy that they would not discriminate against people because of their sexual orientation; and two in five reported that their GP had a clear confidentiality policy (44% Brighton & Hove).¹²

Where we are doing well

The community itself has an increasing number of assets, in the form of independent support groups, including Allsorts Youth Project, LGBT Switchboard and Brighton Bothways and BLAGSS (Brighton Lesbian and Gay Sports Society).

Brighton and Hove Clinical Commissioning Group and Brighton & Hove City Council have commissioned the LGBT Health and Inclusion Project, which consults local LGBT people, and uses the information gathered to improve access to services, service provision and delivery.

Predicted future need

As the LGB population of Brighton & Hove ages, they will have additional health and wellbeing needs.

What we don't know

Data on the age, gender, ethnicity and geographical location of the LGBT population in the city is difficult to describe as it is not routinely collected.

Further information

Main sources of information:

- One of the main sources of local information on LGB people is the Count Me In Too (CMIT) research project which utilised data collected in 2006. This was undertaken by the University of Brighton, Spectrum and members of the LGBT communities, and the findings are based on the results from a self-selected survey of 69 focus group attendees and 819 questionnaires <http://www.countmeintoo.co.uk/>.⁴
- The 2010 Annual Report of the Director of Public Health looked at the community resilience of LGBT communities in the city.

- The 2012 Health Counts Survey of over 2,000 adults in the City provides much recent evidence for equalities groups in the City.
- Key findings reflected in other sections of this report are also highlighted.
- Stonewall conducted the largest ever survey of gay and bisexual men's health needs with 6,861 respondents from across Britain and 167 respondents from Brighton & Hove.²⁸ In Brighton & Hove a higher percentage of respondents (96%) were gay, 2% bisexual and 2% other (91; 7%; 2% across Britain).
- A similar survey of lesbian and bisexual women across was conducted in 2007. Brighton & Hove (130 respondents) results are presented here – 80% of respondents were lesbian, 15% bisexual and 5% other (82%; 15%; 4% across Britain).²⁹

The LGBT Health and Inclusion Project <http://lgbt-hip.org/>

Last updated

July 2013

²⁸ Guasp A. Gay and Bisexual Men's Health Survey. Stonewall 2012. <http://www.healthyives.stonewall.org.uk/lgb-health/gay-and-bisexual-men/default.aspx> [Accessed 10/07/2013].

²⁹ Prescription for Change: Lesbian and bisexual women's health check 2008. <http://www.healthyives.stonewall.org.uk/lgb-health/lesbian-and-bisexual-women/> [Accessed 10/07/2013].

4.2.4 Pregnancy and maternity

Why is this issue important?

This section describes the key demographic trends for pregnancy and births for the city and separate sections show the key health and wellbeing issues for preconception and pregnancy care; and maternal and infant health.

Impact in Brighton & Hove

Fertile female population: Population estimates from the Office for National Statistics (ONS) show that there were 65,900 women of child-bearing age (15-44 years) in Brighton & Hove in 2011: 48% of the female population. This compares with 40% in England and 38% in the South East.¹

General fertility rate: The general fertility rate is the number of live births per 1,000 females aged 15-44 years. In 2011, Brighton & Hove had a rate of 49.9 live births per 1,000 women aged 15-44. This is lower than England (64.2) and the South East (63.8). Table 1 shows the general fertility rates trend from 2004 to 2011, however it should be noted that 2004-2010 figures are not currently available based upon Mid Year Estimates revised for Census 2011 changes and so these figures are subject to change.²

	Brighton & Hove	England	South East
2004	47.7	58.4	57.4
2005	49.0	53.5	57.3
2006	52.1	60.6	60.1
2007	50.6	62.1	60.8
2008	53.6	63.9	62.5
2009	52.5	63.8	62.6
2010	53.0	64.4	65.5
2011	49.9	64.2	63.8

Source: Office for National Statistics Vital Statistics Tables
 Note: 2004-2010 figures are not currently available based upon Mid Year Estimates revised for Census 2011 changes.

¹ Office for National Statistics. Population Estimates for England and Wales, Mid-2011 (2011 Census-based). Published September 2012. Available at: <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-262039> [Accessed 08/07/2013]

² ONS Vital Statistics.

Births: Since 2005, when there were 645,835 live births in England and Wales, the number of live births has increased by 12% to 723,913 in 2011. This has significantly changed the average number of children per woman³ - in 2010 this was two children for the first time since 1973 but this has fallen slightly to 1.93 in 2011.⁴

In Brighton & Hove, the number of live births was 3,291 in 2011, an increase of 8% (3,035 births) from 2005 but the same number as in 2010.⁵

Births by country of birth of mother: Across England, there was a continued rise in the proportion of births to mothers born outside the UK: 29% in 2009 from 14% in 1998. However, in 2010 there was a slight fall, with 26% of births to mothers born outside the UK and this has remained the same in 2011.⁶

Table 2: Live births (numbers and %) for the ten most common countries of birth of mother for non-UK born mothers, Brighton & Hove 2011

Country	Number	%
Poland	72	2.2%
Bangladesh	32	1.0%
France	31	0.9%
India	31	0.9%
Germany	30	0.9%
Australia	27	0.8%
United States	26	0.8%
Japan	22	0.7%
Zimbabwe	21	0.6%
Ireland / Slovakia*	20	0.6%
Total	3,306	-

Source: Office for National Statistics Annual Births Files. * Ireland and Slovakia had the same number of births in 2011 and so are both included in the table

The picture is similar in Brighton & Hove where in 1998 14% of births were to mothers born outside

³ The Total Fertility Rate is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates.

⁴ Birth Summary Tables - England and Wales, 2011 (Final). Available at: <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-276693> [Accessed on 08/07/2013].

⁵ Office for National Statistics Vital Statistics Tables.

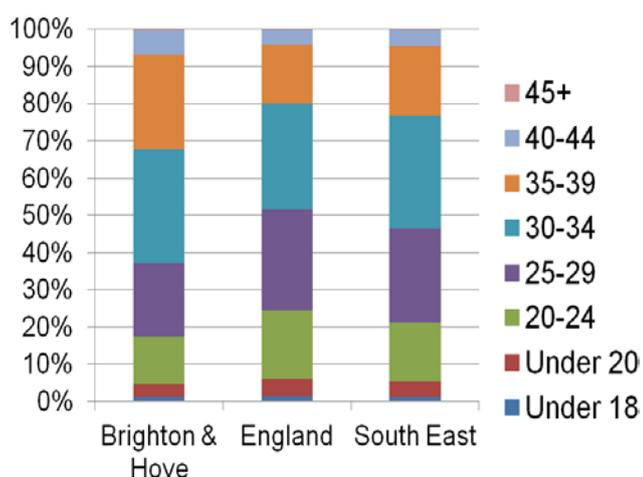
⁶ Office for National Statistics. Parents' Country of Birth - England and Wales, 2011. Published August 2012. Available at: <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-231415> [Accessed 08/07/2013]

4.2.4 Pregnancy and maternity

the UK, rising to 26% of births in 2011.⁷ The greatest proportion of non-UK born mothers in the city is mothers born in the EU (9.3%) and Africa (4.6%). Until 2003 the most common country of birth outside of the UK was Bangladesh, but in more recent years those born in Poland have a greater number of births (Table 2).⁸

Age: Women in Brighton & Hove are much more likely to have children at an older age than across the South East and England (Figure 1). In particular, the proportion of births to mothers in their twenties is considerably lower (33% Brighton & Hove, 42% South East and 46% England). Conversely, the proportion of births to mothers aged 35 or over is much higher (57% Brighton & Hove, 50% South East and 45% England).

Figure 1: Births by mothers' age group, 2011



Source: Office for National Statistics, Births by Area of Usual Residence of Mother, England and Wales, 2011. Available at <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-272510>

Marital status: In 2011, 52% of live births in the city were within marriage. In the South East this was higher at 58% and in England it was 54%.⁹

Ward level: St Peters and North Laine, Moulsecoomb and Bevendean, Hanover and Elm Grove, and Hollingdean and Stanmer wards have the highest number of female residents aged 15-44 years. However Goldsmid has the highest number of births. General fertility rates are highest in Wish and Westbourne wards (Table 3).

Table 3: Female population and general birth rate by ward, 2011

Ward	Live births	Females aged 15-44	General fertility rate
Brunswick and Adelaide	124	2,996	41.4
Central Hove	127	2,418	52.5
East Brighton	184	3,179	57.9
Goldsmid	249	3,922	63.5
Hangleton and Knoll	165	2,708	60.9
Hanover and Elm Grove	196	4,902	40.0
Hollingdean and Stanmer	182	4,512	40.3
Moulsecoomb & Bevendean	176	5,233	33.6
North Portslade	136	2,120	64.2
Patcham	167	2,649	63.0
Preston Park	204	3,584	56.9
Queens Park	131	3,666	35.7
Regency	116	2,978	39.0
Rottingdean Coastal	113	2,450	46.1
St Peters and North Laine	206	6,022	34.2
South Portslade	127	1,992	63.8
Hove Park	102	1,821	56.0
Westbourne	163	2,247	72.5
Wish	154	2,010	76.6
Withdean	164	2,793	58.7
Woodingdean	105	1,737	60.4
Brighton & Hove	3,291	65,900	49.9

Source: Office for National Statistics Vital Statistics Tables and ward level Mid Year Population Estimates 2011 (experimental: Census 2011 based)

⁷ Office for National Statistics. Vital Statistics Tables

⁸ Office for National Statistics Annual Births Files

⁹ Office for National Statistics. Vital Statistics Tables

4.2.4 Pregnancy and maternity

Predicted future need

Population projections have an essential role in assessing the future need for services and understanding changes in birth rates is an important driver of population change.

Fertile female population projections: The fertile female population of the city is projected to decrease by 2% over the next decade (2011 to 2021), but to remain stable across the South East and to increase by 1% across England.¹⁰

Projected births: To estimate future numbers of births the projected general fertility rate is multiplied by the projected fertile female population (and divided by 1,000).

The number of births per year in the city is projected to increase by 5% from 2011 to 2021 – to around 3,500 births per year. This compares with a projected increase of 5% in England and 2% in the South East.¹¹

What we don't know

Information on birth certificates is restricted to the mother's country of birth - traditionally used as a proxy for ethnic origin. However, the value of this has diminished over time as subsequent generations have been born in England.

Sexual orientation, religion, caring responsibility and disability are also not recorded on birth registration.

All projections are based upon assumptions of how the population will change. There could well be unknown factors which mean that these patterns change in unforeseen ways and so projections will always have a degree of uncertainty around them.

Key evidence and policy

The ONS Population Hub gives the methods used for population estimates and projections, along with the estimates:

<http://www.statistics.gov.uk/hub/population>

¹⁰ Office for National Statistics. Subnational Population Projections, Interim 2011-based. Published September 2012. Available at: <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-274527> [Accessed 08/07/2013]

¹¹ Office for National Statistics 2011 births data and Subnational Population Projections, Interim 2011-based. Published September 2012. Available at: <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-274527> [Accessed 08/07/2013]

Recommended future local priorities

See maternal and infant health and maternity care.

Key links to other sections

- Our population
- Parenting
- Maternal and infant health
- Teenage conceptions and teenage parents
- Maternity care

Further information

ONS Population Estimates

<http://www.statistics.gov.uk/hub/population>

Births and deaths profile:

<http://www.bhlis.org/profiles/profile?profileId=170&geoTypeId=>

Last updated

July 2013

4.2.5 Gender identity and trans people Brighton & Hove JSNA 2013

Why is this issue important?

The term transgender, or trans, is used as an umbrella term to describe people whose gender identity differs from their biological sex at birth. Some transgender people will choose to transition socially and some will also take medical steps to physically transition to live in the gender role of their choice.

The term trans also includes a broader group of people who find their personal experience of their gender differs from the assumptions and expectations of society, such as people who are intersex, androgyne, polygender or genderqueer. They may also experience some of the issues related to being labelled by others as a gender that doesn't match their gender identity.

National research reveals significant inequalities in health and wellbeing faced by trans people^{1,2,3} including an increased risk of mental ill health.

There is no reliable information regarding the size of the trans population in the UK. Recent estimates⁴ suggest that 0.6% to 1% of adults may experience some degree of gender variance. A small proportion will have presented for, and undergone, medical gender transition (approximately 12,500 and 7,500 respectively).

Key outcomes

National outcomes

None of the indicators in the national Public Health, NHS or Adult Social Care Outcomes Frameworks are specifically focussed on trans people, but cover all people. However gender reassignment is a 'protected characteristic' in the Equality Act 2010 and public sector organisations are required to have due regard to the need to advance equality of opportunity and eliminate discrimination faced by trans people.⁵

¹ Browne K, Lim J. Count Me In Too. Trans People. Additional Findings Report. University of Brighton and Spectrum; 2008.

² Williams et al. The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document; 2013

³ MacNeil et al. Trans Mental Health Study 2012. The Scottish Transgender Alliance, 2012

⁴ GIRES. The Number of Gender Variant People in the UK - Update 2011. GIRES; 2011

⁵ Mitchell, Howarth. Trans Research Review. Equality and Human Rights Commission. Research Report 27; 2009.

Local outcomes

In 2013 a Brighton & Hove Trans Equality Scrutiny Panel made a set of recommendations to address Trans needs and set up some clear outcomes for the Council and NHS. Both the Council and NHS have adopted these recommendations and are in the process of turning them into outcomes.

Impact in Brighton & Hove

In 2006, a survey, Count Me In Too¹, was conducted of the LGBT population of Brighton & Hove. Of a total of 804 respondents, 5% (43) were trans, although it is unclear if this representation is proportionate.

A 2009 report⁶ used data from health services to estimate the prevalence of "people who have presented with gender dysphoria" by police force area level. This suggested that Sussex had the highest prevalence in England (more than twice the national average) and the report concluded that this was related to the perception that Brighton & Hove is a favourable environment for trans people.

In the 2012 Brighton & Hove Health Counts survey 0.9% of respondents (18 out of 2,014) indicated that they did not identify as the gender they were assigned at birth.

Allsorts, a project based in Brighton to support and empower young people under 26 years who are lesbian, gay, bisexual, trans* or unsure (LGBTU) of their sexual orientation and/or gender identity, are in contact with 55 young trans* people.⁷ Each quarter Allsorts survey the young people they are in contact with and the latest survey (January-March 2013) was completed by nine trans* young people. All had experienced mental health problems (things like depression and anxiety that had left them feeling unable to cope) and had felt low and had been troubled by fears, obsessive thoughts or habits.

With a small sample it is not possible to compare exact percentages from this survey with all young people, however the results indicate some significant health and wellbeing issues within this group. More than two thirds of respondents, in the last three months had:

⁶ Reed et al. Gender Variance in the UK: Prevalence, Incidence Growth and Geographic Distribution. GIRES; 2009

⁷ Allsorts submission in the 2013 JSNA call for evidence

4.2.5 Gender identity and trans people Brighton & Hove JSNA 2013

- suffered some form of homophobic/biphobic/transphobic incidents/ discrimination/ harassment or bullying
- difficulties with relationships
- been drunk

More than a third of respondents had:

- done something to injure or harm themselves
- contemplated suicide
- had unprotected sex⁷

In 2013 the results of the Brighton & Hove Trans Equality Scrutiny Panel were published.⁸ This aimed to highlight the challenges and inequalities facing transgender people locally and to make some recommendations for change. It set out to answer the question: *what needs to be done to make things fairer for trans people to live, work and socialise in the city?*

The panel identified:

- A lack of knowledge on numbers and needs of trans people accessing services. The report recommended a needs assessment is conducted.
- The importance of health and health services including experience of primary care and the transition pathway (including Gender Identity Clinic), and mental health needs. Therefore a number of recommendations are made for health bodies, including the Clinical Commissioning Group.
- Some evidence of inadequate or inappropriate service provision in Housing, adult social care, sports and leisure. Many of these findings echoed those reported in Count Me In Too.

Where we are doing well

The community has a number of assets, in the form of independent support groups, including the Clare Project, Transformers (run by the Allsorts Youth Project), FTM Brighton and MindOut.

Local good practice includes:

- the publication of a Trans* Inclusion Toolkit for schools and colleges⁹ (jointly produced by Brighton and Hove City Council and Allsorts Youth Project)
- the LGBT Health and Inclusion Project, which is commissioned by the City Council and the Clinical Commissioning Group to consult local LGBT people, and use the information gathered to improve access to services, service provision and delivery.

The Allsorts survey suggests that less than a third of young trans* people they surveyed had taken drugs in the last three months, and over two thirds had never smoked. Although over a third of young people had had unprotected sex in the last three months, the same number had been tested for an STI in the same period.⁷

Local inequalities

Overall, Count Me In Too demonstrates higher needs among trans people than the LGB community. Directly comparable information is not available in all cases for the whole population, so in some cases the results below are compared with the LGB community.

Count Me In Too¹ found that the majority of the trans respondents were White British (93%) and identified as female (67%). Trans respondents were significantly more likely to be over 45 years than the LGB respondents, with only 9% under 26. Over a third of trans people surveyed (35%) reported a disability or long-term health impairment. This is significantly higher than the proportion of disabled working age women and men in the city (19% and 20% respectively for 2010/11).

As well as being more likely to report long-term health impairments, only 44% of trans people reported that they were in 'good/very good' health, compared with 76% of all people in the city.¹⁰

Count Me In Too found that trans people report difficulties in accessing a trans friendly or non-transphobic GP; find sexual health information that

⁸ Brighton & Hove City Council. Brighton & Hove Trans Equality Scrutiny Panel. 2013

⁹ Brighton & Hove City Council. Trans Inclusion Toolkit: Supporting transgender and gender questioning children and young people in Brighton and Hove schools and colleges; 2013

¹⁰ Brighton & Hove City Council. The Place Survey; 2008. <http://consult.brighton-hove.gov.uk/portal/lsp/place/place08> [Accessed 06/08/2013]

4.2.5 Gender identity and trans people Brighton & Hove JSNA 2013

is appropriate to their gender identity or sexuality; and that there is general dissatisfaction with gender reassignment services. Opinions echoed those found nationally¹¹: that there were delays in access to the service and that the 'one size fits all' approach was unacceptable.

Count Me In Too¹ reported that trans people were twice as likely to have thoughts of suicide and five times more likely to have attempted suicide in the past year than LGB people, with only 26% reporting 'good/very good' emotional wellbeing. 86% of trans people reported mental health difficulties, including depression (76%) and anxiety (71%). Respondents described the need for mental health support both during and after transition.

Trans people are more likely to experience hate crime both in the street and at LGBT venues, with 26% reporting experiences of physical violence. 47% reported direct or indirect discrimination from providers of goods, services or facilities in the city, and 64% had experienced domestic violence, compared with 18% of men and 28% of women nationally.

The apparent under-reporting of hate crime, including trans related incidents, was noted by the Trans Equality Scrutiny Panel.⁷ There is a need to improve the processes and systems for the recording of transphobic crimes and incidents.

Count Me In Too¹ also highlighted inequalities in employment and housing. Trans respondents were 11 times less likely to earn over £30,000 a year and the majority earned less than £10,000 a year. A third of trans respondents lived in social housing; over half reported that they had struggled to find housing; and 36% had experienced homelessness.

Predicted future need

As the trans population of Brighton & Hove ages, they will have additional needs for health and wellbeing. Little is currently known about what these needs will be, as this will be the first generation who have taken hormone therapy for a prolonged period, or undergone gender reassignment surgeries in the 1960s or 1970s.¹²

¹¹ Equality and Human Rights Commission. A review of access to gender reassignment services (England Only); 2011 <http://www.equalityhumanrights.com/legal-and-policy/equality-act/>

¹² Age UK. Transgender issues in later life. Factsheet 166; 2010.

What we don't know

The number and demographics of trans people living in the city is unknown. With no published research into the health and wellbeing of trans people since Count Me In Too it is unclear if the inequalities above have changed. Indeed, work has been done to reduce them, e.g. the LGBT Health and Inclusion Project intervention ('Clued Up') to increase uptake of sexual health services among trans people.

Key evidence and policy

The Equality and Human Rights Commission, the Government Equalities Office and the Home Office recently published guidance for public authorities on meeting the needs of trans people, including recommendations for healthcare providers, local government and social care.^{13 14 15}

Recommended future local priorities

1. Implement the action plan agreed based on the recommendations of the Brighton & Hove City Council Trans Equality Scrutiny review.
2. Continue joint working with the trans community through the LGBT Health and Inclusion Project.
3. Improve knowledge by conducting a multiagency needs assessment.
4. Support existing assets of the trans community: independent, volunteer-run support groups.

Key links to other sections

- Emotional health and wellbeing;
- Suicide prevention

Further information

Count Me In Too

<http://www.countmeintoo.co.uk/>

The LGBT Health Inclusion Project

¹³ Equality and Human Rights Commission. Provision of Goods, Facilities and Services to Trans People. Guidance for public authorities in meeting your equality duties and human rights obligations; 2010.

¹⁴ Government Equalities Office. Equality Act 2010: What do I need to know: A quick start guide to gender reassignment for voluntary and community organisations in the provision of goods and services; 2010.

¹⁵ Home Office. Advancing Transgender Equality: A plan for action. HM Government. London, UK; 2011

4.2.5 Gender identity and trans people Brighton & Hove JSNA 2013

<http://lgbt-hip.org/>

Brighton & Hove Trans Equality Scrutiny Panel

<http://www.brighton-hove.gov.uk/content/council-and-democracy/councillors-and-committees/trans-equality-scrutiny-panel-2013>

Last updated

August 2013

Why is this issue important?

Refugees have fled persecution and human rights abuses in their countries of origin and therefore bring with them to the UK the health problems associated with traumatic past histories, difficult and dangerous journeys, and the challenges of settling in a new community and country.

Asylum seekers and refugees are recognised to have high health need compared with other groups, with evidence that their health deteriorates in the first 2-3 years following arrival in the UK.¹

The 1951 Refugee Convention provides an internationally recognised definition of a refugee which then imposes on a state the duty to protect and support a person granted Refugee Status. An asylum seeker is an individual who has applied for protection in a country (has asked to be formally recognised as a refugee) and is going through the legal process of waiting for this application to be determined.²

Whilst there is a clear legal distinction between asylum seekers and those with Refugee Status, the subjective experiences of those going through the process will make it difficult to differentiate the health needs of these two groups. In addition, there is an overlap with the general black and minority ethnic communities, wider migrant communities and other vulnerable migrant groups who may share many of the same challenges and needs, including those whose asylum applications have been refused.

Health needs of refugees and asylum seekers:

Mental health: Low-level and acute mental health problems are often experienced as result of displacement, isolation, uncertainty, loss of social status and poverty. Many may suffer Post-traumatic Stress Disorder from atrocities and multiple losses. Anxiety, depression and sleep problems are common.³

¹ Burnett A, Fasil Y. Meeting the health needs of refugees and asylum seekers in the UK: An information and resource pack for health workers. Department of Health; 2002. Available at: http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_073382.pdf [Accessed 29/04/2012].

² UNHCR. The 1951 Refugee Convention. Available at: <http://www.unhcr.org/pages/49da0e466.html> [Accessed 29/04/2012].

³ Mind. A civilised society: mental health provision for refugees and asylum seekers in England and Wales. Mind: London; 2009.

Maternal health: The 8th Confidential Enquiry into Maternal and Child Health⁴ identified a significant reduction in the deaths 28 from 35 among Black African mothers. These improvements demonstrate how maternity services have changed to reach out and care for a group of vulnerable mothers, many of whom have sought refuge within our shores and who often present with medical and social challenges and for whom difficulties in the asylum seeking process may delay access to antenatal care. Some women may have been victims of rape or sexual violation leading to unwanted pregnancies or sexually transmitted infections. Female genital mutilation can lead to obstetric complications. There is low uptake of breast and cervical screening amongst asylum seeker and refugee women.⁵

Communicable diseases: Depending upon the country of origin, circumstances of migration and underlying health, some groups of asylum seekers and refugees may have high rates of certain diseases e.g. malaria, tuberculosis (TB), HIV and hepatitis. Lack of trust and appropriate information may delay diagnosis and access to treatment and care. In 2010, 73% of TB cases reported in the UK, almost 60% of newly diagnosed cases of HIV, and 80% of Hepatitis B infected UK blood donors were born abroad.³

Sexual health: Cultural or religious beliefs around sexual practices; the availability and use of contraception; and experience of sexual violation may influence rates of sexually transmitted infections.⁵

Uptake of healthcare services: A number of factors affect the uptake of healthcare services:

- Understanding of the UK health system, and in particular the role of the GP
- Differing health seeking behaviours and expectations of healthcare services
- Language, literacy and cultural differences

⁴ Confidential enquiry into maternal and child health. Saving Mothers Lives: reviewing maternal deaths to make motherhood safer, 2006-2008. The 8th report of confidential enquires into maternal deaths in the UK; March 2011.

⁵ Health Protection Agency. Migrant health: infectious diseases in the non-UK born populations in the UK. An update to the base line report; Dec 2011. Available at: http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1317131996733 [Accessed March 2012]

- Cultural awareness and sensitivities of the UK health and social care workers that may impact on proactive offering of help
- Changing entitlements to healthcare services
- Poverty acting as a barrier to access⁴

Key outcomes

None of the indicators in the Public Health, NHS or Adult Social Care Outcomes Frameworks are specifically targeted at refugees and asylum seekers. However, there is Department of Health guidance on providing NHS treatment for asylum seekers and refugees.⁶

Impact in Brighton & Hove

We do not know exactly how many refugees live in Brighton & Hove. However, it is estimated that there are 250 asylum seekers living here at any one time.⁷

Nationally, the number of applications for asylum in the UK in 2012 was 21,785 (excluding dependants), 10% higher than in 2011 (19,865).⁸ The top ten countries from which asylum applicants in the UK originate are Pakistan, Iran, Sri Lanka, Indian, Bangladesh, Afghanistan, Syria, Nigeria, Albania and Eritrea. Of the total, 37% had been granted asylum, 50% cases had been refused; of these 27% were allowed through on appeal and a further 13% were awaiting decision or appeal. There were 24% fewer people granted permission to stay permanently (settlement), falling to 126,891, the lowest level in the last five years. Those who are most likely to be approved (given leave to remain in the UK in the longer term) are from Syria, Eritrea, Sudan, Sri Lanka, Somalia and Iran.⁹ There were fewer applications from unaccompanied children over 2012 1,168. Of these 22% from Afghanistan with 82% male. Data for dependants, including women and children is not yet available but in 2011 only 275 of applications

were by women and varies hugely by country with the majority of applicants from Pakistan, Iran, Nigeria, Eritrea and China.⁹

Brighton & Hove currently has no designated accommodation for asylum seekers. Most asylum seekers in the city will therefore be dependent for accommodation and support on members of their own communities and they may have come to Brighton & Hove because those communities exist here. We can conclude, therefore, that our significant Iranian and Sudanese communities will be continuing to receive and support new arrivals from these countries, many of whom will be granted leave to remain here, possibly indefinitely.

As well as these asylum-seeking households, 60 unaccompanied asylum-seeking children and care leavers are being looked after by Brighton & Hove City Council. In addition, there are a small number of young people placed in Brighton & Hove by other local authorities.¹⁰ There are a very small number of asylum seekers being supported by adult social care because of their high mental and physical health needs.

Quantifying our refugee population is more difficult. Many members of our Sudanese Coptic Christian community, for example, which has around 5,000 members, would no longer consider themselves to be refugees, although the first generation arrived in the UK as a result of persecution and conflict and may still have some of the social and mental health difficulties associated with displacement to a new culture.

However, Brighton & Hove Refugee and Migrant Forum counts amongst its members a number of organised groups representing a wide range of refugee populations – various groups from Sudan (both Christian and Muslim), Iran, Sierra Leone, Gambia, the Kurdish community and the Oromo community from Ethiopia, and we are also aware of refugee populations in the city from Afghanistan, Palestine and elsewhere.

⁶ Department of Health. Guidance on providing NHS treatment for asylum seekers and refugees. 2012

<https://www.gov.uk/government/news/guidance-on-providing-nhs-treatment-for-asylum-seekers-and-refugees>

⁷ Brighton & Hove Refugee & Asylum Seekers' Forum 2012.

⁸ Gov.uk. Immigration statistics Oct-Dec 2012. Available from;

<https://www.gov.uk/government/publications/immigration-statistics-october-to-december-2012> [Accessed 21/05/13]

⁹ British Refugee Council Information briefing; asylum statistics Feb 2013> Available from URL; www.refugeecouncil.org.uk.

¹⁰ Mind. Commissioning mental health services for refugees, asylum seekers and vulnerable migrants; Summative report of local scoping and initial consultation. NHS Brighton and Hove; December 2011.

Where we are doing well

There are a number of local community organisations that work with refugees and asylum seekers which could provide strong links for developing two way communication, trust and joint initiatives with these communities.

There is an updated directory of services for the refugee and asylum seeking communities..¹¹

Asylum seeking children and young people under 18 who arrive in Brighton & Hove separated from their parents or other caregivers are assessed for support by the Council's 16+ support team.¹²

In recognition of the specific needs of these populations there are a number of targeted statutory sector posts including a specialist case worker post in Adult Social Care and a Specialist Community Safety Manager.

Local inequalities

Nationally applicants tend to be young, in 2011, over half (58%) were between the ages of 21 -34 and 73% male and many with general health needs similar to those of the UK population of the same age.

For young age groups, acute infectious illnesses, minor accidents and trauma, reproductive health issues and child health concerns tend to be the most commonly encountered health needs. Around 30% of asylum seekers are single young men.

Ethnicity acts as a risk factor for certain conditions such as sickle cell disease or thalassaemia.¹³

Predicted future need

Migration to the UK – by those seeking asylum and others – is unpredictable and dependent on world events and EU migration policies as well as UK government policy.

Changes in funding for support services, Legal Aid for immigration matters and UK Border Agency priorities will impact on the ways that the needs of asylum seekers and refugees are met. The ongoing

programme of welfare reform will also have implications for the resident refugees and there is a greater need for budgets for interpreters and translation.

What we don't know

There is a lack of detailed information about refugees and asylum seekers living in the city.

There are also a number of other vulnerable migrant groups and little is known about their health and wellbeing needs. These include:

- Undocumented or irregular migrants including people with No Recourse to Public Funds
- Victims of people trafficking
- Other new arrivals to the UK entering our BME communities e.g. recently arrived spouses or family joiners
- Migrant workers from the EU and outside the EU
- International students and their families

Key evidence and policy

Taylor K. Asylum seekers, refugees, and the politics of access to health care: a UK perspective. *British Journal of General Practice* 2009; 59 567):765-772 (October 2009)

The UK Border Agency co-ordinates the Governments policy on asylum seekers and refugees. <https://www.gov.uk/uk-border-agency>

Independent advice and support is provided by the British Refugee Council
<http://www.refugeecouncil.org.uk/>

Recommended future local priorities

Recommendations from a recent scoping report¹⁴ fall into four broad groups:

1. Data gathering and needs assessment
2. Community engagement and development
3. Demonstrate organisation's commitment to equality and diversity work
4. Development of specific and culturally sensitive outcomes

¹¹ Accessible from URL: <http://www.brighton-hove.gov.uk/index.cfm?request=b1126962>

¹² Accessible from URL: <http://www.brighton-hove.gov.uk/index.cfm?request=c1129245>

¹³ 2 Streetly, A., Latinovic, R., and Henthorn, J. 2010. *J Clin Pathol*, 63, 626-629. Available at: <http://jcp.bmj.com/content/63/7/626.full.pdf>

¹⁴ Mind. Commissioning mental health services for refugees, asylum seekers and vulnerable migrants; summative report of local scoping and initial consultation. NHS Brighton and Hove. December 2011.

4.2.6 Refugees & asylum seekers

Brighton & Hove JSNA 2013

Key links to other sections

- Ethnicity
- Children in need, safeguarding, child protection and looked after children
- Happiness and wellbeing
- Housing needs
- Mental health

[on-providing-nhs-treatment-for-asylum-seekers-and-refugees](#)

Last updated

August 2013

Further information

The **Refugee and Migrant Forum** (chaired and administered by the council's Partnership Community Safety Team) has produced a short directory of local specialist services working with refugees, asylum seekers and other vulnerable migrants in Brighton & Hove. This was last updated in September 2011.

http://www.brighton-hove.gov.uk/downloads/bhcc/socialcare/refugees_and_migrants/Specialist_migrant_services_in_BH_Sept_11.pdf

Brighton Voices in Exile, a registered charity, is the largest provider of services reaching out to asylum seekers, refugees and those with no recourse to public funds within Sussex.

<http://www.brightonvoicesinexile.org>

Health Protection Agency. Migrant Health Guide.

<http://www.hpa.org.uk/MigrantHealthGuide/>

Refugee Council

<http://www.refugeecouncil.org.uk/>

South East Migrant Health Network

<http://migranthealthse.co.uk/>

Understanding the health needs of migrants in the South East region: A Report by the South East Migrant Health Study Group on behalf of the Department of Health. 2010.

http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1284475770868

Dr Linda Morrice Hidden Histories; Migrants in Brighton University of Sussex

<http://www.sussex.ac.uk/cce/hiddenhistories/migrantsbrighton> or

<http://hiddenhistories.euproject.org>

Department of Health. Guidance on providing NHS treatment for asylum seekers and refugees. 2012

<https://www.gov.uk/government/news/guidance->

Why is this issue important?

The majority of care provided within the UK is by family members, friends and relatives. Carers provide unpaid care by looking after an ill, frail or disabled family member, friend or partner. The 2011 Census shows just under six million people provide unpaid care in England and Wales, representing over one tenth of the population (10.3 per cent).¹

Nationally 58% of carers are aged 50 years and over. Nearly 1.5 million,¹ of all carers provide 50 hours or more of unpaid care, 65% of this group are aged 50 years and over.

The evidence identifies that unpaid care has increased at a faster pace than population growth between 2001 and 2011 in England and Wales.¹ It is anticipated that the population of carers will rise to nearer 9 million by 2037, with every year two million people take on caring responsibilities.² The national information reinforces the message from carers regarding the impact on their health, that those providing unpaid care were more likely to report their general health as 'not good', compared with those providing no unpaid care.³ Census 2011 data indicates that the general health declines as hours of unpaid care increases, for example 83% of those providing no unpaid care report "very good or good health", compared to 56% of those providing 50 or more hours for care per week.¹

There are an estimated 177,918 Young Carers in England and Wales, according to the 2011 Census.⁴ Although this has been described as the "tip of the iceberg", as many young carers remain hidden due to a range of reasons, including family loyalty, stigma, bullying, and not knowing where to go for support.⁵ The term "young carer" includes children and young people under 18 years old (aged 5 to 17 years), who provide unpaid care for family members, neighbours or others because of a long

term physical or mental illness, disability or problems related to age.⁵

The number of young carers reported within the Census has increased by 41% within the South East since the 2001 Census, from 17,692 in 2001 to 24,974 in 2011.⁵ It is estimated that young carers are 1.5 times more likely to be from Black, Asian or minority ethnic communities.⁵ Additionally research has identified that the average annual income for families with a young carers is £5,000 less than families who do not have a young carer.⁶

Parent carers are people with parental responsibilities (parents, grandparents, foster parents, adoptee parents and others) who also provide additional care, assistance and support to children with learning or physical disabilities, complex health needs or illness, or emotional behavioural difficulties. Parent carers face issues which are reflected by all carers; however there are further issues which are more specific to the needs of parent carers – including issues related to accessing educational support for the child they care for. Additionally, on average, it costs three times the amount to raise a disabled child compared to raising a child with no disabilities.⁶

Key outcomes

- ***Enhancing quality of life for carers (NHS Outcomes Framework)***
- ***Carers can balance their caring roles and maintain their desired quality of life (Adult Social Care Outcomes Framework)***
- ***Carers feel that they are respected as equal partners throughout the care process (Adult Social Care Outcomes Framework)***

Impact in Brighton & Hove

The 2011 Census data shows that the City has 23,967 people who identify themselves as carers, which represents 9% of the population. Although this a rise of 2,164 people since the 2001 census, proportionally it is the same (9% of the population). Of those carers:

- 68% provide 1 to 19 hours of care a week

¹ Office for National Statistics. 2011 Census Analysis: Unpaid care in England and Wales, 2011 and comparison with 2001.

² Prepare to Care. Carers Week. 2013.

³ Office for National Statistics. Full Story: The gender gap in unpaid care provision: is there an impact on health and economic position? May 2013

⁴ Office for National Statistics. Providing unpaid care may have an adverse affect on young carers' general health. 04/06/2013.

⁵ The Children's Society. Hidden from view: The experience of young carers in England. 2013

⁶ Every Disabled Child Matters. Disabled Children and Child Poverty – briefing paper. 2007

4.2.7 Carers

- 12% provide 20 to 49 hours per week
- 20% provide 50 or more hours per week¹

The economic value of the contribution made by carers in the UK is estimated at £119 billion per year. For Brighton & Hove this is an estimated contribution of £388.7million (Table 1), an increase of £88million (29%) from the 2007 estimate.⁷ The economic value of carers has increased for two main reasons. First, the costs of replacement care have increased from £14 per hour to £18 per hour which is an increase of 24%. Secondly, the numbers of carers has gone up.

Table 1: Number of carers and economic value of unpaid carers in Brighton & Hove, England and the South East, 2011

	Number of carers (estimated numbers 2011)	Economic value of unpaid carers (£millions)
England	5,346,325	£96,495.1
South East	816,582	£13,418.2
Brighton & Hove	22,876	£388.7

Source: Valuing Carers 2011. Calculating the value of carers support, Care UK and University of Leeds. 2011

The Brighton and Hove Adult Social Care Caring for Others Survey (2012) – survey of a sample of adults’ carers known to Adult Social Care, caring for adults - identified three key themes that carers wanted improved locally:

- Increase social contact
- Better and more accessible Information and advice
- More respite options

The Carers survey will form part of the new Carers Action Plan being developed through the Carers Strategy Implementation Group.

Based on national figures we may expect the following in Brighton & Hove:

- Over 1,000 carers may sustain a physical injury through their caring role and over 1,000 may be treated for a stress related illness
- More than 4,500 carers have been caring for at least 10 years and almost 1,000 for five years or more
- Nearly 4,000 carers look after more than one person.⁸

The Carers Centre is commissioned to provide a Young Carers Project, which offers a range of support locally. This includes one to one support; group activities; schools work; and completion of a Young Carers Assessment. The assessment process enables both the project and statutory agencies to respond appropriately to the needs of young carers. The Young Carers Project supported 168 young carers during 2012-13.

Table 2: The issues most important to young carers in Brighton & Hove

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.

Source: Brighton & Hove multi-agency commissioning and development strategy for carers. 2009-2012.

⁷ Care UK and University of Leeds. Valuing Carers 2011: Calculating the value of carers support. 2011.

⁸ Disabled Children and Child Poverty – briefing paper from Every Disabled Child Matters, 2007.

Local research on parent carers, by Amaze the charity that supports parent carers locally, identified that 76% of respondents to their survey in 2011 had experienced mental health issues, and 65% suffered from physical ill-health or injury as a result of their caring role.⁹

The 2013 Parent carers survey, completed by Amaze, showed over 65% of parents said they spent more than 20 additional hours each week caring for their disabled child (over and above 'normal' parental duties), and more than a third said they aren't in paid work because of their caring responsibilities. A further 22% said they had to reduce their working hours because of their caring responsibilities. Yet more than three quarters of respondents have never received any form of respite or short break.¹⁰

Parent carers in the Amaze survey 2013 wanted more residential respite care, information/advice and counselling services. Over two thirds of parent carers said they felt that they neglected themselves, and have limited sleep due to their caring role. Almost one in five feel anxious, stressed or depressed most or all of the time. Many parent carers, within the survey, expressed being 'fearful' that services for their children may be reduced, and 82% of stated there would be a significant or devastating impact on the family if short break/respite services were reduced.¹¹

Where we are doing well

Brighton and Hove have a Joint Multi-Agency Carers Commissioning Strategy, which drives the investment in supporting carers locally. There are excellent dedicated carers' services, both within the statutory services and within the community and voluntary sector.

The Carers Centre, Amaze and the Alzheimer's Society provide a wealth of support to carers, including information and advice, casework, group activities and consultation/engagement opportunities.

⁹Amaze.
http://www.amazebrighton.org.uk/site_content_files/files/your_caring_role_analysis_report.pdf

¹⁰ Amaze Parent Carers Survey May'13 – full report available on www.amazebrighton.org.uk in July'13

Within the statutory services there are currently dedicated Carer Support Workers who work within the Integrated Primary Care Team, provided a range of support to carers. The evaluation of this approach will feed into future commissioning of services for carers. Additionally, among carers of adults, there is good take up of Carers Assessments within Brighton and Hove, which assist in supporting carers needs. Locally, in 2012-13, the local authority exceeded the target for number of carers assessments completed.

The City Council and Clinical Commissioning Group jointly invest in a range of supports for carers, including the Carers Card (discount card for carers) and the Carers Emergency Back Up Scheme.

The Children's Disability service is currently piloting an Individual Budgets approach for disabled children, to provide more personalised support to them and their families. The outcome of this pilot will also inform future commissioning.

Local inequalities

Nationally 58% of carers are women and 42% men, and this is mirrored in Brighton & Hove.¹ Both nationally and locally the percentage of female carers increases as the number of hours of unpaid care a week increases.

More than half (53%) of carers in the city were aged 50 years or over. The peak age for caring in Brighton & Hove is 50 to 64 years (25% of people in this age group are carers).¹

According to the Census 2011 9% of White British people and 6% of BME groups in the City provide unpaid care.¹

The Compass Database (Amaze) records where all disabled children are living in the City. Disabled children and therefore their carers are more likely to be living in the most deprived neighbourhoods in the city, 23% in East Brighton and 24% in Moulsecomb and Bevendean.⁵

There is a direct link between caring for a disabled child and living in poverty (over 50% of disabled children are living in poverty¹¹). Parent carers are much less likely to be able to return to paid work

¹¹ Preston, G. with Robertson, M. (2006), Out of Reach: benefits for disabled children, London: Contact a Family/Child Poverty Action Group

4.2.7 Carers

(38% of respondents to the 2013 Parent carers survey, completed by Amaze, said that they can't be in paid work because of their caring responsibilities and a further 22% have had to reduce their work hours¹⁰) and this continues for longer - during a child's secondary education too when other parents might feel able to return to work.

There is a paucity of data on other equality groups and caring role within the City.

Predicted future need

The number of people who are older, disabled or HIV positive, or who have mental health problems, dementia, a learning disability or substance misuse problems in the city gives some indication of the likely size of future caring needs.

Table 3: Estimate of the numbers of people who may have caring needs by 2020¹²

872 people with a borderline personality disorder
698 people with an antisocial personality disorder
777 people with a psychotic disorder
14,060 with two or more psychiatric disorders, aged 18-64 years
1,099 people aged 18-64 with a moderate or severe learning disability
18,578 dependant alcohol and drug users in the city, aged 18-64 years
18,074 people aged 16-64 in the city with moderate or severe physical disabilities

Source: Institute for Public Care. PANSI www.pansi.org.uk 2013

Although the proportion of older people living in the City has fallen in recent years, the population aged 65 years or over is predicted to increase and become more ethnically diverse. The largest projected increases are in the 70-74 and 90 and over age groups.¹³

¹²Institute of Public Care. Projecting Adults Needs and Service Information (PANSI). Available at: www.pansi.org.uk (password required) [Accessed June 2013]

¹³Office for National Statistics. Interim 2011 based sub national population projections. <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-274527> [Accessed 12/06/2013]

What we don't know

We are awaiting more of the City level data from the Census 2011, regarding carers, which has not yet been released. We do not have local data on carers from protected groups, except age, gender and ethnicity. Through the Carers Strategy Implementation Group we are working with colleagues across the health and social care sector (including key voluntary organisations) in order to collect more detailed information about carers within the City.

Additionally we will be receiving further data from the local Adult Social Care Carers Survey which is currently being analysed nationally, and the local Amaze Parent Carers survey. This information will also form elements of the Carers Strategy revised Action Plan.

Key evidence and policy

The new Care and Support Bill places a greater emphasis on supporting carers, for the first time, carers will be recognised in the law in the same way as those they care for. With new duties which include providing greater information and advice, meeting assessed eligible needs of carers (which is equivalent to the duty to meet the needs of cared for people), and to have a proactive approach to supporting carers to access carers assessments, through increased identification and recognition.¹⁴

A review of international evidence on interventions to support carers found the strongest evidence of effectiveness related to education, training and information for carers.¹⁵ These increased their knowledge and abilities as carers, and suggested it might also improve carers' mental health and ability to cope/resilience. Earlier this year the government's programme of personalisation – *Think Local Act Personal* – published a report which identified 6 key themes for supporting carers, including; Information and Advice; Active and supportive communities; Flexible and integrated support; Workforce; Risk enablement; and Personal budgets and self funding. The report includes a resource of practical examples under

¹⁴ Department of Health. The Care Bill. 2013

¹⁵ Parker G, Arksey H, Harden M. Meta-review of international evidence on interventions to support carers. University of York; 2010.

4.2.7 Carers

each theme, as well as a toolkit to enable a self assessment process to identify how well your Local Authority is doing in supporting carers. The local Carers Strategy Implementation Group will be using this resource to identify areas for improvement locally.¹⁶

Work with carers is underpinned by three specific pieces of legislation:

- Carers (Recognition and Services) Act 1995
- Carers and Disabled Children Act 2000
- Carers (Equal Opportunities) Act 2004

Policy is also shaped by the National Strategy for Carers.¹⁷

Recommended future local priorities

1. **Identification and recognition** – supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset in designing local care.
2. **Realising and releasing potential** – enabling those with caring responsibilities to fulfil their educational and employment potential.
3. **A life outside caring** - personalised support for carers and cared for, enabling them to have a family and community life.
4. **Supporting carers to stay healthy** – supporting carers to stay mentally and physically well.
5. **Young carers** – children and young people to be protected from inappropriate caring and have the support they need to learn, develop and thrive to enjoy positive childhood and achieve good outcomes.
6. **Parent carers** – Support families in claiming all the benefits to which they are entitled and provide support to carers who are able to continue working and support to return to work where/when possible. Provide early intervention services providing appropriate support (including respite) and resilience-

building services during periods of physical and emotional ill-health to prevent recurrence.

Key links to other sections

- Children and young people with disabilities and complex health needs
- Adults with learning disabilities
- Adults with physical disabilities or sensory impairments
- Adults with Autistic Spectrum Conditions
- Older people – social care
- Coronary heart disease
- Diabetes
- Stroke
- Respiratory disease
- Cancer
- Mental health
- Dual diagnosis
- Dementia
- Musculoskeletal conditions
- HIV/AIDS
- End of life care

Further information

Brighton & Hove Multi-agency Commissioning and Development Strategy for Carers. 2009-2012

http://www.brighton-hove.gov.uk/downloads/bhcc/carers_caring/Carers_Strategy_Summary_2010-12pdf.pdf

Brighton & Hove Carers Survey 2009

[http://www.brighton-hove.gov.uk/downloads/bhcc/socialcare/Carers_Survey_-_summary_for_publication_\(3\).pdf](http://www.brighton-hove.gov.uk/downloads/bhcc/socialcare/Carers_Survey_-_summary_for_publication_(3).pdf)

Last updated

September 2013

¹⁶ Amaze Parent Carers Survey May 2013. Available at: www.amazebrighton.org.uk [Accessed July 2013]

¹⁷ Department of Health. Carers at the heart of 21st century families and communities. 2008

Why is this issue important?

In 2008 a cross-government paper was produced recognising the demands and obligations of those serving in the armed forces and the support needed for members of the armed forces, their families, and veterans.¹

The Ministry of Defence (MoD) defines a veteran as “anyone who has served in Her Majesty’s Armed Forces at any time, irrespective of length of service...”. They are a diverse group with differing needs and experiences, including World War II or National Service veterans; others not engaged in combat; younger veterans from more recent deployments; and Reserve personnel. Nationally, an estimated 8% of adults are veterans.²

The health of military populations is generally comparatively good compared to the wider population due to a combination of factors including the required physical fitness, social support networks, and access to healthcare and employment.^{3, 4} However, self-reported long term illness or disability has been found to be much higher amongst veterans (52%) than the general population (35%), with younger veterans today surviving more severe and complex injuries than before and being more likely to report long term health problems.⁵

Physical risks include being wounded in action, including loss of limbs. Medical discharges account for 11% of people who leave the Services each year, mostly due to injuries and musculoskeletal disorders (e.g. knee and back pain).⁶ The most common mental health problems in veterans are depression and anxiety. Post-traumatic Stress

¹ Ministry of Defence (2008) The Nation’s Commitment: Cross-Government Support to our Armed Forces, their Families, and Veterans CM 7424

² Royal British Legion. Profile and Needs of the Ex-Service Community 2005-2020. Royal British Legion; 2006.
<http://www.britishlegion.org.uk/media/33526/summary%20and%20cons.%20Report.pdf> [Accessed 21/08/2012].

³ Pinder RJ, Iversen A, Kapur N, Wessely S, Fear NT. Self-harm and attempted suicide among UK Armed Forces personnel: Results of a cross-sectional survey. *Int J Soc Psychiatry* 0020764011408534.

⁴ Smith TC, Zamorski M, Smith B, Riddle JR, Leardmann CA, Wells TS and the Millenium Cohort Study Team. The physical and mental health of a large military cohort: Baseline functional health status of the millennium cohort. *BMC Public Health* 2007;7:340.

⁵ Royal British Legion. Profile and Needs of the Ex-Service Community 2005-2020. Royal British Legion 2006.
<http://www.britishlegion.org.uk/media/33526/summary%20and%20cons.%20Report.pdf>

⁶ Defence Analytical Services and Advice. Medical Discharges in the UK Regular Armed Forces 2006/07- 2010/11. 14th September 2011.
<http://www.dasa.mod.uk/applications/newWeb/www/index.php?page=66&pubType=0> [Accessed 21/08/2012].

Disorder (PTSD) is often a concern, but the prevalence among Iraq and Afghanistan veterans (4%) is only slightly higher than in the general population (3%).⁷ Younger male veterans in particular are at increased risk nationally of mental health problems and suicide.

The rate of alcohol misuse among veterans (13%) is much higher than in the general population (4%).⁸ However, veterans are less likely to be heavy drinkers than those still serving.⁹ Those deployed in combat, particularly reservists, are at greater risk of PTSD and alcohol misuse. World War II and National Service veterans generally have similar health needs to others of their generation.

Military veterans have been found to face difficulties relating to housing support and adapted housing. In the past this included difficulties establishing a “local connection” in order to be accepted onto the local housing register or to receive homelessness relief. Since resettlement support has improved the number of homeless veterans has markedly decreased, although research suggests that military veterans are still over-represented in the homeless population.¹⁰

Key outcomes

None of the indicators in the Public Health, NHS or Adult Social Care Outcomes Frameworks are specifically focused on veterans. However the NHS Commissioning Board states that Clinical Commissioning Groups (CCGs) should be supported to deliver the Government’s requirement related to the Armed Forces covenant; in particular for Veterans, Reservists and their families (and serving families not covered by Defence Medical Centres), including: commissioning for prosthetics, mental health and establishing a base line for activity, finance and performance.¹¹

⁷ Fear NT et al. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A Cohort study. *Lancet* 2010;375:1783-97.

⁸ Greenberg N, Jones E, Jones N, Fear NT, Wessely S. The injured mind in the UK Armed Forces. *Phil Trans R Soc B* 2011;366:261-267.

⁹ Iversen A, Waterdrinker A, Fear N, Greenberg N, Barker C, Hotopf M, Hull L, Wessely S. Factors associated with heavy alcohol consumption in the UK Armed Forces: Data from a health survey of Gulf, Bosnia, and Era veterans. *Military Medicine*. 2007 Sep;172(9):956-61.

¹⁰ Royal British Legion Literature review: UK veterans and homelessness
¹¹ NHS Commissioning Board (2013) Supporting planning for 2013/14 for Direct Commissioning. First published: 24 January 2013
<http://www.england.nhs.uk/wp-content/uploads/2013/01/direct-commissioning.pdf>

4.2.8 Military veterans

Impact in Brighton & Hove

Identifying the number of veterans, at national or local level, is difficult. Applying national estimates suggests around 17,400 military veterans in the city. Discharge numbers show there were 43 veterans registered by the MoD as resettling in Brighton & Hove in 2010/11.

In 2011/12 there were 580 Armed Forces Pension Scheme recipients and 290 Disablement Pension recipients (veterans receiving compensation for injuries sustained during service, but doesn't include all disabled or injured veterans).¹²

Where we are doing well

Brighton & Hove is part of the Sussex Armed Forces Health Network, working to address specific veterans' health issues. An Armed Forces Mental Health lead is being appointed to further this work.

Local inequalities

We don't have detailed local data for military veterans including estimates of the number of veterans in the city and information on inequalities including age, gender, sexual orientation, ethnicity, religion, marital status, carers or disability.

Predicted future need

The number of veterans in the city is projected to fall considerably from approximately 17,400 in 2010 to around 8,700 by 2027.¹³ In the medium term, the profile of veterans will change. There will be more very elderly (85+) veterans, people who served in WWII and National Service, an increase in the proportion of younger veterans and a large reduction of veterans aged 65-74 years. For younger veterans long term illness or disability and mental health issues are expected to remain the most prevalent health concerns.¹⁴

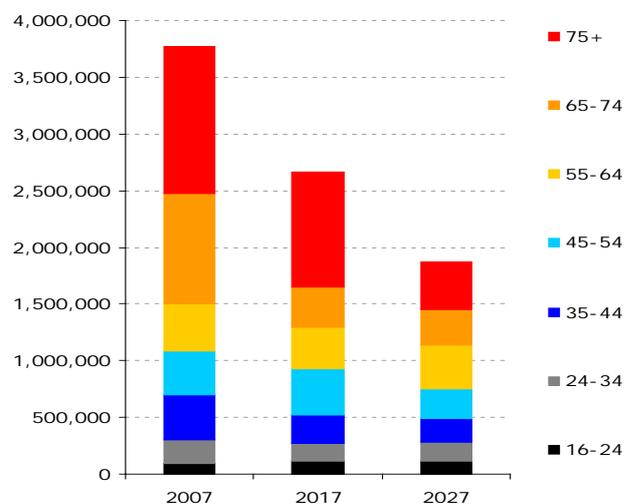
Figure 2 shows the national shift in age profile of the veteran population to a younger average age.

¹² Armed Forces Compensation Scheme data provided by the Ministry of Defence. 2011/12 data.

¹³ Estimates extrapolated from Woodhead et al figures (2007) applied to ONS 2010 based population projections

¹⁴ RBL. Profile and Needs of the Ex-Service Community 2005-2020. Royal British Legion 2006. Figure 4.6
<http://www.britishlegion.org.uk/media/33526/summary%20and%20cons.%20report.pdf>

Figure 1: Projected change in numbers and age profile of veteran population of England 2007 - 2027¹⁵



Source: Office for National Statistics

What we don't know

We don't have good estimates of the number of veterans in the city, and little information on inequalities and population groups.

It is estimated that over half a million veterans in the UK are carers.¹⁶

Additionally, health services generally don't record military service, so we don't have local information on health outcomes in veterans.

Nationally, the majority of veterans are World War II or National Service veterans, with 66% aged 65 years or over. However, evidence suggests that the prevalence of mental health disorders among younger veterans (aged 16-44 years) may be three times that of the UK population of the same age.¹⁷

An estimated 87% of military veterans are men.¹⁸ The proportion of female veterans (13%) is higher than for serving personnel which reflects the World War II conscription of single women in their 20s. There is no specific local data on ethnicity, but at

¹⁵ Woodhead, C. et al. (2009) An estimate of the veteran population in England: based on data from the 2007 Adult Psychiatric Morbidity Survey. Office for National Statistics 2010 based subnational population projections

¹⁶ The Royal British Legion (2005) Profile of the Ex-service community in the UK (revised copy).

¹⁷ Royal British Legion. Profile and Needs of the Ex-Service Community 2005-2020. Royal British Legion 2006.
<http://www.britishlegion.org.uk/media/33526/summary%20and%20cons.%20report.pdf>

¹⁸ The Royal British Legion (2005) Profile of the Ex-service community in the UK (revised copy).

4.2.8 Military veterans

national level an estimated 99% of veterans are White.

Key evidence and policy

The government has committed, through the Armed Forces Covenant,¹⁹ to end any disadvantage military service imposes on people. Veterans are entitled to priority access to treatment for any conditions considered likely to be service related, subject to the clinical needs of all patients.

Recommended future local priorities

1. Continue joint working across Sussex through the Sussex Armed Forces Health Network.
2. Where possible, implement recommendations from the Sussex needs assessment.

Key links to other sections

- Mental health
- Ageing well
- Care of the elderly
- Adults with physical disabilities and sensory impairments
- Alcohol

Further information

Sussex Armed Forces Health Network
<http://www.sussexnetworks.nhs.uk/armed-forces/>

Sussex Military Veterans needs assessment
www.bhlis.org/needsassessments

Last updated

June 2013

¹⁹Ministry of Defence. The Armed Forces Covenant. 2011.
<http://www.mod.uk/DefenceInternet/AboutDefence/WhatWeDo/Personnel/Welfare/ArmedForcesCovenant/> [Accessed 21/08/2012].

4.2.9 Students

Why is this issue important?

Students have particular health needs in terms of mental health, sexual health, smoking, alcohol and drug use and physical activity. There are also issues relating to access to health services, particularly for international students who may be living in the UK for the first time, and the challenges of integrating large student populations into local communities.¹

There are several characteristics of the student population that distinguish them from young adults in the general population that may potentially make them more at risk of ill health:

- Studying for a degree in itself brings emotional and social challenges. New students have often left home for the first time and are learning to manage their own finances, build new social networks and deal with academic pressures, all of which may impact on physical and mental wellbeing.
- Students with a long-term condition may be managing their condition outside of their family home environment for the first time.
- The student population is relatively transient with students often moving between their studies and home, making service provision and continuity for this population challenging.
- There are lifestyle factors associated with student life that may increase the risk of short and long term ill health: alcohol use, smoking, low levels of physical activity and sexual health.
- Students from overseas may originate from countries with high TB rates, where diseases not endemic to the UK are common and where healthcare services are delivered in vastly different ways to the UK.
- Many students live in halls of residence, spending time together in shared areas. This is a risk factor for the propagation of infectious diseases such as measles, meningitis and TB.

Nationally it has been found that students are also struggling with rising debt and fewer employment opportunities.²

¹ Leeds Primary Care Trust. Health Needs Assessment; 2007. Available at <http://www.emua.ac.uk/downloads/LSHNA.pdf>

² Royal College of Psychiatrists. Mental Health of Students in Higher Education, 2011:1-96.

Impact in Brighton & Hove

Brighton & Hove has a substantial student population with two universities: University of Brighton & University of Sussex. According to the 2011 Census students represent 16% of the city's total population aged 16-74 years (or 12% of the total population of the City).³

There has been a sustained increase in the numbers of students at the two universities in the city from around 26,000 in 1995/96 to 35,205 in 2011/12, with many students staying on after university.⁴ Recent increases in numbers have been lower than in previous years.

Around 27,000 students are undergraduates and 8,200 postgraduates. Four fifths of students are full-time and one fifth part-time. This differs by institution – at the University of Brighton 26% of students are part-time compared with 8% at the University of Sussex.

Table 1: Student numbers by university 2011/12

	University of Brighton	University of Sussex	Total
Total number of students	22,075	13,130	35,205
Full-time	16,410 (74%)	12,140 (92%)	28,550 (81%)
Part-time	5,660 (26%)	990 (8%)	6,650 (19%)
Undergraduate	17,665 (80%)	9,345 (71%)	27,010 (77%)
Postgraduate	4,415 (20%)	3,785 (29%)	8,200 (23%)

Source: Higher Education Statistics Authority

Students can register with any GP practice in the city but there is a practice at the University of Sussex, and the Stanford Medical Centre has a branch surgery at the University of Brighton. As would be expected, the University of Sussex Health Centre has a large population in the 15-34 years age group (89% in 2012⁵).

Where we are doing well

According to the 2012 National Student Survey, students at Brighton and Sussex Medical School

³ Office for National Statistics. Census 2011. KS601EW to KS603EW - Economic activity by sex. Available at http://www.nomisweb.co.uk/census/2011/KS601EW/view/1946157280?row_s=cell&cols=c_sex [Accessed 17/08/2013]

⁴ Higher Education Statistics Agency. Statistics by Institution. Available at http://www.hesa.ac.uk/index.php?option=com_content&task=view&id=1897&Itemid=239 [Accessed on 21/08/2012].

⁵ Association of Public Health Observatories, GP practice profiles. Available at <http://www.apho.org.uk/PracProf> [Accessed on 04/07/2013].

4.2.9 Students

(91%) were more likely to be happy with the quality of their university course, compared with the national figure of 85%. At the University of Brighton 82% of students were happy and at the University of Sussex 88% were happy.⁶

General health and limiting long-term illness: The general health of students, as reported in the 2012 Health Counts survey is good with 94% stating they are in good or better health compared with 84% of all respondents. Students (14%) were also significantly less likely to have a limiting long-term illness or disability than all respondents (26%).

Healthy weight: Studies have reported stress-related weight gain and loss in UK university students.⁷ In Health Counts, students were significantly more likely to be a healthy weight (68%) than all respondents (53%).

The University of Sussex practice has significantly lower rates of A&E attendance and hospital inpatient admissions than the England average.⁸ Figures are not available separately for Stanford Medical Centre branch practice.

The University of Sussex Health Centre had the highest number of Chlamydia screens in 2012/13 at 801 young people (27% of the total number of screens across the City).⁹

Local inequalities

The majority of students at the two universities are from the UK (81%) with 7% from the European Union (EU) and 12% (over 4,000 students) from Non-EU countries.

A higher proportion of students from the University of Sussex are from ethnic groups other than White than at the University of Brighton. Though there is greater than 5% of students where ethnicity is not known or not given for both universities. Within the Other ethnic

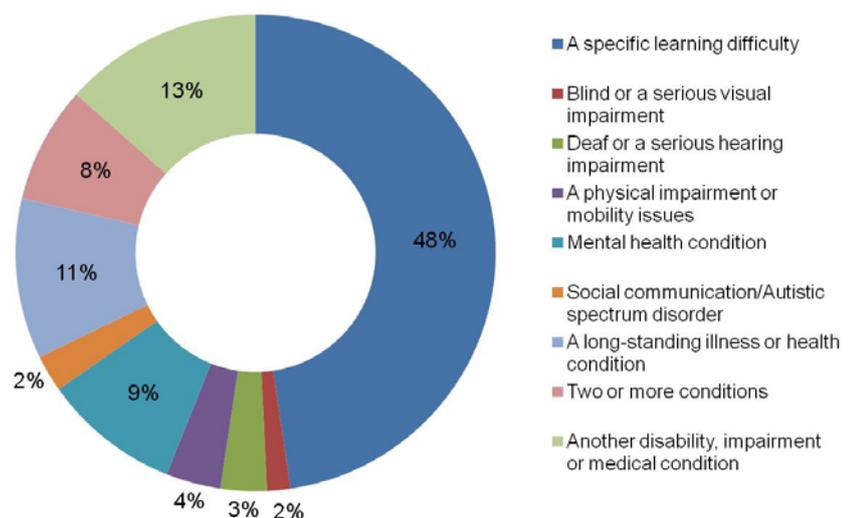
group, 9% of students at the University of Sussex are Chinese (Table 3).

	University of Brighton	University of Sussex	Total
Total number of students	22,075	13,130	35,205
United Kingdom	19,160 (87%)	9,505 (72%)	28,665 (81%)
European Union	1,450 (7%)	1,000 (8%)	2,450 (7%)
Non-European Union	1,465 (7%)	2,630 (20%)	4,095 (12%)

Source: Higher Education Statistics Authority

Across the UK in 2011/12, 9% of undergraduate and postgraduate students had a disability. Figure 1 shows the breakdown of type of disability. The largest group of students are those with a specific learning difficulty, followed by students with a long-standing illness or health condition, a mental health condition or two or more conditions.¹⁰ At both universities in the city, around one in ten students have a disability (Table 3).

Figure 1: First year UK domiciled Higher Education students by disability status 2011/12



Source: Higher Education Statistics Authority

Table 3 shows the student breakdown for both universities by equalities groups. Students at the University of Brighton have an older age structure and a greater proportion is female than at the

⁶ National Student Survey results available from Unistats at: <http://unistats.direct.gov.uk/>

⁷ Serlachius A, Hamer M, Wardle J. Stress and weight change in university students in the United Kingdom. *Physiol Behav* 2007;92(4):548-53.

⁸ Association of Public Health Observatories, GP practice profiles. Available at <http://www.apho.org.uk/PracProf> [Accessed on 04/07/2013].

⁹ NHS Brighton and Hove and Brighton & Hove City Council. *Vital: Annual Report of the Director of Public Health; 2011* Available at <http://www.bhlis.org/PHAR2011> [Accessed 09/08/2012]

¹⁰ Higher Education Statistics Agency. 2011/12 first year students by Ethnicity. Available at <http://www.hesa.ac.uk/content/view/1897/706/> [Accessed on 04/07/2013].

4.2.9 Students

University of Sussex. Nationally a higher proportion of higher education students are female (56%) than male (44%) in the UK. This imbalance is more pronounced among part-time students of whom 61% are female.¹¹

Table 3: Students by equality characteristics, Universities of Brighton and Sussex, 2012

	Brighton (October 2012)	Sussex (December 2012)
Age		
Under 25 years	65%	79%
25-29 years	11%	10%
30 years or over	24%	11%
Gender		
Female	60%	55%
Male	40%	45%
Disability		
Disability	10%	9%
Ethnicity		
White*	75%	67%
Black or Black British	5%	4%
Asian or Asian British	7%	7%
Mixed	3%	5%
Other ethnic group (inc. Chinese)	1%	11%
Refuse / not known	9%	6%

Source: University of Brighton¹² and University of Sussex¹³

*Information is presented as all White ethnic groups as is not broken down to White British, White Irish and White other.

Mental health: The student population has changed enormously over the last decade. Student numbers have grown, more students are entering higher education from socially and culturally-diverse backgrounds and there are more international students.

The 2012 Health Counts survey found that whilst the proportion of students at risk of major depression (42%) was higher than for all

¹¹ Higher Education Statistics Agency.

¹² University of Brighton. Student Equalities Report 2012. January 2013. Available at <http://www.brighton.ac.uk/equality/facts-figures.php> [Accessed 04/07/2013]

¹³ University of Sussex. Student equalities data 2012. Available at <http://www.sussex.ac.uk/ogs/policies/equalityduty/students/data> [Accessed 04/07/2013]

respondents (38%), this difference was not statistically significant.¹⁴

The survey also found that students were significantly more likely to say that they had ever self harmed (19%) than all respondents, however as self harm was generally higher in younger age groups this could be a reflection of the younger age of students.

Alcohol, smoking and illicit drug use: Alcohol use above recommended levels by young people is increasing in the UK, particularly for young women,¹⁵ and this increase is reflected in the student population.^{16,17,18,19} There is some evidence that illicit drug use increased in students between 1973 and 2002²⁰ and that whilst tobacco use has decreased in line with population decreases, smoking prevalence may be higher in some student groups.²¹

However, the 2012 Health Counts survey found:

- Students drinking at increasing/higher risk levels was similar to all respondents (15% students, 17% all respondents)
- The proportion of students who had ever tried drugs (46%) was higher than for all respondents (40%), though the difference was not significant
- Smoking was more common in students (28% daily or occasional smokers) than for all respondents (23%), but again the difference was not significant²²

Physical activity, healthy eating and weight: In a national 2008 study, 70% of university students sampled in the UK did not meet recommended

¹⁴ Brighton & Hove City Council Public Health Department. Health Counts 2012. Report available at www.bhlis.org/surveys

¹⁵ JRF. Drinking in the UK: an exploration of trends. In: Foundation JR, editor, 2009.

¹⁶ Webb E, Ashton CH, Kelly P, Kamali F. Alcohol and drug use in UK university students. *Lancet* 1996;348(9032):922-5.

¹⁷ Gill JS. Reported levels of alcohol consumption and binge drinking within the UK undergraduate student population over the last 25 years. *Alcohol* 2002;37(2):109-20.

¹⁸ Morton F TB. Prevalence of, and factors influencing, binge drinking in young adult university under-graduate students. *Journal of Human Nutrition and Dietetics* 2011;24:277-31.

¹⁹ Dodd LJ, Al-Nakeeb Y, Nevill A, Forshaw MJ. Lifestyle risk factors of students: a cluster analytical approach. *Prev Med*;51(1):73-7.

²⁰ Boland M, Fitzpatrick P, Scallan E, Daly L, Herity B, Horgan J, et al. Trends in medical student use of tobacco, alcohol and drugs in an Irish university, 1973-2002. *Drug Alcohol Depend* 2006;85(2):123-8.

²¹ Watson H, Whyte R, Schartau E, Jamieson E. Survey of student nurses and midwives: smoking and alcohol use. *Br J Nurs* 2006;15(22):1212-6.

²² Brighton & Hove City Council Public Health Department. Health Counts 2012. Report available at www.bhlis.org/surveys

guidelines for physical activity.²³ In addition, two thirds did not eat at least five portions of fruit and vegetables per day.

Locally, Health Counts shows that being physically active at recommended levels is significantly lower in students (16%) than all respondents (25%). Less than half of students were eating five portions of fruit or vegetables per day (48% compared with 52% of all respondents).

Sexually transmitted infections (STIs): Young people (16-24 years) are at highest risk of STIs, accounting for 65% of all Chlamydia and 50% of genital warts and gonorrhoea diagnosed in genitourinary medicine clinics across the UK in 2007.²⁴ Factors contributing to the increased risk include higher rates of sexual partner change and more concurrent partnerships.

One in ten students responding to Health Counts reported that they had ever been diagnosed with a common STI (Genital warts/HPV, Syphilis, Herpes, Chlamydia, Urethritis, Gonorrhoea) compared with 17% of all respondents. This difference was not statistically significant.

Happiness and social connectedness: The Health Counts 2012 survey showed similar levels of life satisfaction, feeling that the things you do in life are worthwhile, and happiness and anxiety yesterday for students and all respondents. Satisfaction with the local area as a place to live was also similar. However, students had a significantly lower feeling of belonging to their immediate neighbourhood (41%) than all survey respondents (58%).

Predicted future need

The period from 2005/06 to 2011/12 saw a growth of around 9,200 students (a 35% increase) at the city's two universities. The impact of student tuition fees is not yet known. For example, the proportion of UK students staying at home rather than moving to a new city may increase with rising tuition fees.

In 2011/12 student numbers at the University of Brighton increased by 4.5% and at the University of

Sussex by 7.4% from the previous year so no reduction in the total numbers of student due to tuition fees is evident at present.

The proportion of UK, EU and international students may also change.

What we don't know

Currently the University of Brighton does not have systems in place to systematically record student data for gender reassignment, religion and belief, sexual orientation and pregnancy maternity.²⁵ Information for the University of Sussex is also not available for these groups of students.

Infectious Diseases²⁶:

Meningococcal meningitis: University students are considered to be at increased risk of invasive meningococcal disease, particularly in institutions that provide catered halls accommodation.²⁷ Since vaccination for Meningococcal C was introduced in 2000, the proportion of meningitis caused by this subtype has reduced.

Measles, mumps and rubella: These vaccine-preventable diseases are more likely to spread quickly in unvaccinated groups living in close proximity. There is a cohort of young adults that may have missed their second MMR vaccination owing to the time it was introduced, putting them at risk of potentially life-threatening infections.

Key evidence and policy

The main health needs identified from the research for students are mental health, alcohol, smoking and sexual health. The evidence and policy for these are given in the relevant sections of this summary.

Tuberculosis: NICE has developed guidance indicating that new entrants into the UK arriving from countries with a high prevalence of TB should be screened for active and latent tuberculosis and

²⁵ University of Brighton. Student Equalities Report 2012. January 2013. Available at <http://www.brighton.ac.uk/equality/facts-figures.php> [Accessed 04/07/2013]

²⁶ Nottingham City Council. JSNA Students; 2012. Available at <http://www.nottinghaminsight.org.uk/insight/jsna/adults/jsna-students.aspx>

²⁷ Neal KR, Nguyen-Van-Tam J, Monk P, O'Brien SJ, Stuart J, Ramsay M. Invasive meningococcal disease among university undergraduates: association with universities providing relatively large amounts of catered hall accommodation. *Epidemiol Infect* 1999;122(3):351-7.

²³ Dodd LJ, Al-Nakeeb Y, Nevill A, Forshaw MJ. Lifestyle risk factors of students: a cluster analytical approach. *Prev Med*;51(1):73-7.

²⁴ Health Protection Agency. Sexually transmitted Infections and Young People in the United Kingdom: 2008 Report. In: *Infections HPACf*, editor. London, 2008.

4.2.9 Students

treated appropriately.²⁸ The guidance specifically includes students as an at-risk population, partly because of the close proximity of living arrangements.

Recommended future local priorities

The 2012 Health Counts survey, along with improved equalities monitoring within the universities means there is now greatly increased evidence available on the health and wellbeing of students within the city. This evidence suggested areas for particular focus include:

- Physical activity
- Mental health and self-harm
- Sense of belonging

Key links to other sections

- Emotional health and wellbeing
- Mental health
- Alcohol
- Substance misuse
- Healthy weight
- Physical activity
- Sexual health

Further information

Higher Education Statistics Authority
<http://www.hesa.ac.uk/>

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July 2013

²⁸ NICE. Clinical diagnosis and management of tuberculosis, and measures for its prevention and control. Clinical Guideline 117, 2011:1-64.

5.1 Life expectancy and healthy life expectancy

Why is this issue important?

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.

Whilst other factors, such as biological or genetic disposition, are important, social inequalities are a key driver of ill-health. It has been estimated that the NHS contribution to any future reduction in the life expectancy gap, whilst significant, is limited and that other factors (the social determinants of health) such as education, employment and housing have a greater impact.

Key outcomes

- **Increased healthy life expectancy (Public Health Outcomes Framework)**
- **Reduced differences in life expectancy and healthy life expectancy between communities (Public Health Outcomes Framework)**
- **Life expectancy at 75 for males and females (NHS Outcomes Framework)**

Impact in Brighton & Hove

	Brighton & Hove	Regional Centres	South East	England
Life expectancy at birth (2008-2010)				
Males	77.7	77.7	79.7	78.6
Females	83.2	82.3	83.5	82.6
Life expectancy at 65 years (2008-2010)				
Males	18.0	17.9	18.9	18.2
Females	21.6	20.9	21.4	20.8
Healthy life expectancy at birth (2001)				
Males	67.9	67.9	71.7	69.1
Females	72.9	72.0	74.8	72.3
Healthy life expectancy at 65 years (2001)				
Males	12.7	n/a	13.7	12.5
Females	15.5	n/a	15.8	14.5

Source: Office for National Statistics

Life expectancy in Brighton & Hove is 77.7 years for males and 83.2 for females (2008-2010). 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 (78.6 years for males and 82.6 years for females).

Life expectancy at age 65 years is 18.0 years for males and 21.6 years for females in the city compared with 18.3 and 20.9 years respectively for England.

Where we are doing well

Life expectancy in the city is higher than it has ever been, and is continuing to increase at a pace of around four months each year for both males and females.

Mortality rates are falling, and this is the case for the most affluent and most deprived people in the city.

Female life expectancy is higher than nationally.

Local inequalities

Despite the narrowing gap in life expectancy between men and women, men tend to develop and die from many conditions earlier than women.

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 2006-2010 the slope index was 10.6 years for males and 6.6 years for females in Brighton & Hove (Table 2). For males this gap is almost two years wider than nationally.

As has been seen nationally, whilst mortality rates in the city are falling in all groups (and therefore life expectancy rising), they are falling at a faster rate in the least deprived quintile and so inequalities are widening¹:

¹ South East Public Health Observatory. Health Inequalities Gap Measurement Tool. http://www.sepho.nhs.uk/gap/gap_national.html [Accessed on 21/08/2012].

5.1 Life expectancy and healthy life expectancy

- In 2001 those living in the most deprived quintile of the city had a mortality rate 1.5 times higher than those in the the least deprived quintile. By 2009 this gap had widened to 1.9 times.
- The gap is smaller for females than males but has increased more for females since 2001. In 2001 males living in the most deprived quintile in the city had mortality rates 1.7 times greater than males living in the least deprived quintile compared with females with a rate 0.6 times greater. By 2009, the male difference was 2.1 times and the female difference was 1.7.

- 3,226 fewer emergency admissions and 1,022 fewer emergency admissions among those aged 65 years or over

Predicted future need

A challenge in reducing health inequalities 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 intervention:

- The mortality rate in the most deprived quintile in the city is projected to become twice that in the least deprived by 2012.⁵
- Whilst mortality rates are lower for females, the relative gap is expected to increase to almost the level of the gap in men by 2012 (2.0 for males and 1.9 for females).⁶

Table 2: Life expectancy inequality by gender, Brighton and Hove

	Brighton & Hove	England	South East
Inequality in life expectancy² at birth (2006-2010)			
Males	10.6	7.3	8.9*
Females	6.6	4.5	5.9*
Inequality in disability-free life expectancy⁵ at birth (1999-2003)			
Males	11.9	10.9	8.9
Females	9.1	9.2	7.0

Source: Association of Public Health Observatories³ and London Health Observatory⁴

*England figures for slope index of inequality in life expectancy are the median for upper tier local authorities.

Using data for 2006-2008 for deaths and 2009/10 for admissions, if those in the 20% most deprived areas had the same death/emergency admissions rates as in the 20% least deprived there would be:

- 59 fewer deaths per year - 12 fewer deaths from cancer among those aged under 75 years and 12 fewer deaths from circulatory diseases among those aged under 75 years

What we don't know

Ethnicity is not recorded on death registration in England. Information on death certificates is restricted to the deceased's country of birth - traditionally used as a proxy for ethnic origin. However, the value of this has diminished over time as subsequent generations have been born in England. In 2012, Scotland became the first UK country to record ethnic origin on death certificates. Death registration also does not record religion, sexual orientation, transgender or whether someone was a carer and life expectancy is not calculated based upon marital status as is a whole population measure.

Current figures on healthy life expectancy are partly based upon 2001 Census data and are therefore relatively old. The Office for National Statistics is due to publish revised figures, incorporating 2011 Census data on health status, but this is not yet available.

Key evidence and policy

Fair Society, Healthy Lives, the Marmot Review of Health Inequalities provides a strategic review of

² Inequality in life expectancy and disability free life expectancy are measured by the slope index of inequality and are measured in years. More information on the indicator is available at <http://www.apho.org.uk/default.aspx?RID=110504> [Accessed on 21/08/2012].

³ Available at <http://www.apho.org.uk/default.aspx?RID=110504> [Accessed on 21/08/2012].

⁴ Marmot indicators for local authorities available at <http://www.lho.org.uk/viewResource.aspx?id=17034> [Accessed on 21/08/2012].

⁵ Mortality data has a time lag in its availability and so 2012 data are projected figures.

⁶ South East Public Health Observatory. Health Inequalities Gap Measurement Tool. http://www.sepho.nhs.uk/gap/gap_national.html [Accessed on 21/08/2012].

5.1 Life expectancy and healthy life expectancy

health inequalities in England.⁷ A life-course based approach is taken, because of the cumulative impact of social, economic, psychological and environmental experiences on health and health inequalities. 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+)

Looking at the contribution of specific causes of death to the life expectancy gap between the most deprived quintile in Brighton & Hove and the national average for men, the biggest contributor 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 gap, followed by lung cancer, other cancers, and suicide and undetermined injury.⁸

The Department of Health has identified the key interventions for reducing the life expectancy gap between the most and least disadvantaged areas (based upon previous PCT areas):

- Greatly increasing the capacity of smoking cessation clinics
- Increasing the coverage of effective therapies for secondary prevention of cardiovascular diseases in people aged less than 75 years
- Primary prevention of cardiovascular disease (all ages) and hypertension through treatment with antihypertensives and statins
- The early detection of cancer

- Interventions aimed at reducing mortality from respiratory diseases, alcohol-related diseases and infant mortality

Matrix for Health England developed a prioritisation method to inform investment in preventative health interventions, based upon the cost-effectiveness, impact on health inequalities, and percentage of people affected.⁹ The results for Brighton & Hove are shown in Table 3.

Recommended future local priorities

The Public Health Strategy for England is adopting the Marmot Review⁸ approach and this will be build on locally. Marmot concluded that reducing health inequalities would require action on six policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

Recommendations around inequalities are throughout the relevant JSNA sections.

⁷ Marmot, Fair Society, Healthy Lives: Strategic Review of Health Inequalities Post 2010, 2010. Available at:

<http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review> [Accessed 21/08/2012]

⁸ London Health Observatory, Health Inequalities Intervention Tool available at: http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesInterventionToolkit.aspx

⁹ <http://help.matrixknowledge.com/>

5.1 Life expectancy and healthy life expectancy

Table 3: Matrix for Health England order of priority for preventative health interventions evaluated to date for Brighton & Hove – national and local interventions.

Category	Intervention	Priority Ranking	Priority Score	Affordability	Certainty
Alcohol	Increases in taxation to reduce population consumption of alcohol	1	11.30 %	★ ★ ★	★ ★ ★
Smoking	Increases in taxation to reduce population smoking rates	2	9.62 %	★ ★ ★	★ ★ ★
Smoking	National mass media campaigns for reducing population smoking rates	3	9.46 %	★ ★ ★	★ ★ ★
Diet, physical activity, obesity	National mass media campaigns to reduce population levels of obesity	4	9.10 %	★ ★ ★	★ ★ ★
Smoking	Brief interventions delivered in GP surgeries to improve quit rates	5	8.98 %	★ ★ ★	★ ★ ★
Alcohol	Brief interventions delivered in GP surgeries to reduce problem drinking	6	8.70 %	★ ★ ★	★ ★ ★
Diet, physical activity, obesity	Brief interventions delivered in GP surgeries to improve uptake of physical activity	7	8.63 %	★ ★ ★	★ ★ ★
Smoking	Nicotine replacement therapy to improve quit rates	8	8.25 %	★ ★ ★	★ ★ ★
STI / teenage pregnancy	Screening and treatment for reducing the prevalence of Chlamydia	9	7.38 %	★ ★ ★	★ ★ ★
Diet, physical activity, obesity	School based group education to reduce population levels of obesity	10	7.25 %	★ ★ ★	★ ★ ★
STI / teenage pregnancy	School based group education for increasing rates of condom use and reducing STIs and unwanted pregnancy	11	6.00 %	★ ★ ★	★ ★ ★
Statins	Statins for primary prevention of stroke and heart disease (demonstrating QALYs for two example CVD risk groups)	12	4.26 %	★ ★ ★	★ ★ ★
Mental health	Assessment and support of caregivers for preventing depression in caregivers	13	0.95 %	★ ★ ★	★ ★ ★
Mental health	Screening and treatment to prevent depression in retirees (age over 65 years)	14	0.12 %	★ ★ ★	★ ★ ★

Source: Matrix for Health England

Key links to other sections

This section links to many within the JSNA but sections with specific reference here include:

- Main causes of death
- Coronary heart disease
- Cancer
- Suicide and suicide prevention
- Alcohol
- Maternal and infant health
- Smoking
- Physical activity
- Diet

Further information

http://www.bhlis.org/health_and_wellbeing/

Last updated

June 2013

5.2 Main causes of death

Why is this issue important?

We need to know how many people are born and die each year – and the main causes of their deaths – in order to have well-functioning health systems.¹

Key outcomes

- **Mortality rate from all cardiovascular disease (including heart disease and stroke) in persons less than 75 years of age (Public Health Outcomes Framework, NHS Outcomes Framework)**
- **Mortality rate from cancer in persons less than 75 years of age (Public Health Outcomes Framework, NHS Outcomes Framework)**
- **Mortality rate from Chronic Liver Disease in persons less than 75 years of age (Public Health Outcomes Framework, NHS Outcomes Framework)**
- **Mortality rate from chronic respiratory diseases in persons less than 75 years of age (Public Health Outcomes Framework, NHS Outcomes Framework)**

- **Mortality rate of people with mental illness (Public Health Outcomes Framework)**

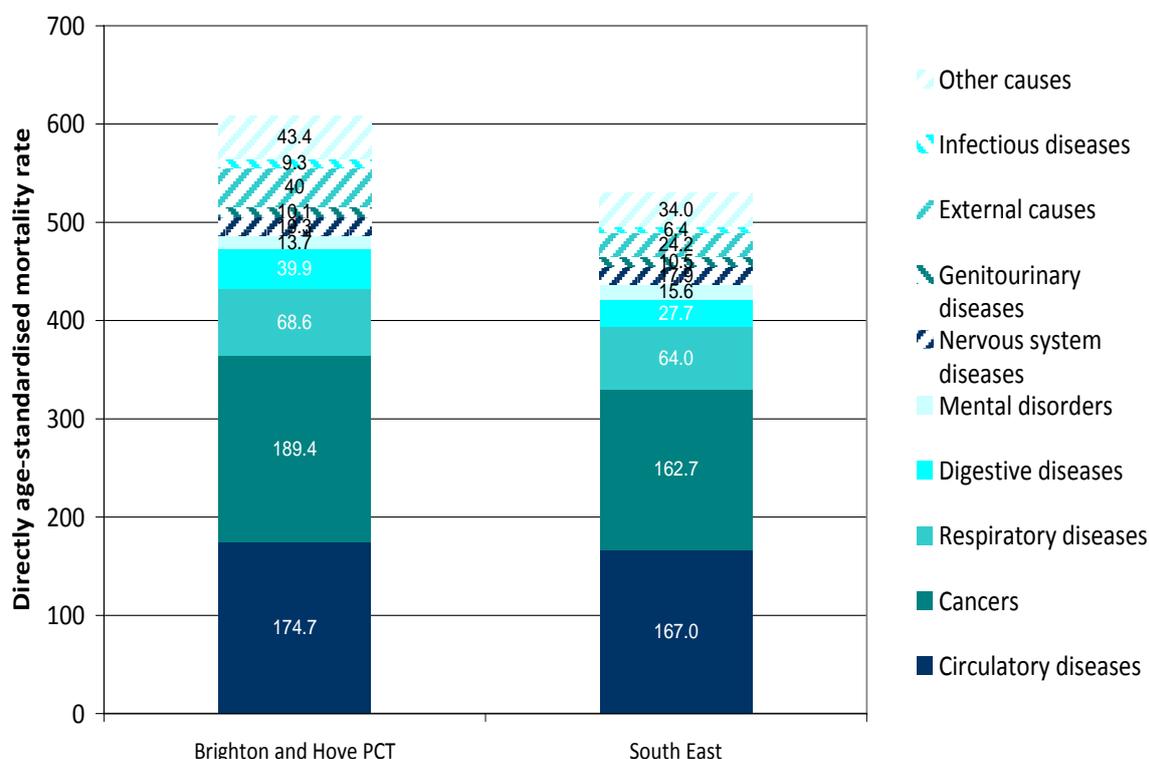
Impact in Brighton & Hove

The commonest causes of death within the city are cancers, circulatory diseases, respiratory diseases and digestive diseases (including liver diseases).

In 2011 there were a total of 2,081 deaths of Brighton & Hove residents. The main causes of death were cancer (30%), followed by circulatory conditions (26%), respiratory conditions (13%). However one in twenty deaths in the city are not caused by disease – these are predominantly accidents or suicide (See figures at end of section).

The main causes of death in the city are similar to the South East but in Brighton & Hove mortality rates are higher for all disease groupings with the exception of mental disorders and genitourinary diseases (Figure 1).²

Figure 1: Cause-specific mortality profiles for Brighton & Hove and the South East, 2005-2009 (directly age standardised rate per 100,000)



Source: South East Public Health Observatory

¹ World Health Organisation. Civil registration: why counting births and deaths is important. Fact sheet N°324; 2007.

² South East Public Health Observatory. Health Inequalities Gap Measurement Tool. Available at http://www.sepho.nhs.uk/gap/gap_national.html [Accessed on 21/08/2012]

Cancer: The recent cancer mortality trend for all ages in the city has been relatively stable but saw a fall in 2008. Mortality from all cancers in under 75 year olds is significantly higher in Brighton & Hove than England and the South East. Mortality rates for cancer in this age group in the city had been increasing since 2002-04 but in 2008-10 were around the 2002-04 level. If current trends continue, Brighton & Hove is unlikely to see a 20% reduction in cancer mortality rates.³ Cancer is explored in more detail in the cancer section.

Heart disease and stroke: Between 2007 and 2009 in Brighton & Hove the mortality rate among the under 75s due to heart disease & stroke was 69 per 100,000 population, compared with 71 in England & 59 in the South East. This is explored in more detail in the relevant section of the report.

Respiratory diseases: The mortality rate in the city for respiratory diseases for those aged under 75 years is similar to the England rate.

Liver disease & chronic liver disease: Mortality rates in those aged under 75 years are significantly higher in Brighton & Hove than in England.

Where we are doing well

The recent trend in circulatory disease deaths for all ages in Brighton & Hove has been downwards.

Local inequalities

Age: The breakdown of cause of death is very different for children, adults and older people. Since there are a small number of deaths in children in the city each year it has not been possible to produce charts showing the main causes of death. In 2010 there were 12 deaths of children aged under one year, with an additional five deaths of children aged 1-14 years.

In 2010 there were 708 deaths of people aged under 75 years (see figures at end of section). Here, the main cause of death is cancer (38%) followed by circulatory disease (24%). Death not caused by disease is the third most common cause of death in this age group and comprises one in 10 deaths.

For those aged 75 years or over (see figures at end of section), the most common causes are circulatory diseases (35%), cancer (25%) and

respiratory diseases (15%). In 2010 there were 1,374 deaths in this age group.

Gender: The main causes of death (for all ages) are similar for males and females. The main difference is the higher proportion of deaths in males to external causes (mainly accidents, suicide and drug or alcohol poisoning). For males, the proportion of deaths to circulatory diseases and cancer are similar, but for females a higher proportion of deaths are due to circulatory diseases than cancer.

Deprivation: Figure 2 compares mortality rates for the most deprived quintile and the least deprived quintile in the city. The large difference seen in overall mortality is present for all commonest causes of death except for diseases of the nervous system or genitourinary system.

Circulatory death 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. Between 2008 and 2010 circulatory death rates in those aged under 75 years in the most deprived quintile of the city were three times higher than for the least deprived quintile. This difference has increased: for the period 2001-2003 the rate in the most deprived quintile was twice that in the least deprived quintile.

For cancer, under 75 deaths rates are increasing in the most deprived group. In 2001-2003 cancer mortality for the under 75s was 1.5 times higher in the most deprived quintile compared with the least deprived and by 2007-2009 this had increased to 1.9.

Predicted future need

If current trends continue, the ONS projects that by 2015 there will be 1,900 deaths per year, and 1,800 deaths by 2020.⁴ Without a change in current trends, inequalities in all deaths and early deaths from cancer and circulatory diseases will widen.

What we don't know

Ethnicity is not recorded on death registration in England, nor is religion, sexual orientation or gender reassignment. National definitions for

³ The national target is to reduce mortality rates from cancer by at least 20% in people under 75 by 2009-2011 (which will be known at the end of 2012).

⁴ ONS sub national population projections (2010 based). Available at: <http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Sub-national+Population+Projections> [Accessed on 21/08/2012].

5.2 Main causes of death

communicable disease deaths and deaths of people with a mental illness have yet to be defined.

Death certification also does not include information on sexual orientation, trans, or carers.

See specific sections for recommended future local priorities

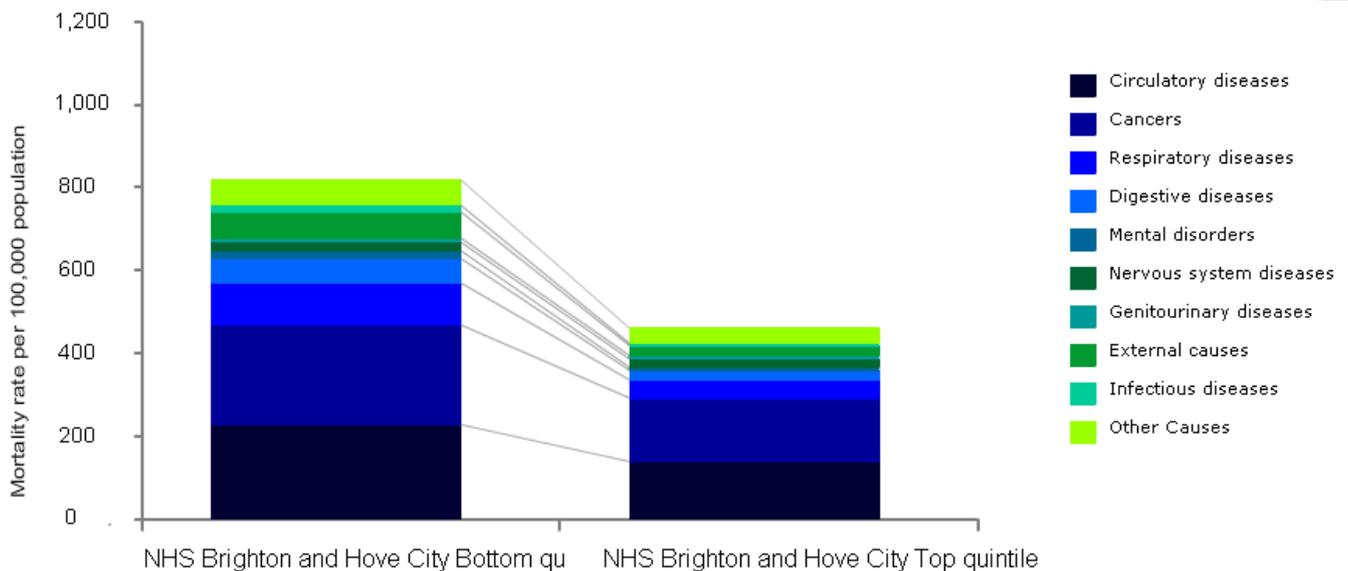
Key links to other sections

- Coronary heart disease
- Cancer
- Respiratory disease
- Suicide

Last updated

August 2013

Figure 2: Mortality rate per 100,000 population for the most and least deprived quintiles of deprivation in Brighton & Hove, 2005-2009

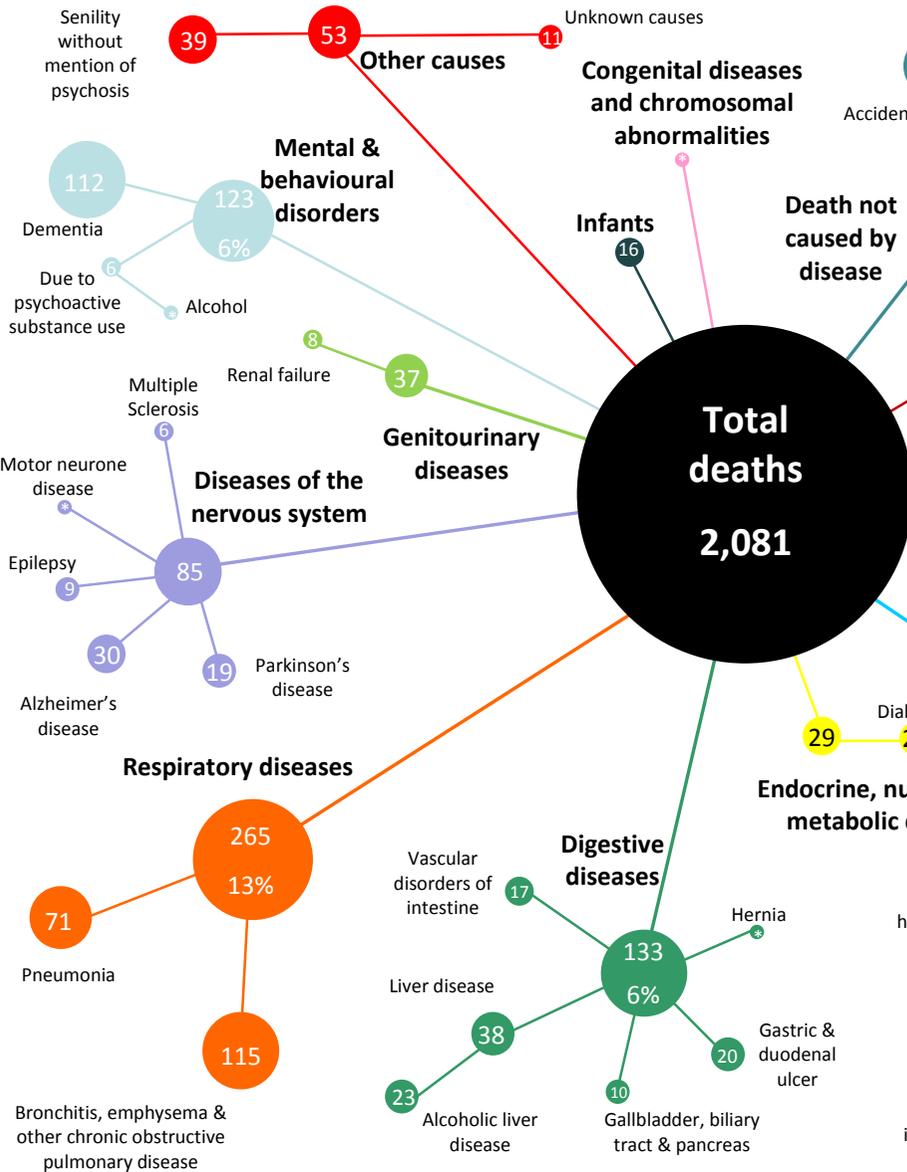


Source: South East Public Health Observatory Health Inequalities Gap Measurement Tool

5.2 Main causes of death

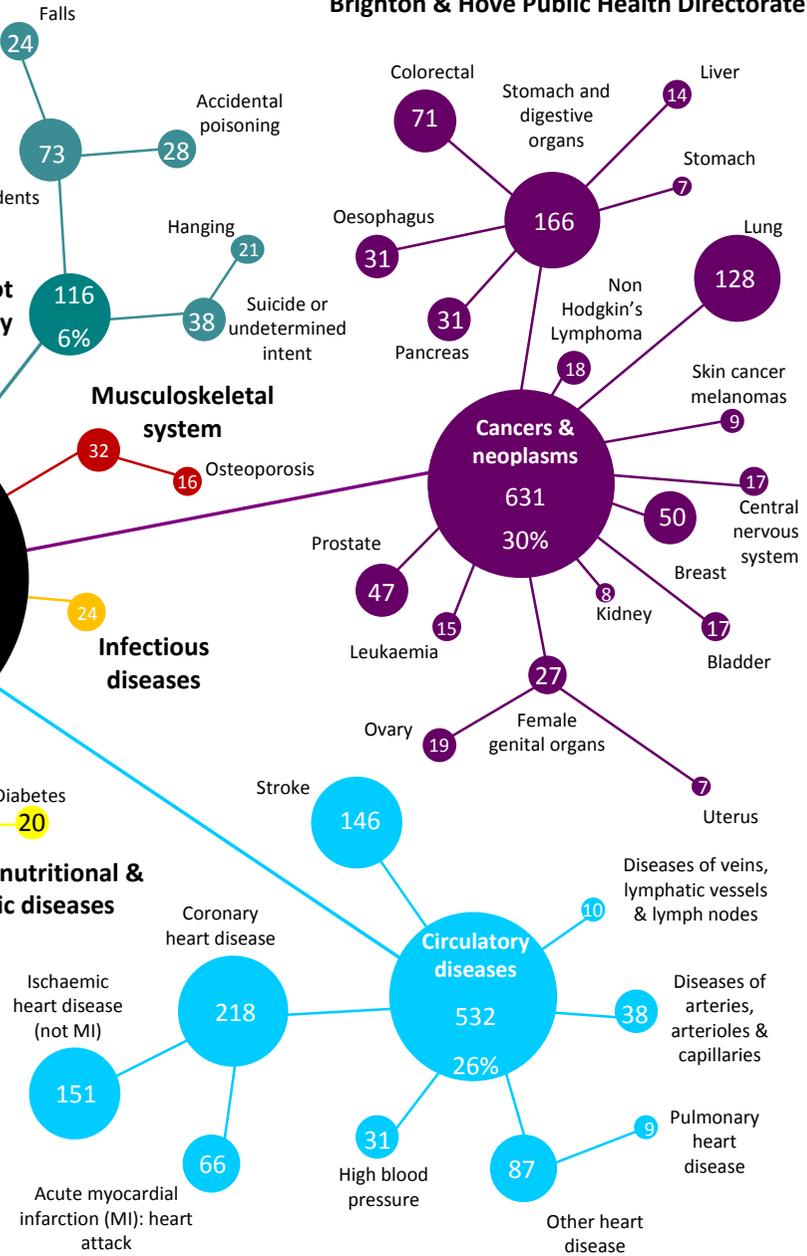
Main causes of death in Brighton and Hove – 2011

Source: Office for National Statistics Vital Statistics tables (VS3) and Public Health Mortality Files



Brighton & Hove JSNA 2013

Brighton & Hove Public Health Directorate



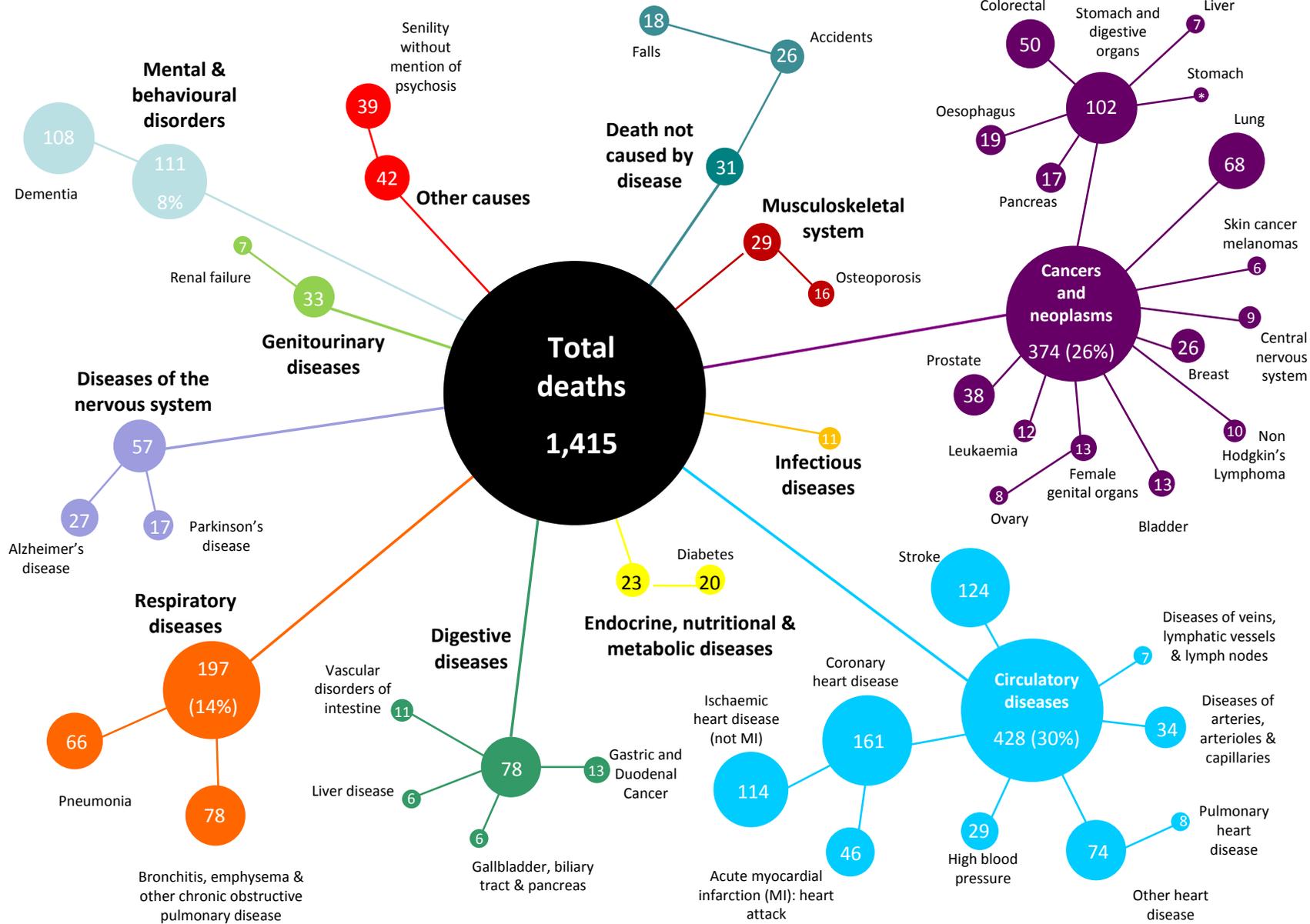
5.2 Main causes of death

Brighton & Hove JSNA 2013

Brighton & Hove Public Health Directorate

Main causes of death in 75s or over - Brighton and Hove – 2011

Source: Office for National Statistics Vital Statistics tables (VS3) and Public Health Mortality Files



Why is this issue important?

Despite efforts to reduce child poverty, the proportion of the UK population living in poverty remains higher than the European Union average¹.

The impact of poverty on children's health and educational outcomes is well documented. Lifetime earnings for children raised in poverty are significantly lower, as are their prospects for employment. Therefore children brought up in poverty are more likely to raise their own children in poverty.¹

Tackling child poverty requires actions across a range of policy areas and across the determinants of health, including: early years' provision; education, skills and employment; parenting support; housing; and benefits and tax credits.²

Key outcomes

- **Children in poverty (Public Health Outcomes Framework)**
- **Reduction in the proportion of children living in poverty (Child Poverty Act 2010)**

Impact in Brighton & Hove

The latest national data for 2010 shows that 20.6% of children in Brighton & Hove, or approximately one in every five live in poverty. This is a drop of 1.4% on 2009. This does not mean however, that family income has increase. Nationally income levels have fallen in this period and so the 60% median line has also fallen. This means some family incomes are now above that relative poverty line. This includes those families whose income is below 60% of the national average and who are on either in-work or out-of-work benefits.³

The level of child poverty in the city is the same as the England average 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 15%.³

Through a process of gathering national evidence, listening to professionals and collating information

from individuals and families, particular challenges to reducing child poverty in the city are found to predominate in addition to the national risk factors for poverty.

Higher than average numbers of adults, children and young people in Brighton & Hove are affected by health conditions and lifestyles that both cause and contribute to families living in poverty. In turn this impacts on the ability of these children to climb out of poverty as adults. The most affected groups are:

- 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, the city presents a very challenging environment to gain affordable employment. For those with basic skills levels the available work is low paid, part-time and/or casual often entailing unsociable hours that make childcare more difficult to source.

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 & Hove. This can be seen most acutely in the cost of private sector rental prices, alongside limited social housing, and pressure on the availability of family sized homes from the growth of multiple occupancy housing.

Where we are doing well

The Local Authority and Advice partners are working closely to provide timely and accurate information and advice for residents affected by

¹ Fair Society, Healthy Lives: The Marmot Review; 2010.

² Joseph Rowntree Foundation. Available at: <http://www.jrf.org.uk/child-poverty> [Accessed on 23/08/2012].

³ HMRC. Child Poverty Revised Measure Snapshot. 2010. Available at: <http://www.hmrc.gov.uk/statistics/child-poverty-stats.htm#2>

6.1.1 Child poverty

benefit changes. The Council has two advice commissions; targeting council tenants and residents affected by changes to Council Tax Benefit respectively.

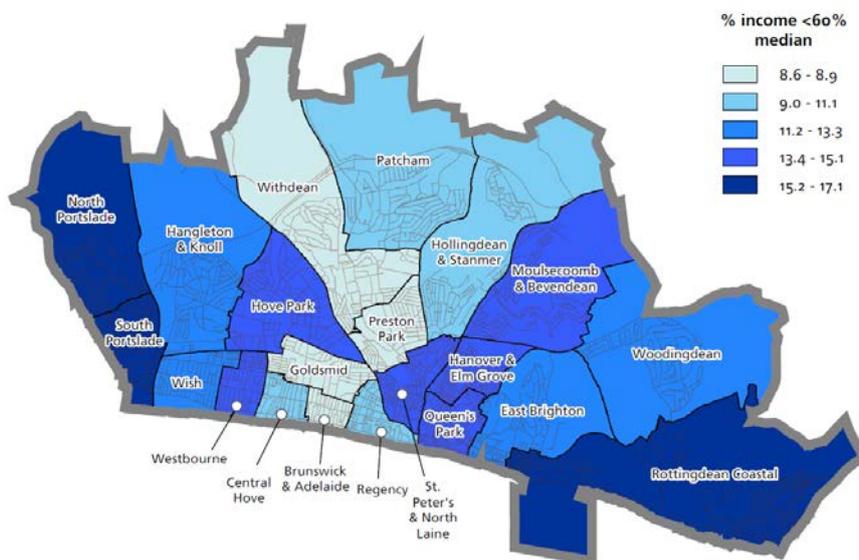
The Council has agreed a Financial Inclusion Commission which will focus funding from Autumn 2013 on access to banking services; financial advice and training for those residents most affected by the downturn in the economy and benefit changes.

The Council along with a range of partners is delivering support for families with complex needs through the Stronger Families Stronger Communities Programme. This three year programme has a target to support positive changes in 675 families by March 2015.

Local inequalities

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 Black and Minority Ethnic groups; lone parent families; families with a disabled child; or adults who are not in receipt of disability benefits; and families with three or more children.

Figure 1: Child Poverty Index - the percentage of children living in poverty



Public Health Intelligence, Brighton and Hove
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Source: Department for Work and Pensions

Within Brighton & Hove the level of child poverty varies widely between communities. East Brighton has the highest level of child poverty at 47% and Withdean has the lowest at 7% (Figure 1).⁴

Detailed mapping of child poverty within the city allows 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.

Routine data does not identify the circumstances of individual families, so 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 poverty.

Predicted future need

The need of some families currently in poverty, e.g. families with disabilities, lone parent families and larger families with more costly housing needs is likely to increase due to changes in the Welfare system. In Brighton & Hove approximately 250 families will see reductions in income with the introduction of the Benefit Cap from July 2013. Preliminary evidence from contact with families affected by the Benefit Cap indicates families will, wherever possible, try to absorb the impact of reductions in benefit rather than undertake to move out of the City.

The existing need for affordable family housing is likely to be exacerbated by reductions in local housing allowance. There is therefore an increased risk of homelessness or displacement to less expensive neighbouring authorities. The cumulative impact of reductions in a range of benefits is difficult to predict. The impact of the introduction of Universal Credit will only become clear in the months following its major roll out from April 2014.

⁴ Brighton & Hove City Council. Child Poverty Needs Assessment; 2011. Available at <http://www.bhlis.org/needsassessments> [Accessed 23/08/2012].

6.1.1 Child poverty

What we don't know

Currently child poverty data does not reflect the ethnicity of families so we do not have a clear picture of how child poverty affects different ethnic groups in the city.

We do not know what the impact of the wide number of changes in benefits will be on families in the city.

We do not know to what degree the current economic climate will affect the number of jobs available locally.

It is difficult to evidence the extent to which parental mental health is a driver of poverty.

Key evidence and policy

Brighton & Hove Child Poverty Needs Assessment and Commissioning Strategy (www.bhlis.org). (Includes a catalogue of key national evidence on all aspects of poverty)

Recommended future local priorities

Brighton & Hove Child Poverty Commissioning Strategy recommends a focus on:

- Lone parents, because this is the majority family type living in poverty.
- Children and families with disabilities because they have a high risk of living in poverty and a greater risk of reduced income as a result of recent benefit changes.
- Families with a complex range of problems because the impact on children's life chances is great as is the cost of intervening to support those families.
- Investigating further the extent to which Black and Minority Ethnic families are living in disadvantage.

Key links to other sections

- Employment and unemployment

Further information

Child poverty needs assessment
<http://www.bhlis.org/needsassessments>

Child poverty strategy
http://www.bhlis.org/children_and_young_people/

Last updated

May 2013

Why is this issue important?

Parenting is rightly a public health issue.¹ Poor parenting skills are linked to poor health outcomes for children: limiting long term illness, social, emotional and behaviour difficulties and poor dental health for children.² The mental health of a significant proportion of children is compromised by poor parenting. Adverse childhood experiences and poor childhood mental health lead to increased risks of low educational attainment, reduced productivity, increased criminality and violence, mental disorder, unhealthy lifestyles and ill-health in adulthood (Figure 1). There is also a relationship between childhood abuse and household dysfunction and many of the leading causes of death in adults.³

Figure 1: The Adverse Childhood Experiences



Source: *The Adverse Childhood Experiences (ACE) Study*, Vincent J Felitti, MD, FACP et al, 1998

Research has shown that effective interventions that improve parenting have an impact on:

- Improving child health and wellbeing⁴
- Improving parent wellbeing⁵
- Improving family functioning⁶
- Improving health and mortality outcomes for adults⁷

¹ Joseph Rowntree Foundation. O'Connor T, Scott S. Parenting and Outcomes for children; 2007.

² Parkes A, Wight D. Growing up in Scotland: Parenting and children's health; 2011.

³ Felitti MD et al. The Adverse Childhood Experiences (ACE) Study; 1998.

⁴ See: Allen G MP. Early Intervention: The Next Steps; Jan 2011; Lindsay G et al. Parenting Early Intervention Pathfinder Evaluation; 2008; and Prinz RJ, Sanders MR et al. Population-based prevention of child maltreatment: The US Triple P system population trial; 2009.

⁵ FAST, Triple P evidence.

⁶ Department for Children, Schools and Families. Mooney A, Oliver C, Smith M. Impact of Family Breakdown on Children's Wellbeing; 2009.

⁷ Vincent J, Felitti, MD et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse

- Strengthening communities⁸

There is currently a national focus on working with families to improve outcomes for children. The government's Troubled Families⁹ agenda aims to reduce crime/antisocial behaviour, get adults back into work and getting children back into school through coordinated work with families. Early Intervention: The Next Steps shows that working with parents at an early stage in children's lives helps prevent future problems and saves money.¹⁰

Key outcomes

- **School readiness (Public Health Outcomes Framework)**
- **Child development at 2-2.5 years (Public Health Outcomes Framework)**
- **First-time entrants to the youth justice system**

Impact in Brighton & Hove

According to child benefit data there are around 30,000 families in the city. The Department for Work and Pensions estimates that the number of troubled families (families with multiple problems - at least 5 of the disadvantages below) in Brighton & Hove is between 660 and 690.

- No parent in the family is in work
- The family lives in poor quality or overcrowded housing
- No parent has any qualifications
- The mother has mental health problems
- At least one parent has a long-standing limiting illness or disability
- The family has low income (below 60% of the median)
- The family cannot afford a number of food and clothing items¹¹

Childhood Experiences (ACE) Study; 1998; Sanders MR. Strengthening the population level effects of evidence based parenting interventions; 2008.

⁸ FAST evidence

⁹ Communities and Local Government. The Troubled Families Programme; March 2012

¹⁰ Allen G. Early Intervention: The Next Steps; 2011.

¹¹ Cabinet Office Social Exclusion Taskforce. Reaching Out: Think Family: Analysis and themes from the Families At Risk Review. 2007. Available from http://webarchive.nationalarchives.gov.uk/+http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/think_families/think_families_full_report.pdf [Accessed 18/05/2012]

6.1.2 Parenting

It is estimated nationally that around 40% of these families will also experience additional child factors including: Special Educational Needs (SEN); exclusions from school; involvement with the police; and running away from home.¹¹

Brighton & Hove has higher numbers of children on child protection plans, children in need and children in care than the England average or statistical neighbour average.

The 2010 Annual Report of the Director of Public Health on Resilience¹² highlighted that the high levels of domestic violence, substance misuse and teenage conceptions in the city have an adverse impact on family relationships and stability.

Where we are doing well

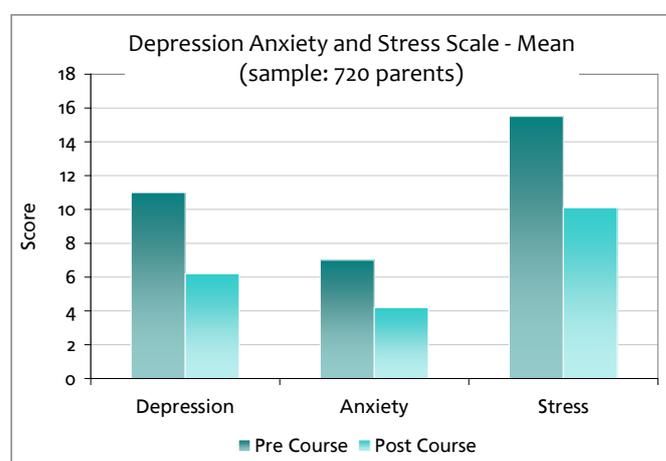
Brighton & Hove City Council have invested in three evidenced-based parenting programmes: Triple P (Positive Parenting Programme), which incorporates a principle of self-efficacy, promoting parental competence and self-sufficiency, FAST (Families and Schools Together) and FNP (Family Nurse Partnership).

Around 1,900 parents are estimated to have completed Triple P courses. Triple P has been shown to result in predictable decreases in child behaviour problems maintained over time.¹³ Pre- and post-Course standardised questionnaires are completed by parents. Local data show that 73% (1,351 parents) of participants see an improvement in their child's behaviour; 87% (1,360) see an improvement in the way they parent; 84% (1,027) see an improvement in their confidence and self-efficacy; 58% (1,185) see a decrease in their levels of depression; 48% (1,181) see a decrease in anxiety; and 65% (1,183) see a decrease in stress. Moreover, there was a statistically significant improvement in all score between the pre-course and post-course questionnaires.

Parenting interventions have been shown to have a positive impact on parental mental health and wellbeing (Figure 2). Evidence, from post-course satisfaction questionnaires, shows that parents value Triple P parenting interventions.

The Triple P multi-intervention programme is available in a range of formats at all levels of need across the age range. These can be accessed directly by parents and carers or delivered by primary care practitioners, teachers and a range of other professionals. Brighton & Hove pioneered the use of parent co trainers to deliver Triple P level 4 groups alongside professionals. This was evaluated as part of the Parenting Early Intervention Pathfinder¹⁴ with positive outcomes.

Figure 2: Mean pre- and post-Course 'Depression, Anxiety and Stress Scale'¹⁵ scores for Brighton & Hove.



Source: Brighton & Hove Parenting Team

Stepping Stones Triple P, offered in Brighton & Hove by Amaze, offers parents of children with disabilities and SEN an effective programme that reduces child behaviour problems and improves parental competence, skills and satisfaction.¹⁶

78 families have completed one of the three FAST programmes in Brighton & Hove primary schools. Pre- and post-Course questionnaires from FAST programmes that have run in two local primary schools show a statistically significant drop in family conflict from the level you would expect to see in 'distressed' families to within the normal range (data from 38 families and two programmes). Teachers report increased parental involvement in children's education.

National FAST research has shown statistically significant improvements in parental involvement with education, social relationships and social support plus better coping with stress and

¹² Annual Report of the Director of Public Health Brighton and Hove 2010.

¹³ De Graaf I et al. Effectiveness of Triple P on Behaviour Problems in Children; Netherlands; 2007.

¹⁴ Lindsay G et al. Parenting Early Intervention Pathfinder Evaluation; 2008.

¹⁵ Lovibond SH, Lovibond PF. Manual for the Depression Anxiety Stress; 1995.

¹⁶ Saunders M, Mazzuchelli T. Stepping Stones Triple P research; 2000.

6.1.2 Parenting

improved relationships. In addition, drop-out rates were low - typically around 20%.¹⁷

There is good evidence that outcomes for both children and adults are strongly influenced by factors in pregnancy and the first years of life. In 2012 Brighton and Hove started a city wide Family Nurse Partnership (FNP), a voluntary preventative programme for vulnerable young first time mothers. It aims to improve pregnancy outcomes, improve child health and development and improve parents' economic self-sufficiency.

Local inequalities

Estimating the distribution of families with complex /multiple needs across the city gives the approximate numbers per ward. It is not currently possible to give more accurate estimates and these figures should be treated as a guide. The starting figure is the estimated 660-690 troubled families in the city. As these families are unlikely to reside uniformly across wards we adjusted these figures.¹⁸

The Stronger Families Stronger Communities Programme has identified 539 of the 675 families that will be prioritised for services.¹⁹

Triple P in Brighton & Hove:

Sex: 15% of parents are male and 85% female.

Sexual orientation: 97% of parents identify as heterosexual; 1% as homosexual; 2% as other.

Race / ethnicity: From a sample of 919 parents, the ethnicity of parents attending groups corresponds to the demographics of the city's population.²⁰

Marriage and civil partnership: 39.9% of parents are married and 0.9% in a civil partnership compared with 0.2% of the city's adults in a civil partnership and 12% of households married with dependent children.

Child poverty: The University of Warwick evaluated the Parenting Early Intervention Pathfinder: of the

247 Brighton & Hove parents in the sample 76% had an income below the poverty line.

Table 1: Estimates of the number of families with multiple/complex needs by ward

Ward	Total number of families	Families with multiple / complex needs
Brunswick and Adelaide	685	15
Central Hove	675	17
East Brighton	1,740	73
Goldsmid	1,585	36
Hangleton and Knoll	2,080	52
Hanover and Elm Grove	1,615	34
Hollingdean and Stanmer	1,660	44
Moulsecoomb and Bevendean	1,985	66
North Portslade	1,530	32
Patcham	1,860	28
Preston Park	1,875	30
Queens Park	1,185	44
Regency	580	17
Rottingdean Coastal	1,305	17
St Peters and North Laine	1,270	30
South Portslade	1,355	36
Hove Park	1,375	15
Westbourne	1,120	27
Wish	1,325	27
Withdean	1,775	22
Woodingdean	1,295	26
Brighton & Hove	29,875	690

Source: Brighton & Hove City Council

¹⁷ Macdonald L. Aggregate FAST UK Evaluation of 15 schools in 15 LEAs; 2010.

¹⁸ Using child benefit data to identify the total number of families per ward and calculating their distribution across the city; applying this distribution to the DWP estimate; adjusting the above figure according to the percentage difference between the ward and Brighton & Hove Index of Multiple Deprivation score 2010.

¹⁹ CLG. The Troubled Families Programme; 2012.

²⁰ 2009 Office for National Statistics data (www.bhllis.org)

Predicted future need

The city's population is projected to rise by 4% between 2010 and 2020 with increased numbers of children under 15 years. However, the number of births per year in the city is projected to remain stable at around 3,300.²¹ The increased population and increased numbers of children could create pressure on city services and may increase the demand for parenting advice and interventions.

The trend in children subject to Child Protection Plans and the number of children in care is increasing, and it is a priority of children's services to reduce the number of children at risk of suffering harm through earlier intervention.

What we don't know

Information on family income, age, religion, belief and gender reassignment are not currently collected from parenting programmes. Dropout and retention information is not clear and research into this is underway. The service has highlighted a need to investigate the number of children subject to family separation and breakdown.

Key evidence and policy

NICE guidelines²² on the management of conduct disorder in children under 12 years recommends manual-based parenting programmes such as Triple P as the treatment of choice. Key evidence and references to policy are documented above.

International and national evidence shows that investment in evidence-based parenting interventions reduces pressure on services and saves money. The Department for Education estimates that the delivery of an evidence-based parenting programme could save on average £81,624 per family, with local authorities directly saving £40,341.²³ An international cost analysis found the cost of Triple P universally would be recovered in a single year by the 10% reduction in

the number of families where abuse/neglect occurred.²⁴

Specific guidance for a range of services includes:

Drug and Alcohol Treatment: Guidance on development of local protocols between drug and alcohol treatment services, Safeguarding Boards and children and family services.
<http://www.nta.nhs.uk/uploads/supportinginformation.pdf>

Offender Management: Guidance on how prisons, probation trusts, and children and family services should work together to support children and families of offenders.
<http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/ig00638/>

Mental health: Guidance for a whole family approach for professionals working with parents suffering with mental ill-health.
<http://www.scie.org.uk/publications/guides/guide30/>

Neighbourhood policing: Early intervention, prevention and whole family practice guidance for neighbourhood policing managers and practitioners.
<http://www.neighbourhoodpolicing.co.uk/publication.asp>

Young carers and their families: Associations of Directors of Adult and Children's Services model local protocol setting out how services should work more closely together to prioritise support for the person being cared for as well as the young carers.
<http://www.adass.org.uk/images/stories/MOU%20Working%20Together%20to%20support%20young%20carers.pdf>

Recommended future local priorities

Public Health and children services are working to encourage wider access to and availability of parenting training support in the city.

A whole population approach to parenting programmes has been proven to be effective in preventing adverse childhood experiences and behaviour problems as well as reducing mental health problems in parents and overall providing

²¹ ONS sub national population projections (2010 based).
<http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Sub-national+Population+Projections> [Accessed 23/08/2012]

²² NICE Guidelines 102, 2006

²³ Department for Education. Intensive Support for Families with Multiple Problems: The Business Case; 2008.

²⁴ Foster M et al. Cost of a Public Health Infrastructure for Delivering Parenting and Family Support; 2007; Triple P – An invaluable investment in your region's future: www.triplep-staypositive.net.

better outcomes for children and their families.²⁵ A whole population approach is necessary to de-stigmatise and normalise parenting issues.²⁶

There will be a continued need for intensive interventions for families with complex needs.

The following are in development:

- A Big Parenting Debate launched in July 2013 with press and social media campaigns as well as qualitative research with communities across the city. This will help capture the voice of the city, improve understanding of needs and inform the development of a parenting policy and strategy.
- Workplace parenting intervention²⁷
- Interventions to improve parenting and reduce parental conflict in times of family breakdown²⁸
- An online parenting course²⁹

Key links to other sections

- Carers
- Children in need
- Education
- Not in education, employment and training
- Under 18 conceptions and teenage parents
- Young offenders
- Emotional health and wellbeing and mental health
- Substance misuse
- Alcohol

Further information

www.triplep.net

Last updated

June 2013

²⁵ Prinz R, Sanders M. Population based prevention of child maltreatment; 2009

²⁶ Joseph Rowntree Foundation. O'Connor T, Scott S. Parenting and outcomes for children; 2007.

²⁷ Th. Sanders MR, Ralph A, Thompson R, Sofronoff K, Gardiner P, Bidwell K and Dwyer S. Every Family: A public health approach to promoting children's wellbeing. Brief Report; e University of Queensland; 2005.

²⁸ Department for Children, Schools and Families. Mooney A, Oliver C, Smith M. Impact of Family Breakdown on Children's Wellbeing; 2009.

²⁹ Sanders M et al. Every family: A public health approach to positive parenting. The University of Queensland

6.1.3 Children in need

Why is this issue important?

Looked after children and young people are much more likely to be unemployed, involved in crime and identified as having a substance misuse problem.¹ Though some do well, the educational achievement of looked after children as a group remains unacceptably low.

Both young women and young men in and leaving care are more likely than their peers to be teenage parents. Looked after children and care leavers have long been over-represented in our prisons. Research published by the Social Exclusion Unit in 2002 suggested that 27% of the adult prison population had once been in care.²

Care leavers are also more likely to have, and are more at risk of, mental health problems than young people generally.³ Research has shown that up to 20% of those in care experience homelessness within two years of leaving.⁴

Key outcomes

- **Emotional well-being of looked after children (Public Health Outcomes Framework)**
- **Families are given early help to prevent the need for a Child Protection Plan**
- **Those with a Child Protection Plan are kept safe and receive appropriate support**
- **Children who are looked after do well in school, and are healthy, and care leavers secure employment, further education or training and suitable accommodation**

Impact in Brighton & Hove

Brighton & Hove's rates of Referrals, Initial and Core Assessments and Initial Child Protection Conferences placed it in the top ten out of 152 local authorities in England and it is expected, based on current activity, that this will continue in 2013.

Performance against timescales has improved significantly since the Advice, Contact and Assessment Service (ACAS) was formed in September 2011, with 93% of Initial Assessments

and 82% of Core Assessments being completed within timescales during 2012/13. The single assessment was launched in April 2013 and initial figures reveal that visits to children and completion within reviewed target dates are good.

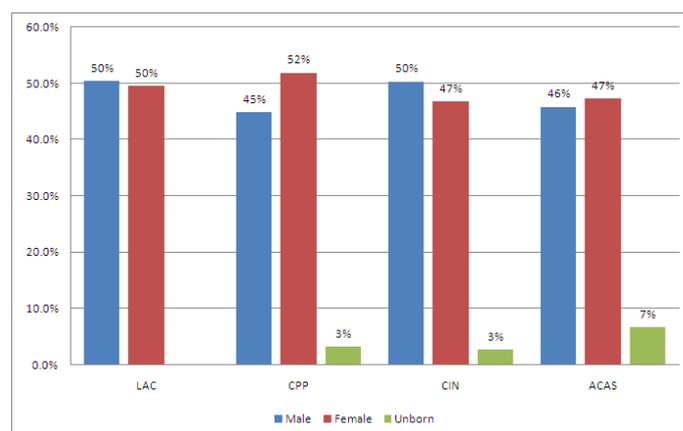
The number of children who are the subject of a Child Protection Plan has fallen by 31% from a peak of 440 in March 2011 to 305 in May 2013. However, our rate per 10,000 (61.1) remains higher than the England average (37.8).

The number of children in care proceedings has fallen over the last 12 months whilst the number of children in pre-proceedings has risen, which demonstrates that work is being undertaken at an earlier stage. The rate of children looked after in Brighton & Hove is high at 91 per 10,000 children in May 2013, higher than the 2012 national average (59 per 10,000) and the average for our statistical neighbours⁵ (70.5 per 10,000). The 2012 rate ranks Brighton & Hove joint 23rd highest out of 152 local authorities in England.

The number of Children in Need requiring a Plan has remained stable over the last year and was 727 children as at May 2013.

Local inequalities

Figure 1: Social Care activity by gender, July 2013



Source: Carefirst Data July 2013

Figure 1 shows the gender breakdown of children allocated to ACAS, Children in Need (CIN), children who are the subject of a Child Protection Plan (CPP) and looked after children (LAC). There are more males in all categories except for children subject of

¹ NICE. Costing report: Promoting the quality of life of looked after children and young people; October 2010.

² Social Exclusion Unit. Reducing offending by ex-prisoners: London; 2002.

³ Broad, 1999; NLCAS, 2005; Ryan, 2008; DCSF and DoH, 2008.

⁴ Biehal et al. Moving On: Young People and Leaving Care Schemes. London, HMSO; 1995.

⁵ Statistical Neighbours (SN) are ranked in order of statistical closeness, with the top SN being closest: Bristol, Bournemouth, Portsmouth, Reading, Sheffield, Southampton, Bath and North East Somerset, Southend-on-Sea, York and Plymouth

6.1.3 Children in need

a CPP where 52% are female and 45% male (3% unborn or unknown gender). This is in contrast to the England average where 50% of children who are the subject of a CPP as at 31st March 2012 are male and 48% are female (2% unborn or unknown gender). Half (50%) of children looked after in the City were male compared with 56% in England.

Table 1 shows that 81% of looked after children in the City are White (compared with 78% nationally) and 76% of children who are the subject of a CPP are of White ethnicity (the same as England).

Table 1: Social Care Activity by Ethnicity, July 2013

Ethnicity	LAC %	CPP %	CIN %	ACAS %
Asian or Asian British Sub Total	3.1%	1.6%	3.2%	4.8%
Black or Black British Sub Total	3.1%	5.5%	3.5%	3.6%
Mixed Sub Total	11.2%	12.6%	9.5%	8.4%
Other Ethnic Groups Sub Total	1.3%	3.5%	1.7%	1.4%
White Sub Total	81.3%	75.8%	78.8%	70.6%
Not Stated Sub Total	0.0%	0.0%	0.8%	3.3%
Information Not Yet Obtained Sub Total	0.0%	1.0%	2.4%	7.9%
Total	100.0%	100.0%	100.0%	100.0%

Source: Carefirst Data July 2013

A greater proportion of children who are the subject of a CPP are in younger age groups whereas a greater proportion of looked after children are aged 10 or over. At March 2012, 27% of children subject of a CPP were aged 1-4 (compared with 31% nationally) and 33% were aged 10-15 (compared with 26% nationally). The age profile for looked after children as at 31st March 2012 is broadly similar to England.

Analysis of social care activity (provision of core social work services to children with identified needs) reveals there is a correlation between wards with high deprivation and high need. East Brighton has the highest rate of Children in Need followed by Woodingdean, Queen's Park, while the Regency ward has the lowest rate.

Research has been carried out into why Brighton & Hove has such high rates of social care activity compared with similar areas. Looking at deprivation and other contextual factors, Brighton & Hove was 42nd worst of 124 authorities - just outside the top third worst authorities. The city is not an outlier in terms of the levels of problems in the population.

Predicted future need

The Welfare Reform agenda and changes to housing, council tax and incapacity benefit are likely

to place families under additional pressure which could result in increased demand for services.

Key evidence and policy

The Munro Review of Child Protection and Safeguarding will drive local systems to review how they deliver social care, with an emphasis on flexibility for professionals on exercising judgement. Working Together to Safeguard Children guidance (statutory guidance for social workers used by a wide range of professionals with concerns about children) will be revised to comply with Munro's recommendations.

The ACAS, CIN Team and Children in Care teams are holding regular Quality and Standards meetings to: inform and develop their service improvement plans; develop additional performance measures and analysis to evidence the effectiveness of service areas; and monitor and evaluate the audit process.

Recommended future local priorities

The Social Work Transformation Programme will improve the effectiveness of interventions, with a focus on early help and support for vulnerable groups. It will also re-design systems to reduce the administrative burden on front-line staff.

Work is underway to ensure looked after children can exit care safely into supportive environments.

Key links to other sections

- Education; Domestic and sexual violence; Substance misuse and alcohol; Sexual health; Not in education, employment and training

Further information

Department for Education Data, Research and Statistics

www.education.gov.uk/researchandstatistics

Department for Education Statistical Gateway

www.education.gov.uk/rsgateway/whatsnew.shtml

Research in Practice www.rip.org.uk/

Last updated

August 2013

6.1.4 Education

Why is this issue important?

There is a large and persistent association between education and health. Policies that impact educational attainment could have a large effect on population health.¹

Evidence shows that good attendance links to attainment and safeguarding and is a protective factor related to other health and wellbeing outcomes such as teenage pregnancy and substance misuse.² Young people who have been bullied have a significantly lower Key Stage 4 (GCSE) score than those who haven't been bullied. In addition, being bullied has impacts on a young person's mental health with, for example, 15% of persistently bullied children saying they self-harm.³

Key outcomes

- **School readiness: foundation stage profile attainment for children starting Key Stage 1 (Public Health Outcomes Framework)**
- **Truancy rate/pupil absence (Public Health Outcomes Framework)**

Impact in Brighton & Hove

Attainment

In the Early Years (birth to five years) children in Brighton & Hove continue to achieve much higher than the national outcomes for all pupils. 100% of Children's Centres in the city have been judged good or outstanding compared to 69% in England.

Brighton and Hove was listed in the top ten local authorities for the quality of children's centres and early years childcare providers in the Ofsted annual report with 87% of early years childcare providers judged good and outstanding compared to 73% in England. National evidence illustrates that there is a direct correlation between disadvantage and the

outcomes of the Early Years Foundation Stage (EYFS) profile.⁴

At Key Stage 1 (age 5 - 7) in 2012 overall standards in the city, reading remained in line with the national, whilst there was an increase in writing standards; they are now just below national. However in maths we are above national.

At Key Stage 2 (age 7 - 11) overall standards for the percentage of pupils who attained at least level 4 (the expected level) in both English and Maths in 2012 in the city were up by 6 percentage points from 2011 however national results rose by seven percentage points and so we are one percentage point below national. The percentage of pupils achieving level 5 (above expected level) in both Maths and English is above national. This is an indication that the success of more able pupils is continuing. The percentage of pupils making two levels of progress in English and Maths was below national in 2012, and Maths remains a key area for improvement across all key stages.

80% of Primary schools, 100% of Special Schools and 78% of maintained Secondary Schools and Academies in Brighton & Hove have been judged to be good or outstanding by Ofsted. Two primary schools are currently graded as inadequate and are in special measures.

In 2012 56.4% of pupils achieved 5 A*-C grades including English and Maths in Brighton & Hove (compared with 59.4% for England). However, provisional figures for 2013 suggest that local performance improved to 62% (final confirmed local data and comparative data for England will be published in 2014).

Attendance: Overall absence rates at Brighton & Hove primary schools are in line with the national rate. However, overall and persistent secondary school absence is above England and the South East.

Bullying: In the 2012 Safe and Well School Survey 90% of 7-11 year olds in primary schools and 78% of 11-16 year olds in secondary schools reported that they enjoyed coming to school. There has been a 12% reduction in secondary age students

¹ Cutler DM, Lleras-Muney A. Education and Health: Evaluating Theories and Evidence; 2006.

² Department for Education and Department for Health: Teenage Pregnancy Strategy Beyond 2010 and NICE: Interventions in schools to prevent and reduce alcohol use among children and young people.

³ Department for Education. Bullying Amongst the Worst Affected Report. 2011. Available at

<https://www.education.gov.uk/publications/eOrderingDownload/Reducing%20Bullying%20Amongst%20the%20Worst%20Affected.pdf> [Accessed on 23/08/2012].

⁴ Department for Education. Achievement of Children in the Early Years Foundation Stage Profile DfE RR034; Sept 2010.

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reporting that they had been bullied this term since 2005 and a 14% reduction in 7-11 year old pupils.

Table 1: Overall and persistent absence, 2011/12

	National	South East	Brighton & Hove
Overall absence rate			
Primary	4.4%	4.3%	4.4%
Secondary	5.9%	6.0%	6.5%
Persistent absence rate (based on new definition of 15%)			
Primary	3.1%	2.9%	3.1%
Secondary	7.4%	7.8%	9.3%

Local inequalities

Special Educational Needs (SEN): At Key Stages 1 and 3 (Key Stage 3: age 11-14) more progress has been made to raise attainment and narrow the gaps in attainment between children with Special Education Needs and their peers. However, this still remains as area for concern.

At Key Stage 1, the significant investment in the Every Child a Reader and Every Child Counts programmes for identified children in targeted schools has had a measurable impact on performance in literacy and mathematics for low attaining pupils.

At Key Stage 2, the SEN gap has narrowed at Level 4, but widened at Level 5. A Strategy for Closing the Gap has been launched and we have growing evidence of effective practice and interventions that is being shared with schools across the city.

At Key Stage 3, the percentages of pupils with SEN gaining Level 5+ in English, Mathematics and Science all showed good improvement and attainment gaps are narrowing in all three subjects.

At Key Stage 4, the gap in the proportion of SEN and non SEN children achieving 5+ A* - C grades including English and Maths increased by 7% points compared with 2011, and was higher than at any time since 2006. This was because the performance of non SEN students improved, while the performance of SEN students declined compared with 2011 - although still significantly

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higher than in the five years before 2011, and almost four times higher than in 2006. The national gap narrowed by 1 percentage point and the gap for statistical neighbours remained the same. This is a priority area for the city schools.

Free School Meals: 'Closing the gap' in attainment between pupils entitled to free school meals and those not entitled is an important national and local priority. The 'Pupil Premium' introduced by the current government provides additional funding which schools are using specifically to help disadvantaged pupils achieve more.

At all Key Stages other than Key Stage 2, there was a widening of the gap in the performance of pupils entitled to free school meals. At Key Stages 2 and 4, the free school meals gap is significantly wider than that for England. Continuing to raise the performance of disadvantaged pupils so that this gap is narrowed remains a key priority. We have developed a strategy and allocated funds to address this vital issue.

Ethnicity: 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.

Looked after children: There has been an improvement in the attendance of children in care and a decrease in the number of fixed term exclusions they receive in the 2012. Achievement in Maths at Key Stage 1 and 2 was better than in 2011 and above the national average. Although achievement in Reading and Writing at Key Stage 1 was below the 2011 figure and the national average, at Key Stage 2 achievement in English was better than 2011 and above the national average.

In Key Stage 4 children in care continued a three year upward trend in the overall number of GCSEs they achieved although the percentage who gained 5 A*-C including English and Maths was below that of 2011 and the national average. It should be noted that 15 students (44%) within the cohort of 34 had special educational needs.

Enjoying school: In the 2012 Safe and Well School Survey, lesbian, gay, bisexual and unsure 11-16 year old students and those who state they get extra help, are more likely to disagree that they

6.1.4 Education

enjoy coming to school than other groups. In primary schools the data does not show as significant differences between equality groups.

Predicted future need

As the number of pupils in vulnerable groups (e.g. Free School Meals, Special Educational Needs) continues to increase, schools and supporting agencies need to plan carefully the allocation and use of resources, such as the Pupil Premium.

National education policy continues to promote Academies and Free Schools and there are currently two secondary academies and a bi-lingual free school. From September there will be a Primary academy and a secondary free school and we expect that this trend will continue. This is presenting a range of challenges as we develop new protocols and ways of working.

There has been a further increase in schools working in partnership to support and challenge each other. This different way of working can build in economies of scale and joint funding applications, but may also increase demand on services.

What we don't know

Attainment data related to religion and belief, sexual orientation and trans pupils is not available.

Key evidence and policy

Equality Act, 2010

<http://www.legislation.gov.uk/ukpga/2010/15/contents>

Department for Education - Resources to help raise the attainment of children who receive Pupil Premium

<http://www.education.gov.uk/schools/pupilsupport/premium/a00218585/ppresources>

Recommended future local priorities

1. Improvements in achievement and attainment for all pupils continue to be our main focus. Within this we are focusing on closing the achievement gap for vulnerable pupils and improving maths outcomes at all key stages.

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2. Good attendance continues to be a priority because of its relationship to attainment and wellbeing. Schools now hold the day to day responsibility for improving attendance and the local authority needs to quality assure schools' systems in addressing attendance and compliance with the regulations surrounding school attendance and challenge where necessary.
3. Schools need to continue to be supported to develop safe learning environments that improve health and wellbeing and attainment through the Healthy Settings Programme and further develop whole school approaches to anti-bullying and equality. In July 2013 a Trans Toolkit for Schools is being launched which will support schools to develop practice which will support transgender pupils and students and prevent transphobia.⁵

Key links to other sections

- Not in education, employment or training
- Emotional health and wellbeing and mental health
- Children in need
- Children and young people with disabilities and complex health needs
- Trans

Further information

BHLIS Education and learning page

http://www.bhlis.org/education_and_learning/

Department for Education – Data, Research and Statistics

<http://www.education.gov.uk/researchandstatistics>

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August 2013

⁵ Brighton & Hove City Council. Trans Inclusion Toolkit: Supporting transgender and gender questioning children and young people in Brighton & Hove schools and colleges. 2013

6.2.1 NEET

Why is this issue important?

Engagement in learning and educational attainment is critical if young people are to make a success of their lives. Evidence shows that being not in education, employment or training (NEET) between the ages of 16 and 18 is a major predictor of later unemployment, low income, teenage motherhood, depression and poor physical and mental health. Young people who are NEET are at risk of not achieving their potential, economically or socially.¹

National research by York University suggests that there is a reasonable expectation that one in six young people who are NEET will never secure long-term employment, with the average individual lifetime public finance cost of a young person who is NEET at £56,300 equating to £12 billion across all young people who are NEET. The total associated loss to the economy, individuals and their families is just over £22 billion.²

Key outcomes

- **16 – 18 year olds not in education, employment or training (NEET)**

Impact in Brighton & Hove

Brighton & Hove City Council, through its Youth Employability Service (YES), is responsible for the delivery of Targeted Information, Advice and Guidance Support services for 16-18 year olds who are NEET in the city. This contributes to the local authority's strategic priority of providing early support to young people up to the age of 19 (24 if they have special needs) who are most vulnerable, and working with partners to minimise the number of young people who are not in employment, education or training (NEET). The Department for Education measures a local authority's annual performance against the 16-18 NEET and unknown indicators as an average of November, December and January figures. Figures for 2012 – 2013 show the best 16-18 NEET figures since the Department started to measure annual performance using the three month average in this way (Table 1).

¹ LSN. Tackling the NEETs Problem, LSN Learning, London; 2009.

² The University of York. Estimating the life-time cost of NEET: 16-18 year olds not in Education, Employment or Training - research undertaken for the Audit Commission; July 2010.

Table 1: Annual percentage of 16-18 year olds who are NEET and whose current situation is not known (%), 2004 - 2012

Nov, Dec, Jan average	16 – 18 NEET	16 – 18 Not Known
2004	8.86%	8.08%
2005	10.68%	6.13%
2006	10.85%	10.85%
2007	9.24%	5.29%
2008	7.78%	4.61%
2009	8.73%	3.98%
2010	7.45%	3.60%
2011	7.87%	12.82%
2012	6.65%	4.75%

Source: Brighton & Hove City Council – Aspire database

In March 2012 66 NEET young people completed a *Tell Us What You Think* questionnaire to seek young people's views on the current education, employment and training opportunities available to people aged 16 to 19 in Brighton & Hove and to ascertain their views on the raising of the participation age. This survey was published in March 2012.

Finding work and/or work with training was by far the most preferred option. Only seven (11%) of those interviewed stated that returning to full-time education was their preferred next step and of these most were aged 16. This would suggest that older NEETs are less likely to return to full-time or part-time education.

Almost three quarters (73%) of the young people felt lack of job opportunities was the main barrier to finding work, followed by lack of experience (70%) but very few saw lack of personal skills as a barrier to securing work. However, employer surveys indicate that lack of personal skills is a significant barrier to the selection of young people.³

³ CBI. Education and Skills Survey; February 2011.

6.2.1 NEET

A third of the young people interviewed cited lack of support as a barrier to finding work and when asked what help they would like from the Youth Employability Service the young people stated that they would predominantly like help to find and apply for a job.

Where we are doing well

As well as the NEET percentage itself, it is important to consider the level of 'not knowns' i.e. not knowing what a young person is currently doing: the higher the not known figure, the less valid / reliable the NEET figure. The Department for Education (DfE) considers anything more than 5% not known makes the NEET figures statistically invalid. We can say with justification that in Brighton & Hove we know what 95.25% of our 16-18 population are doing – something which many local authorities cannot claim. We also should bear in mind that DfE changed the way NEETS and not knowns are calculated in 2011, moving from actual age to academic age. In theory this has made it more challenging to achieve these results.

Statistical neighbour figures published by DfE in January 2013 show that Brighton & Hove is on a par with the mean of our statistical neighbours in terms of the NEET figures but better than several individual authorities - Portsmouth (7.8%), Reading (8.3%), Bristol (8%) and Plymouth (7.7%). We are also much better in terms of not knowns so our NEET statistics are seen as very reliable. By way of comparison, Bournemouth 'not knowns' is 17.9%, Bristol 18.6%, and Southampton 8.2%. Locally, East Sussex is 9.1% and West Sussex at 20.8%.

Table 2: NEET and Not Knowns – comparison with statistical neighbours , January 2013

	16 – 18 NEET	16 – 18 not knowns
Brighton & Hove	6.8%	4.2%
Mean for statistical neighbours	6.7%	10.2%

Source: Department for Education

Brighton & Hove has achieved this improvement with a much reduced, reconfigured, and rebranded Youth Employability Service (YES) with a cumulative reduction in funding of over £1.3 million since

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Connexions was restructured in 2010/11. These figures are impressive given the economic climate, and represent excellent value for money.

A recent LGA report Hidden Talents II: re-engaging young people, the local offer, published in January 2013, includes a case study on YES and some of the innovative solutions the service has developed to achieve these results. The report is available on the LGA's website: [Hidden Talents Report](#). Following from this, Brighton & Hove, as one of three 'expert councils', was asked to attend an LGA workshop in April to explain to 28 other authorities our approach to reducing NEETs and tracking the not knowns.

Local inequalities

There is strong evidence to suggest that young people in vulnerable groups are more likely to be NEET and to require more concentrated support if they are to move forward into a learning outcome. Young people outside formal education and training often have health and other personal issues to deal with and becoming NEET is a consequence of other factors. Figures for vulnerable groups in February 2013 show:

Age: Although we are currently operating below our target rate for the city across the 16 – 18 age range, it is clear that the NEET percentage increases with age. Table 1 shows the number of NEETs in February 2013 by academic age, which includes some who have turned 19.

Table 3: NEETS by academic age, Brighton & Hove, February 2013

Age	16	17	18	Total 16-18
Number	78	154	207	439

Source: Brighton & Hove City Council – Aspire database

Gender: the NEET gender split is 229 (52%) male, and 210 (48%) female. However, of the 87 NEET young people not available to the labour market, young women make up 86% (75) mainly because they are either young mothers (50) or pregnant (8).

Ethnicity: The ethnic make-up of the NEET population is predominantly White British (87%), reflecting the population as a whole.

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Learning difficulties / disabilities: 75% (330) of the NEET group are classified as having some form of learning difficulty / disability (LDD). Of these, 108 were classified as having emotional and behavioural difficulties (EBD) and 70 of the total LDD group have had a formal statement of special educational needs of which 38 were for EBD.

Qualification levels: 58% (253) of NEETs available to the labour market have qualifications below NVQ2 (five A* - C GCSE or equivalent). Of these, 38 have no qualifications at all, 115 (26%) have NVQ2 or equivalent, and only six have qualifications above level 2.

Exclusion / attendance: 35 (8%) had a history of exclusion or poor attendance at school.

Accommodation Issues: 36 (8%) have issues with housing, including living in hostels, rough sleeping or sofa surfing.

In care / care leaver: 43 (10%) are either looked after or care leavers.

Offending behaviour: 19 (4%) young people are either supervised by the Youth Offending Service or have an offending background.

Substance misuse: 26 (6%) have self-declared substance misuse issues including alcohol.

Young carers: 6 (1.4%) young people are recorded as a carer for someone other than their own child.

Table 4: Top five wards with the greatest concentration of NEETs February 2013

Wards	16-18 NEETs	% of total
Moulsecoomb and Bevendean	77	18%
East Brighton	61	14%
Hanover and Elm Grove	37	8%
Hangleton and Knoll	35	8%
Hollingdean and Stanmer	34	8%

Source Brighton & Hove City Council – Aspire database

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NEETs by ward: Of the 21 wards in Brighton & Hove, some have much higher levels of NEETs compared with the city average. Table 4 shows the top five wards with the greatest concentration of NEETs.

Predicted future need

The economic climate and government education and welfare policy changes are likely to impact on the NEET agenda in the coming years. In particular, raising the participation age (RPA) to 17 years of age in 2013 and 18 years of age in 2015 may serve to reduce the number of NEET young people. The RPA agenda is a key element in supporting young people in Brighton & Hove back into employment, education and training; the City Council has the main responsibility for achieving this.

The rates of participation in all forms of learning in Brighton & Hove for 16 and 17 year olds (93.8% and 86.4% respectively – DfE March 2013) are relatively strong. However, those who are not participating will frequently have already begun to become disengaged in school or face significant personal challenges. Engaging these young people requires further development of innovative and often non-mainstream provision, pre-16 as well as post-16, and strong mechanisms for early identification and ongoing individual support.

Since September 2012, schools have had the statutory duty to secure access to independent careers guidance for pupils in Years 9 - 11. With the demise of Connexions in schools, supporting pupils to make informed decisions has become increasingly important, especially in light of raising the participation age and the increased range of provision available to young people.

Unlike many other authorities, Brighton & Hove has retained from its former Connexions Service a well-qualified Youth Employability Service (YES) which focuses on supporting those who are NEET, or at risk of becoming NEET, into employment, education and training. Providers work closely with the Youth Employability Service team and recognise it as a single point of contact with these young people.

YES has recently extended its remit to work with more vulnerable groups of young people. This includes linking with schools to offer early help and

6.2.1 NEET

support to young people in year 11 who are at risk of not making a successful transition into employment, education or training at 16. Support is also being offered to young people in care by allocating a YES adviser to the Virtual School for Children in Care. Close working links have been developed with Jobcentre Plus, the Youth Offending Service, the Intensive Team for Families, the substance misuse service (RUOK), the Family Nurse Partnership to support teenage parents and supported housing organisations and hostels.

The work of the YES team also directly impacts on the council's child poverty and the Stronger Families, Stronger Communities strategies. NEET young people within workless households have worse educational outcomes than their peers. The work of the YES team also supports the main preventive agenda for Children and Families. Young people leaving NEET to access work or training are less likely to become involved in anti social behaviour and crime or require costly interventions by the Social Work teams. There are also community cohesion benefits to residents, family and friends in supporting their young people into secure work and training and there will also be a benefit to the community in the reduction in the costs caused by worklessness.

What we don't know

There are gaps in our data around some of the equalities groups.

Lesbian, gay, bisexual and transgender (LGBT): We do not record the numbers of LGBT young people who are NEET but it is recognised that this group of young people often experience disruption to their education / training because they have to leave their family home because of their sexuality and are thereby disadvantaged in their employment opportunities and rates of pay available. The Director of Public Health Report 2008 estimates the number of 13 – 19 year olds identifying as LGBT as between 2,336 to 3,893.

Marital status: This information is not recorded on the Aspire database although it is unlikely to be significant because of the age of the young people we work with.

Religion: This information is not recorded on Aspire.

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Census 2011 data: There may be a discrepancy between the official ONS 2011 Census data and that recorded on Aspire. The difference between the Aspire count and the ONS 2011 Census is because Aspire is updated annually with Yr 7 data from the School Census which excludes young people attending private schools. In addition, some young people move to Brighton after the initial data upload and never come to the attention of services who record on Aspire. It is this latter group who are more likely to be NEET in the city.

Key evidence and policy

Audit Commission: *Against the Odds*, 2010.

www.audit-commission.gov.uk

Department for Education: *Statutory Guidance on the Participation of Young People in Education, Employment or Training for Local Authorities*.

March 2013

<http://www.education.gov.uk/home/schools/guidanceandadvice/g00222993/stat-guide-young-people-edu-employ-train>

Education and Skills Act 2008.

<http://www.legislation.gov.uk/ukpga/2008/25/contents>

LGA: Hidden Talents II: re-engaging young people, the local offer. January 2013

http://www.local.gov.uk/c/document_library/get_file?uuid=fe612120-4c27-4d97-a855-74244b511410&groupId=10171

Recommended future local priorities

1. To strengthen links between learning providers, employers and support agencies for NEET young people via the Brighton & Hove Apprenticeship Group (BHAG) and the Investing in Young Brighton & Hove Programme as part of the City Employment and Skills Plan. To include the provision of an annual Brighton Your Futures event in partnership with Brighton & Hove City Council, Jobcentre Plus, National Apprenticeship Service, and other partners. By supporting young people along the pathway to an apprenticeship or other recognised qualification, Brighton & Hove employers will have access to a stronger, indigenous pool of potential employees.

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2. All agencies supporting NEET young people to work within the agreed Single Apprenticeship Pathway for Brighton & Hove. This includes working closely with the new Apprenticeship Training Agency and Skills Shop in Queens Road.
3. YES to continue to develop creative ways of engaging NEET young people in order to encourage and support them to access the learning opportunities available to them across the city. This will include further developing the use of social media, including Facebook and Twitter, for which the service has already gained national recognition.
4. Brighton & Hove City Council to continue to coordinate the introduction of the Raising of the Participation Age (RPA) including the development of 'Awareness Indicators / Risk of NEET Indicators' (RONI) and evaluation of effectiveness, to secure strong and effective guidance, identification and tracking arrangements.
5. Brighton & Hove City Council to conduct an analysis of reasons for drop-out at age 17 and in year, and the development of measures to address these. This includes the Planned Transfer Process whereby YES advisers offer support to young people before they leave post-16 learning early in order to broker appropriate alternative provision to avoid them becoming NEET.
6. Brighton & Hove City Council to work with City College to pilot a broader Vocational Options programme from 2012/13 to address the issue of some learners becoming NEET at 16 in the first six weeks and some learners not progressing and becoming NEET at 17.
7. YES to work within Brighton & Hove City Council's Early Help strategy by building on the RONI and other awareness indicators to offer support to vulnerable young people who are NEET or at risk of becoming NEET via the developing triage / single point of referral structures within Children's Services. This to involve more integrated work with youth services, YOS and the Intensive Team for Families (ITF).

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8. To further develop 'vulnerable learners protocols', which underpin the effective two-way exchange of information between providers so that learners' needs are met. Vulnerable learners include young offenders, young people with learning difficulties, teenage parents and children who are looked after.
9. Brighton & Hove City Council to support children who are looked after and care leavers: through dialogue with children themselves and professionals, identifying and developing the support they need to progress and stay in learning. This to include ring-fenced apprenticeships for care leavers.

Key links to other sections

- Employment and unemployment
- Education
- Child poverty
- Under-18 conceptions and teenage parents

Further information

Brighton & Hove City Council: NEET Performance Improvement Reports April 2012 to March 2013.

Department for Education: NCCIS data on NEETs

http://www.bhlis.org/education_and_learning/

<http://www.bhlis.org/economy/>

Last updated

May 2013

6.2.2 Employment and unemployment Brighton & Hove JSNA 2013

Why is this issue important?

Employment is important for many reasons. It gives people a sense of purpose and personal achievement, routine, structure, identity, status, social contacts and support. It is particularly crucial for people with mental illness who are more sensitive to the negative effects of unemployment which can add to feelings of social exclusion.¹

Unemployment is both a cause and a result of ill-health. The effects of unemployment on health can be linked to poverty and low income amongst the unemployed. There are also significant psychological consequences from being out of work, especially for the long-term unemployed. Conversely, people with poorer health are more likely to be unemployed; this is particularly true for people with long-term disabilities.²

Helping more people to find or stay in work is a key element of government welfare policy, recognising that a fulfilling working life is generally good for health and wellbeing.

Key outcomes

- **Increase employment of people with long-term condition including those with a learning difficulty/disability or mental illness (Public Health Outcomes Framework, NHS Outcomes Framework)**
- **Improved functional ability, and ability to work, in people with long-term conditions (Adult Social Care Outcomes Framework)**
- **Improved functional ability, through employment, in people with mental illness (Adult Social Care Outcomes Framework)**
- **Promote the City's employment and skills needs to internal and external partners and agencies (Brighton & Hove City Employment and Skills Plan 2011-2014)**
- **Support the creation of at least 6,000 new jobs by 2014 (Brighton & Hove City Employment and Skills Plan 2011-2014)**

- **Ensure local residents are equipped to compete for jobs in the city's labour market (Brighton & Hove City Employment and Skills Plan 2011-2014)**

Impact in Brighton & Hove

The employment rate (the percentage of those economically active in employment) in the city between Jan 2012 and Dec 2012 was 71.3% of people of working age, the same as the national rate and lower than the South East (75%) (see Table 1).³ This was an increase of 1% in Brighton & Hove from the previous year. The large student population is likely to deflate the overall rate. The entry of students into the lower skilled labour market will impact on the employment opportunities for lower-skilled residents.

Table 1: Employment and unemployment - All people, Jan 2012-Dec 2012

	Brighton & Hove (numbers)	Brighton & Hove (%)	South East (%)	Great Britain (%)
Economically active [†]	145,400	78.5	79.6	76.9
In employment [†]	132,200	71.3	74.7	70.7
Employees [†]	105,500	57.6	63.6	60.6
Self employed [†]	25,500	13.3	10.7	9.6
Unemployed (model-based) [§]	11,800	8.2	5.9	7.9

Source: Office for National Statistics annual population survey

[†] Numbers are for those aged 16 and over, % is a proportion of economically active people

Unemployment There are estimated to be 11,800 unemployed people in the city. This is 8.2% of those who are economically active. The unemployment rate is an important indicator as it highlights unused available labour, which impacts on the economic growth of the city.

¹ Department of Health. The Public Health Responsibility Deal; 2011. Available at <http://www.wp.dh.gov.uk/responsibilitydeal> [Accessed on 23/08/2012].

² Marmot M. Fair Society, Healthy Lives: Strategic Review of Health Inequalities Post 2010, 2010. Available at: <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review> [Accessed 21/08/2012]

³ ONS annual population survey. Available at <https://www.nomisweb.co.uk/> [Accessed on 23/08/2012].

6.2.2 Employment and unemployment Brighton & Hove JSNA 2013

In 2012 the gross median weekly pay for full-time workers resident in the city was £529, a rise of £2.00 from 2011. Average earnings are lower in Brighton & Hove than in the South East (£556) but higher than Great Britain (£508).⁴

Out-of-work benefits: There were 25,240 people of working age in the city claiming one or more Department for Work and Pensions benefits in November 2012 (Table 2). This was 4% lower than in August 2011, but remains almost 500 people more than in May 2008. The majority of the increase since 2008 is explained by more people receiving Job Seekers Allowance.⁴

Table 2: Working-age client group - key benefit claimants (November 2012)

	Brighton & Hove (numbers)	Brighton & Hove (%)	South East (%)	Great Britain (%)
Total claimants	25,240	13.1	10.3	14.1
Job seekers	5900	3.1	2.4	3.6
ESA and incapacity benefits	12,790	6.6	4.5	6.3
Lone parents	1,830	0.9	1.0	1.3
Carers	1,720	0.9	1.0	1.3
Others on income related benefits	610	0.3	0.3	0.4
Disabled	2,060	1.1	1.0	1.1
Bereaved	240	0.1	0.2	0.2
Key out-of-work benefits†	21,220	11.0	8.2	11.6

Source: Department of Work and Pensions benefit claimants - working age client group

† Key out-of-work benefits includes the groups: job seekers, ESA and incapacity benefits, lone parents and others on income related benefits.

Note: % is a proportion of resident population aged 16-64

Almost a quarter (23%) of all working-age benefits recipients in November 2012 were for Job Seekers

Allowance (JSA) and half (51%) were for Employment and Support Allowance (ESA) or Incapacity Benefit, an overall rate of 10% of the working age population in Brighton & Hove compared with 7% in the South East and 10% in Great Britain.

Rising unemployment may also result in loss of income for individuals and increased pressure on government spending on social benefits.

There were 1,830 lone parents claiming Income Support in Brighton & Hove in November 2012 – 0.9% of the working-age population the same rate in the South East and slightly lower than Great Britain 1.3%.⁴

In 2008, 93% of the working population in the city was employed in the service sector, with 3% in both manufacturing and construction. The majority of workplaces are small and medium sized with 10 or less employees.⁴

However, there are large numbers of local people who continue to find it difficult to find jobs and progress through the labour market. These people tend to have low qualification levels and many also have significant health problems and often need long-term, personalised support before they are in a position to enter or re-enter the labour market.

Where we are doing well

Overall, Brighton & Hove residents have high qualification and skill levels. Indeed, the quality of its resident population is a key asset for potential inward investors. The Economic Development team has secured funding to enable pre-employment training courses to be offered to unemployed people interested in finding work in hotels, restaurants or retail. This has been made possible through collaboration with City College and the participation of local employers willing to offer work experience placements.

Local inequalities

There is a gender divide in average weekly earnings with full-time female earners averaging £486.50 per week compared with £548.50 per week for males in the city, an 11% difference. However, the differential is much lower in Brighton & Hove than across Great Britain (18%) or the South East (22%).

⁴ Office for National Statistics. NOMIS site. Available at <https://www.nomisweb.co.uk/Default.asp> [Accessed on 23/08/2012].

6.2.2 Employment and unemployment Brighton & Hove JSNA 2013

National employment rates are higher for males (75%) than for females (65%). This 10% gap is also seen in the South East with 80% of males and 70% of females in employment. In Brighton & Hove, the gap between male and female employment rates is only 6%. Male employment rates are lower than the South East and national rates whilst female employment rates are also lower than the South East but higher than national rates.⁴

The employment rate for disabled people aged 16-64 (51%) is higher than England (49%) but lower than the South East (56%). The Annual Population Survey 2010 shows that 38% of disabled working age residents in Brighton & Hove with a mental health problem are in employment - higher than England (27%) and the South East (24%). However, the percentage of residents with a sight or hearing disability in employment is only 39% which is lower than both England (46%) and the South East (55%). Only 42% of Brighton & Hove residents with health problems associated with blood pressure; heart problems; stomach, liver or kidney problems; or diabetes are in employment, compared with 49% in England and 60% in the South East. For the employment rate of disabled people to equal that of non-disabled people, there would need to be 6,600 more disabled people in work.⁵

The Brighton & Hove Health Counts survey 2012 highlights the benefits of being in employment versus being unemployed. The survey shows that employed residents are less likely to smoke, experience bodily pain, suffer from depression, self harm or have a long term illness. Employed residents are also more likely to be in good or better health, eat five or more portions of fruit and vegetables a week than those who are unemployed.⁵

Predicted future need

Brighton & Hove's employment challenge is widely acknowledged. It has too few jobs for its resident population and the quality of many of the jobs that it has is insufficient to meet the skills and qualification levels of its residents. Whilst many areas are wrestling with how to retain talent and improve the skills of their local populations, in

Brighton & Hove, the overriding issue is how to make better use of its human capital. At least 6,000 new quality jobs will be needed by 2014 if we are to maintain the current employment rate of 70%.

The Government has removed the default retirement age so people can choose to work for longer. Many employers need to know more about what it means for their business and workers.

The recession hit the UK hard in 2009 although the effects in Brighton & Hove have not been as bad as in some parts of the country. The local economy however, remains precarious, as the service and hospitality industries are vulnerable to consumer spending and there is local evidence it is reducing.⁶

Brighton & Hove's unique independent retail businesses could suffer more than other types of retail businesses since these firms have smaller markets and weaker financial management systems than larger mainstream retail organisations.

The effects of the recession on the health of the population will depend on job losses, how long people remain unemployed and the wider impact on people's lives such as how it affects their relationships and whether they lose their home.

What we don't know

There is a lot of equalities data not routinely available both locally and nationally including Age, sexual orientation, ethnicity, religion, marital status and carers.

The relationship between unemployment and health has been extensively studied. However, the effects on lifestyle factors such as smoking and alcohol use are hard to predict.

Key evidence and policy

Brighton & Hove City Employment and Skills Plan 'Better skills, better jobs, better lives' 2011 – 2014.

Brighton & Hove Business Survey 2010. Step Ahead Research Ltd

Brighton & Hove City Council. State of the City Report. 2011 <http://www.bhlis.org>

⁵ Brighton & Hove City Council and NHS Brighton and Hove. Health Counts Survey. 2012. Available at www.bhlis.org/surveys

⁶ STEP AHEAD RESEARCH Ltd. Brighton & Hove Business Survey 2010.

6.2.2 Employment and unemployment Brighton & Hove JSNA 2013

Labour Market Statistics, April 2012

<http://www.ons.gov.uk/ons/rel/lms/labour-market-statistics/april-2012/statistical-bulletin.html>

UK Unemployment Labour Market Statistics,
<http://www.hrmguide.co.uk/jobmarket/unemployment.htm>

Office for National Statistics NOMIS
<https://www.nomisweb.co.uk/Default.asp>

Department of Health. 2009. Valuing employment now – real jobs for people with learning disabilities. Available at

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101401

Last updated

August 2013

Recommended future local priorities

1. The city's employment and skills priorities are reflected in aligned strategies and plans, including those developed by the Coast to Capital Local Enterprise Partnership.
2. Ensure that local residents are equipped to compete in the city's labour market.
3. Economic partnership to work closely with colleges and training providers to ensure that provision reflects local need.

Key links to other sections

- Not in education, employment or training
- Transport and active travel
- Health in the workplace
- Happiness and wellbeing
- Mental health

Further information

Brighton & Hove City Employment and Skills Plan
'Better skills, better jobs, better lives' 2011 – 2014

Brighton & Hove Economic Strategy 2008 - 2016
Raising Our Game. Available at:
http://www.brighton-hove.gov.uk/downloads/bhcc/economicdevelopment/economic_strategy_2008-2016.pdf

Brighton & Hove Business Survey 2010. Step Ahead Research Ltd. Available at <http://www.brighton-hove.gov.uk/downloads/bhcc/economicdevelopment/2010BusinessSurvey.pdf>

State of the City summary 2011. Available at
<http://www.bhlis.org/population/>

Why is this issue important?

The workplace has direct influences on the physical, mental, economic and social well-being of employees and in turn of their families. Most of our waking hours are spent in work. Being in good quality employment is good for mental and physical health; it empowers people and reduces poverty and social exclusion. Promoting well-being at work is essential not only for a person's health and wellbeing, but it is also good for business as it can reduce sickness absence and improve productivity.¹

Across England around 135 million working days were lost due to sickness absence – approximately five days per employee – in the year to March 2011.² Stress and back pain are the two biggest causes of absence from work. More than 90% of people with common health conditions could be helped to return to work if basic principles of good healthcare and workplace management principles were followed. The total annual cost of Statutory Sick Pay to employers is estimated to be more than £1.5 billion.³ It is estimated that British business could save up to £8 billion a year if it managed mental health at work more effectively.⁴

Being in employment is protective of health; jobs need to offer a decent wage, opportunities for in-work development, good management practices, the flexibility to enable people to balance work and family life, and protection from adverse working conditions that can damage health.⁵

Offering advice and support to public and private businesses to promote physical and mental health and wellbeing in the workplace benefits employees as they are encouraged to embrace a healthier lifestyle, not only for themselves, but also their families. It also benefits business through a reduction in sickness absence, greater staff

engagement and productivity and reduced staff turnover.⁶

Key outcomes

- ***Increase employment of people with long-term condition including those with a learning difficulty/disability or mental illness (Public Health Outcomes Framework / NHS Outcomes Framework)***
- ***Improved functional ability, and ability to work, in people with long-term conditions (Adult Social Care Outcomes Framework)***
- ***Improved functional ability, through employment, in people with mental illness (Adult Social Care Outcomes Framework)***
- ***To reduce sickness absence rates – Placeholder (Public Health Outcomes Framework)***
- ***To support workplaces to adopt health and well being initiatives for their workforce (Public Health Responsibility Deal)***

Impact in Brighton & Hove

In 2011, around 131 million days were lost through absences due to sickness or injury, a fall of around 26% since 1993 where 178 million days were lost (these figures include employees and self-employed, aged 16+, across the whole of the UK).

The percentage of hours lost to sickness in the private sector is lower than in the public sector, 1.6% and 2.6% respectively. There are a number of things to consider when interpreting these differences such as:

- There are differences in the types of jobs between the two sectors and some sectors have higher likelihoods of sickness than others.
- On average, women have more sickness absence than men and the public sector employs a higher proportion of female workers.
- The analysis only counts someone as sick if they work fewer hours than contracted for. It would exclude someone who is sick and makes up for the lost hours at a later point in the week. It is possible that individuals in smaller workforces are under more pressure to make up any lost

¹ Marmot M. Fair Society, Healthy Lives: Strategic Review of Health Inequalities Post 2010, 2010. Available at: <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review> [Accessed 21/08/2012]

² Workplace Wellbeing Charter England; 2011. www.wellbeingcharter.org.uk

³ Black C (Dame) and Frost D (CBE). Health at work – an independent review of sickness absence; 2001.

⁴ NICE (2009) public health guidance 22. Promoting mental health through productive and healthy working conditions: guidance for employers.

⁵ Marmot M (Sir). Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post – 2010; 2010.

⁶ Black C (Dame). Working for a Healthier Tomorrow. Review of the health of Britain's working age population; 2008.

6.2.3 Health in the workplace

hours and these workforces are more prominent in the private sector.

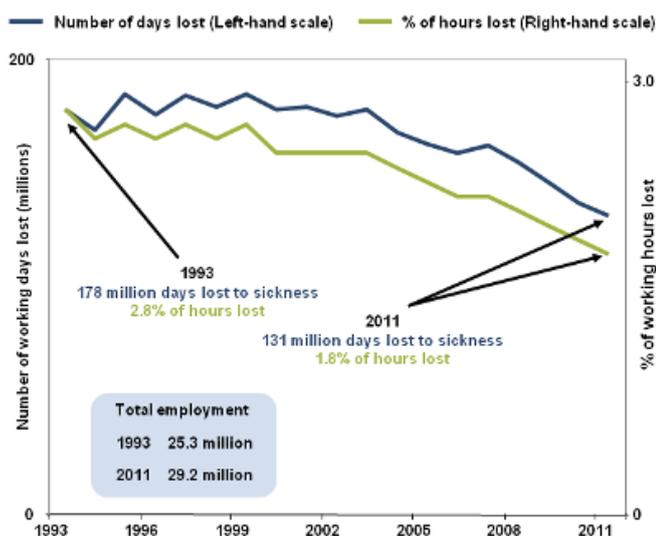
- Individuals within the private sector are also more likely to not be paid for a spell of sickness than individuals within the public sector.

Looking at differences between men and women in the two sectors, women in the public sector lost the highest percentage of their hours in 2011 at 3.0%. Men in the private sector lost the fewest at 1.5%.

Self-employed people, at 1.2% of working hours lost, took less sickness than employees in 2011 (1.9% of working hours lost). Self-employed people do not generally have the same sick-leave cover as employees do and would therefore have more incentive to make up any hours lost due to sickness. Also self-employed individuals are more likely to lose out financially if they lose working hours.

The South East region has a slightly lower 17.% than the UK 1.8% average for sickness absence rates (October 2010 to September 2011).

Figure 1: Sickness Absence levels, all persons 16+, annual average 1993-2011, UK



Source: Office for National Statistics, Labour Force Survey⁷
<http://www.ons.gov.uk/ons/rel/lmac/sickness-absence-in-the-labour-market/2012/rpt-sickness-absence-in-the-labour-market---2012.html>

This information is not routinely collected at local authority level.

⁷ <http://www.ons.gov.uk/ons/rel/lmac/sickness-absence-in-the-labour-market/february-2012/index.html>

Where we are doing well

Workplace Health is one of three themes outlined in the Healthy City Partnership and a workplace health sub-group was established in 2010. The group's main objective is to improve the health and wellbeing of everyone living and working in Brighton & Hove, and to reduce health inequalities across the city. The Workplace Health sub-group action plans have been developed promoting the following:

- The Workplace Wellbeing Charter is being promoted to all businesses across the City (Target: five businesses to be accredited in 2013-14)
- Active and Healthy Workplace fund (up to £500 per business) for small and medium enterprises (SMEs), to deliver programmes that improve workplace health and wellbeing of staff (nine businesses received funds in 2012/13).
- Promoting NHS Health Checks (over 700 checks given in 2012/13) and other health promotion opportunities to workplaces

The Council's health and safety team enforce the Health and Safety at Work etc Act 1974 in

approximately 9,000 workplaces in the city. The team's role is to ensure workplaces are safe and do not cause ill-health to workers, residents and visitors. The team achieves this by supporting businesses to comply with their legal obligations.

Total days lost by reason (2011)	
Musculoskeletal problems*	35.0m
Minor illnesses	27.4m
Other	18.1m
Stress/Depression/Anxiety	13.3m
Gastrointestinal problems	10.3m
Prefer not to disclose	5.8m
Respiratory conditions	5.3m
Genito-urinary problems	5.0m
Heart/Blood pressure	4.5m
Ear/Nose/Throat	3.8m
Headaches/Migraines	1.6m
Serious mental health	0.7m
Diabetes	0.5m



Local inequalities

Currently there are no figures for sickness absence by age, gender, ethnicity, religion, marital status, sexual orientation for the city. This information is not routinely collected by local authority.

The Brighton & Hove Health Counts 2012 survey shows that employed residents are less likely to smoke, experience bodily pain, suffer from

6.2.3 Health in the workplace

depression or self harm than those who are unemployed.⁸

Women have consistently higher sickness absence rates than men but both sexes have seen a fall over the past 20 years. Men have gone from losing around 2.5% of their hours due to sickness in 1993 to around 1.5% in 2011. Over the same period women have seen a reduction from 3.3% to 2.3%. There was also a difference between men and women in the reasons for being off work – other than minor illnesses such as coughs and colds, the top reason for men to be off work was musculoskeletal problems, whereas the main reason for women was stress, depression and anxiety.⁹

Predicted future need

Ongoing consultation with local businesses indicates that employers can see the benefits of addressing the health and wellbeing of employees but are concerned that the cost(s) involved will affect their profit margins. Further work is needed to promote the benefits to employers.

What we don't know

We don't know what impact the global economic crisis will have on businesses across the city over the next few years.

We are likely to see: Employers and employees facing increasing financial pressures; and a reduction in employment in the public sector.

There is no local data on sickness absence to explore how the current sickness absence system could be changed to help people stay in work.

Key evidence and policy

Dame Carol Black. Workplace Wellbeing Charter England (2011). www.wellbeingcharter.org.uk

Dame Carol Black Working for a Healthier Tomorrow. Review of the health of Britain's working age population (2008). www.dwp.gov.uk/docs/hwwb-working-for-a-healthier-tomorrow.pdf

Improving health and work: changing lives The Government's Response to Dame Carol Black's Review of the health of Britain's working age population (2008). www.dwp.gov.uk/.../hwwb-improving-health-and-work-changing-lives.pdf

Fair Society, Healthy Lives. The Marmot Review – Strategic Review of Health Inequalities in England post 2010. www.instituteofhealthequity.org/.../fair-society-healthy-lives-the-marmot-review

NICE public health guidance 22: Promoting mental wellbeing through productive and healthy working conditions: guidance for employers. www.nice.org.uk/PH22

Management of long-term sickness and incapacity for work (PH19). Public health guidance March 2009. Guidance for primary care and employers on the management of long term sickness and incapacity <http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11779>

Recommended future local priorities

The Local Authority, NHS, businesses, and the voluntary sector should continue to lead the way in promoting health and wellbeing in the workplace:

1. Recognise their vital roles in improving public health.
2. Use the work environment to help people maintain or improve their health.
3. Commissioning programmes which promote healthy lifestyles, and identify and work towards reducing the barriers to health, work and wellbeing.
4. Improved access to support for those who are unemployed or off sick from work with mental health problems or musculoskeletal problems.
5. Provide NHS Health Checks in workplaces as they will reach men, who are hard to reach through traditional channels.
6. Promote the Health for Work Advice Line for Small Businesses – free occupational health advice (Tel: 0800 077 8844).
7. Ensure that young people have a healthy work experience.

⁸ Brighton & Hove City Council and NHS Brighton and Hove. Health Counts Survey. 2012. Available at www.bhllis.org/surveys

⁹ Office for National Statistics. Labour Force Survey. 2012

6.2.3 Health in the workplace

8. Special attention should be paid to the mental health needs of men and young people aged 16-24 being made redundant.
9. Need to monitor the effects of the later retirement age on people now having a longer working life.
10. Steps need to be taken so organisations can reduce levels of sickness and absenteeism.
11. Maintain the health of staff as they grow older (an issue that is becoming increasingly important with our ageing population).
12. Employers to promote a culture where employees can discuss stress and mental distress openly without stigma or discrimination.
13. Support in place for staff returning to the workplace, with a particular focus on those with a mental health condition.

Key links to other sections

- Transport and active travel
- Employment and unemployment
- Happiness and wellbeing
- Healthy weight (adults and older people)
- Mental health
- Physical activity and sport

Further information

Workplace Wellbeing Charter. *Self Assessment Standards* www.wellbeingcharter.org.uk

Health, Work and Wellbeing: *A Review of the health of the working age population* by Dame Carol Black <http://www.dwp.gov.uk/docs/hwwb-working-for-a-healthier-tomorrow.pdf>

Taking *Care of Business* Mind Campaign www.mind.org.uk/employment

Health and Safety Executive The Health and Safety of Great Britain: Be part of the solution. 2009 <http://www.hse.gov.uk/strategy/strategy09.pdf>

Change 4 Life www.nhs.uk/Change4Life

Last updated

July 2013

6.3.1 Young offenders

Why is this issue important?

National research has found that health outcomes for offenders are poorer than for the general population. This cohort is recognised as a vulnerable group, with complex psychosocial and physical health needs. Health outcomes in later life include an increased risk of medical problems, substance dependence, poorer self-reported health, lower body mass index, mental health problems, depression, suicide and early pregnancy in females. Studies of young offenders have also established high rates of significant ill-health, injuries, and substance and alcohol misuse.¹

Death rates of male community offenders aged 15 to 44 years were found to be four times the rate of the general population.²

Key outcomes

- **Reduce the number of first time entrants to the youth justice system (youth justice and Public Health Outcomes Framework)**
- **Reduce the number of young people sentenced to custody**
- **Reduce the number of young people re-offending and the number of re-offences)**

Impact in Brighton & Hove

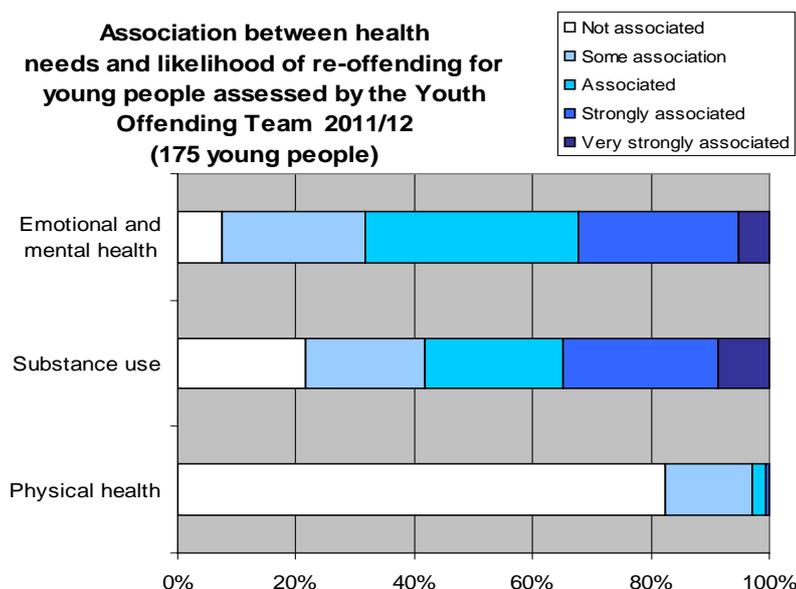
In 2011/12 there were 88 first time entrants to the youth justice system which is just below 1% of the Brighton & Hove 10-18 population.³ This figure has reduced significantly since peaking at 609 first time entrants in 2006/7. The number of young people offending in Brighton & Hove each year has nearly halved from 811 in 2006 to 430 in 2009.⁴

The majority of young offenders were found to have some association between mental and emotional health and substance misuse and a risk of future re-offending (as identified through the youth justice assessment tool, Asset). Overall

physical health appears to have a much lower association with future offending (Figure 1).

Young offenders in the city are almost twice as likely to have witnessed violence in the family as the whole population.⁵ Additionally young offenders are more likely to be victims of crime than the wider population of young people generally.

Association between health needs and likelihood of re-offending for young people assessed by the Youth Offending Team 2011/12 (175 young people)



Where we are doing well

As a well-resourced multi-agency team, the Youth Offending Service has specialist staff who work directly with young offenders' needs including speech and language difficulties, mental health, substance misuse and sexual health.

Brighton & Hove is a Pathfinder area for the Youth Justice Liaison and Diversion pilot⁶ project. Young people are diverted from the criminal justice system at the point of arrest if they are found to have mental health needs. This project has contributed to the reduction of the number of young people entering the youth justice system, with sixty referrals over the last twelve months.

Local inequalities

Young men are over represented in the youth justice system making up 75% of the population

¹ MacDonald W. The Health Needs of Young Offenders. The National Primary Care Research and Development Centre. The University of Manchester; November 2006.

² Sattar G. Rates and Causes of Death Among Prisoners and Offenders under Community Supervision. Home Office Research Study 231; November 2001.

³ Based on 2010 population estimates provided by the Youth Justice Board.

⁴ Ministry of Justice quarterly statistical release .

⁵ Brighton and Hove City Council. Brighton and Hove Parent Support Strategy 2008-2011.

⁶ Funded by the Department of Health.

6.3.1 Young offenders

supervised by Brighton & Hove Youth Offending Service which is in line with national figures.⁷

In Brighton & Hove the Black and Minority Ethnic (BME) population of young offenders is proportionate to that of the city as a whole. However, it has been found that BME young men are more likely to remain in the youth justice system.

A disproportionately high number of young offenders have special educational needs identified (83%), with the majority being Behaviour, Emotional and Social Development (BESD) needs.⁸ Previous analysis has shown that at least a third of young offenders in Brighton & Hove have at some point had a statement of special educational needs.

73% of young people supervised by the Youth Offending Team in March 2012 have ever been in receipt of free school meals, an indicator of low family income.

Predicted future need

It is predicted that the number of young people in the youth justice system will reduce or remain stable over the coming years. These young people are likely to continue to present with multiple and complex needs.

What we don't know

There is little data held on the youth justice case management system around the health needs of young offenders beyond those that impact on offending behaviour. For example, it is believed that many young offenders are not registered with a GP and do not regularly visit a dentist. This could increase the risk of interactions with the health service being in times of crisis rather than at a primary or preventative level.

Wellbeing indicators are not captured on Asset, the assessment tool for youth justice. The tool includes a section for positive or protective factors but this does not contribute towards the assessment score.

Key evidence and policy

The [Youth Justice Board](#) publishes policy, guidance and best practice on statutory aspects of delivering youth justice services.

The Green Paper '[Breaking the Cycle: Effective punishment, rehabilitation and sentencing of offenders](#)' was published in December 2010 and outlines the current Government's plans on managing and reducing offending and re-offending.

The new, to be appointed, Police Crime Commissioner role will have responsibility for 18% of the youth justice budget.

Recommended future local priorities

1. Evaluation of the effectiveness of health interventions on reducing risk of re-offending to inform the Youth Offending Service Menu of Effective Interventions
2. Manage and implement any additional health and wellbeing initiatives to be delivered to young offenders under the governance of the Health and Wellbeing Board.
3. Ensure crime prevention and the Youth Offending Team signpost service users to universal health services as part of the intervention plan and exit plan.

Key links to other sections

- Child poverty; Parenting; Children in need, safeguarding, child protection and looked after children
- Young people not in education, employment and training
- Housing needs
- Social connectedness; Community resilience
- Emotional health and wellbeing; Smoking and substance misuse; Sexual health (young people); Under 18 conceptions and teenage parents
- Mental health
- Learning disabilities

⁷ Youth Justice Statistics 2010/11 England and Wales. Youth Justice Board. Ministry of Justice Statistics Bulletin.

⁸ Of cases open in August 2011.

6.3.1 Young offenders

Further information

A detailed needs assessment is being produced for youth crime prevention and offending and will be due for completion in early June 2012.

A Youth Justice Plan is created annually

<http://www.brighton-hove.gov.uk/content/children-and-education/teenagers/youth-justice-plan>

Last updated

Reviewed July 2013

6.3.2 Crime, anti-social behaviour and safety

Why is this issue important?

Crime and disorder (including anti-social behaviour) can have a significant impact upon physical health and mental wellbeing. 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.¹ Repeat victimisation will deepen these negative impacts. 13% of respondents to the Crime Survey in England and Wales in 2012 reported high levels of worry about violent crime, 12% about burglary, and 8% about car crime.

The Crime Survey for England and Wales 2011/12 found 26% of respondents who had experienced or witnessed drink-related antisocial behaviour said it had a moderate or high impact on their quality of life; the respective impact of groups hanging around on the streets was 31%.

Key outcomes

National

- **Rates of violent crime, including sexual violence (Public Health Outcomes Framework)**
- **Older people's perception of community safety (Public Health Outcomes Framework – place holder)**

Local

- **Police recorded crimes**
- **Feelings of safety**
- **Police recorded anti-social behaviour incidents**

Impact in Brighton & Hove

Table 1 shows the level and trend in certain crime groups reported to the police in the city. Certain crime types have a particular tendency to be under-reported, including low-level assaults, criminal damage and thefts from the person, so the

actual level of crimes in the city will be substantially higher.²

	Number 2012/13	% change from 2011/12	% change from 2009/10
Total crimes	23,602	-0.1%	-3.4%
Violence against the person	4,150	-2.9%	-14.2%
Domestic burglary	1,143	+44.5%	-6.9%
Vehicle crime	1,739	-10.2%	-23.0%
Criminal damage	3,005	-11.5%	-26.1%
Theft and handling	11,564	+3.8%	+15.9%

Source: Sussex Police

Total crimes, previously on a downward trend, have stabilised during 2012/13. While violence against the person offences, criminal damage and vehicle crimes have all decreased in 2012/13, there have been increases in the last year in domestic burglary (following particularly low numbers in 2011/12).

Theft and handling offences have also risen (principally linked to theft of personal property from people visiting the commercial area in the city centre), continuing an increasing trend, but were beginning to decline again in the second half of 2012/13. Compared with matched comparator areas,³ we have better than average rates for domestic burglary and vehicle crime, about average or slightly poorer crime rate for total

¹ Stafford M et al. Association Between Fear of Crime and Mental Health and Physical Functioning. American Journal of Public Health; November 2007.

² Home Office. Crime in England and Wales 2011/12: Annual trend and demographic tables. 2012.

³ Data for 2012/13. Brighton & Hove's group of 15 'Most Similar' Community Safety Partnerships as assigned by the Home Office

6.3.2 Crime, anti-social behaviour and safety

crime, thefts and violent crimes, but a criminal damage rate which is among the poorest of our comparators.

Violent crime, including robbery and public place assault can also have a big impact on physical health and mental wellbeing, lasting into the long term. Domestic and sexual abuse also have significant consequences and are covered in a separate section (section 7.3.8).

Other crimes, such as bicycle theft, can also impact upon health. There were 1,000 cycle thefts recorded in the city in 2012/13, compared with 988 in 2011/12. Tackling cycle theft is important to promote sustainable transport, as well as encourage healthier lifestyles amongst residents.

Anti-social behaviour and hate-motivated incidents also have a detrimental impact on individuals and communities, affecting quality of life and wellbeing and sometimes causing significant harm.

Between 2009/10 and 2011/12 there were 577 admissions to hospital for violence of Brighton & Hove residents.⁴ In order to compare with other areas a directly age standardised rate per 100,000 population is produced: for Brighton & Hove the standardised admission rate was 67.0 per 100,000 people, very similar to the England rate of 67.7 per 100,000 people.⁵

When asking local people about their priorities for community safety in their local neighbourhoods, anti-social behaviour, and speeding or parking issues tend to predominate.⁶ These issues have a bearing on the extent to which city residents will use and enjoy their local environment, connect with their neighbours, interact in wider social settings, and enjoy a good quality of life.

Of respondents to the City Tracker telephone survey in Sep/Oct 2012, 98% reported feeling safe

outside in their local neighbourhood during the day and 81% after dark, 97% also felt safe outside in the city centre, but this figure dropped to 61% after dark. In their own home 99% felt safe during the day and 98% after dark.⁷

Where we are doing well?

Brighton & Hove is covered by a network of Local Action Teams (LATs) which are community based and are supported by the Police, Council and others. LAT meetings provide local fora for people to raise issues of concern and seek solutions.

The Community Safety Projects Team works with the LATs in a number of ways, including identifying and carrying out environmental improvements which reduce the opportunity for crime or anti-social behaviour, and capacity-building work, such as helping to develop LAT websites to assist with communication, and enabling information sharing between LATs.

Brighton & Hove has been one of five national pilot areas for the Community Trigger, prior to the new powers to be granted under the forthcoming Anti-social Behaviour Act.⁸ This has provided victims and communities the right to require action is taken where an ongoing problem has not been addressed. It helps in making sure that no-one suffering the harmful effects of anti-social behaviour and hate crime falls through the net.

Local inequalities

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

Fear of crime is influenced by a range of socio-demographic factors such as age, gender and health. The City Tracker survey showed that a

⁴ The number of emergency hospital admissions for persons resident in the area where the primary diagnosis or any of the secondary diagnoses are ICD-10 codes X85-Y09, for all ages, for the years 2009/10 to 2011/12

⁵ Hospital Episode Statistics, Health and Social Care Information Centre (HSCIC) and ONS mid-year population estimates for 2009 and 2010. Taken from Public Health England. Public Health Outcomes Framework Data Tool. Available at <http://www.phoutcomes.info/> [Accessed 13/08/2013]

⁶ Brighton & Hove Strategic Assessment of Crime and Disorder, 2012.

⁷ Brighton & Hove Strategic Partnership. City Tracker Survey. 2012. Available at www.bhlis.org/surveys [Accessed 13/08/2013]

⁸ Home Office. Empowering communities, protecting victims: summary report on the community trigger trials. 2013. Available at: <https://www.gov.uk/government/publications/empowering-communities-protecting-victims-summary-report-on-the-community-trigger-trials> [Accessed 13/08/2013]

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lower percentage of females, as well as those with a limiting long-term illness or disability (LLTI), felt safe outside in their local area and in the city centre after dark. Those aged 45 and over were less likely to feel safe in their local neighbourhoods and the city centre after dark, as well as those aged under 25 compared with those aged 25-44.⁷

Reports to the police of hate incidents which are targeted at people because of who they are, such as racist or religiously-motivated crimes or incidents against lesbian, gay, bi, or trans people, have been declining over recent years, but remain of particular concern to these communities.

During 2012/13 the Anti-social Behaviour and Hate Crime Casework Team started to operate a duty line for receiving reports, and in its first year of operation (May 2012 to April 2013) 613 incidents have been recorded on the duty system, of which 386 related to ASB, 86 to race, 30 to disability, 16 to sexual orientation, three to trans gender, one to religion and 91 others. Over that 12 month period there were 126 new cases for the team.

Of those surveyed in the 2012/13 LGBT Trust and Confidence Survey, 23% reported they had experienced a hate crime or incident in the last 12 months related to their sexual or gender identity. Verbal abuse and negative comments were the most common form of incident, many of which go unreported.⁹

A recent Trans Equality Scrutiny Panel, set up to highlight the challenges and inequalities facing transgender people in Brighton & Hove, recommended robust recording of police and community safety data on trans-related crimes and incidents should be developed and used to inform preventative measures, alongside further work to encourage reporting of hate crime.¹⁰

Although older people are less likely to experience crime, if they do so, the impact can be much greater than it is on younger people. Research into

older victims of burglary in sheltered housing 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.¹¹ There were 12 distraction burglaries recorded in 2012/13, all with victims who were over 50 years of age.

The age and lifestyle of the significant student population in the city matches a number of risk factors for being a victim of crime. For example they are within the highest risk age-group for violent crime and sexual offences, often live in housing of multiple occupation at a higher risk of burglary or theft, and are likely to be in possession of portable electronic items of value.

Different identities interact in highly complex ways with demographic and situational characteristics to increase the risk of victimisation of hate incidents and the level of harm caused. For instance, people may be targeted, or be more likely to suffer from hate crime or anti-social behaviour due to an intersection/overlap of different identities (for example their gender, ethnicity or disability), resulting in multiple-discrimination or compounding of harm.

A number of social and demographic factors can also affect fear of violence. The 2012 Health Counts Survey showed that those with a long-term illness, disability or health problem were more likely to have felt stressed or anxious some, all, or most of the time in the last three months by fear of violence against both themselves, and family or friends. Those who did not feel that they belonged to their immediate neighbourhood were also more likely to have a greater fear of violence against both themselves and their family or friends. Those who saw or spoke to their neighbours less than once a week were more likely to fear of violence against themselves than those who had contact with their neighbours at least once a week. BME people, those renting from a housing association or local authority, carers, and those without

9 LGBT Community Safety Forum, Brighton & Hove LGBT Trust and Confidence Survey Report 2012/13

10 Brighton & Hove City Council, Report of the Overview and Scrutiny Committee, Trans Equality Scrutiny Panel, January 2013.

¹¹ Donaldson R. Experiences of Older Burglary Victims, Home Office Findings No. 198; 2003.

6.3.2 Crime, anti-social behaviour and safety

qualifications were also more likely to fear violence against family or friends.¹²

Predicted future need

While Brighton & Hove continues to be characterised as a vibrant, diverse and much visited city, policies, infrastructure and services need to ensure this happens safely and without negative impacts. Important 'drivers' of crime and disorder in the city are alcohol and drug misuse. Work to address these issues continues to be important and will bring health benefits to substance misusers and safety benefits to the community as a whole.

For the most part, crime figures to date do not suggest a particular increase in response to the economic downturn. An exception to this may be the increase observed in thefts. However, welfare reform, as well as national changes to housing policy will have consequences for a number of the city's residents, and may leave vulnerable people insecurely housed. There has been a national increase in the number of rough sleepers, which is also evident in Brighton & Hove. The number of rough sleepers that the Rough Sleepers Team work with rose by 24% between 2010/11 and 2011/12, and by 37% (to 1,163) between 2011/12 and 2012/13.¹³ The number of police arrests for begging increased from 25 in 2010/11 to 62 in 2011/12, but then decreased to 51 in 2012/13.

What we don't know

A Sussex Police audit of hate crimes has brought into question the consistency of police recording, making interpretation of trend data difficult. With ongoing work, data may stabilise at a higher level than previously.

As well as issues around recording, there is work to be done to encourage greater levels of reporting of all types of hate crime, so that problems can be identified and addressed. Work to encourage reporting of hate crimes against marginalised, and

vulnerable individuals within these communities, also continues to be important.

National research shows that less than half of all domestic violence incidents are reported to the police.¹⁴ For more information on domestic and sexual violence and abuse see section 7.3.8.

Nationally, it is argued that the economic downturn is likely to result in an increase in racist and religiously motivated incidents, and the growth of far-right extremist groups. Due to the issues mentioned above, it remains to be seen if this is the case locally.

Local survey data around feelings of safety has been collected in 2012 in the City Tracker telephone survey. However, methodological changes from previous surveys make it difficult to assess changes over time.

Key evidence and policy

In April 2013, the Sussex Police and Crime Commissioner launched her first Police and Crime Plan, 'Safer in Sussex', identifying crime and community safety, victim focus, public confidence and value for money as four key strategic objectives. http://www.sussex-pcc.gov.uk/wp-content/uploads/2013/03/SPCC_Police_and_Crime_Plan.pdf

The government's Equality Strategy (December 2010) reiterated its commitment to tackle all hate crimes and violence. 'Challenge it, Report it, Stop it', the government's plan to tackle hate crime published in March 2012, sets out three key objectives:

- prevent hate crime happening by challenging attitudes that underpin it, and early intervention to prevent escalation of incidents;
- increase the reporting of hate crime by building victims' confidence and improved access to support; and
- improving the operational response to hate crime.

¹² NHS Brighton & Hove and Brighton & Hove City Council. Health Counts. 2012. Available at www.bhjis.org/surveys [Accessed 13/08/2013]

¹³ CRI, Rough Sleepers Street Services and Relocation Team Annual Report, April 2012 to March 2013

¹⁴ Brighton & Hove Community Safety, Crime Reduction and Drugs Strategy 2011-14

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<https://www.gov.uk/government/publications/hate-crime-action-plan-challenge-it-report-it-stop-it>

Reducing anti-social behaviour has also been identified as a priority for the government. A 2010 Her Majesty's Inspectorate of Constabulary (HMIC) report recommended a more harm-centred approach to tackling anti-social behaviour which includes assessing the vulnerability and degree of risk of victims and witnesses of anti-social behaviour. Following this, in February 2011 a consultation paper 'More effective responses to anti-social behaviour' was published highlighting the government's intention to introduce new tools and powers to assist front line practitioners in tackling anti-social behaviour.

<https://www.gov.uk/government/publications/antisocial-behaviour-consultation-on-more-effective-responses>

Work within families to ensure children and young people get a good start in life reduces risk for involvement in crime or anti-social behaviour in the future. The government's Troubled Families programme is a new initiative tasked with improving the outcomes for families with issues around anti-social behaviour, educational attendance/ behaviour, and worklessness.¹⁵

The 2012 Department of Health report 'Protecting People, Promoting Health; a public health approach to violence prevention for England' states that violence is a major cause of ill health and poor wellbeing in the population, and lays out the responsibility of public health to help prevent violence.

<https://www.gov.uk/government/publications/a-public-health-approach-to-violence-prevention-in-england>

Research has shown that citizenship, neighbourliness, social networks and civic participation are key elements of social capital and lead to lower crime rates by impacting on the precursors of crime: levels of trust; respect; and self-esteem within and between community members.¹⁶

Recommended future local priorities

1. Ongoing work in neighbourhoods to involve local residents in identifying and tackling issues which are important to them.
2. Continued work to manage the night-time economy safely, especially to prevent violent crime.
3. Tackling perpetrators of anti-social behaviour and hate incidents and supporting victims. Further work is needed to encourage the reporting of hate crimes.
4. Designing-out crime and maintaining the quality of the local environment.
5. Improving information and support networks and social structures for older people and providing better co-ordination of services.

Key links to other sections

- Alcohol
- Substance misuse
- Emotional health and wellbeing
- Mental health
- Domestic and sexual violence
- Parenting
- Youth justice
- Noise pollution
- Offenders and Offending
- Social connectedness

Further information

Brighton & Hove Community Safety, Crime Reduction and Drugs Strategy 2011-14 and annual Strategic Assessment: www.safeinthecity.info

Last updated

May 2013

¹⁵ Communities and Local Government. 'The Troubled Families Programme'. 2012

¹⁶ Office for National Statistics. Social capital a review of the literature. 2001

Why is this issue important?

The Home Office has estimated that around 50% of crime is committed by 10% of offenders and the most prolific 0.5% commit 10% of crimes. Repeat offenders are often some of the most socially excluded in society. They will typically suffer from multiple disadvantages and in addition to the problems above, may also have social problems, unemployment, finance and debt.

According to the 2009 Department of Health report 'Improving Health, Supporting Justice', offenders are much more likely than average to be subject to factors such as mental illnesses, personality disorders, learning disabilities, substance misuse, homelessness and poor educational achievement. This report pointed out that offenders can often experience problems in accessing health and social care services.

The type of offences committed by prolific offenders are often 'acquisitive crimes' (mostly, burglary, theft and shoplifting) and the proceeds from these crimes often fund illicit drug use. These crimes have a significant impact on actual and perceived levels of safety by individuals, businesses and communities. Successful actions to both prevent and reduce offending by prolific offenders not only brings about changes in the behaviour and improved life opportunities for individual perpetrators, but also brings significant benefits to communities in Brighton and Hove.

It is important that the families of offenders are taken into consideration. For offenders, having family relationships can reduce the likelihood that they will re-offend in the future. Receiving family visits while in prison has been associated with more successful employment and accommodation outcomes.¹ At the same time, children's lives can be strongly influenced by family circumstances. Criminal behaviour can be passed down the generations within a family.²

The section of the JSNA on crime, anti-social behaviour and safety describes the association between crime and how safe people feel.

Key outcomes

- ***People entering prison with substance dependency issues who are previously not known to community treatment – Placeholder (Public Health Outcomes Framework)***
- ***People in prison who have a mental illness or a significant mental illness – Placeholder (Public Health Outcomes Framework)***

Impact in Brighton & Hove

Data from the Ministry of Justice are available on reoffending by drug-related offenders. Of drug misusing offenders who offended in Brighton & Hove between July 2010 and June 2011, 60% of them went on to reoffend in the following 12 months, roughly the same as the national average. This compares with 25% of all offenders during that same period.

Sentencing options for courts include Alcohol Treatment Requirements (ATRs) and Drug Rehabilitation Requirements (DRRs). In Brighton & Hove during 2012/13 44% of ATRs were successfully completed (against a target of 50%) and 59% of DRRs were completed (against a target of 50%).

There has been local monitoring of reoffending by 'priority and prolific offenders' (PPOs) since this was implemented as a national indicator (NI30). As of April 2012 there were 82 PPOs being worked with who had committed 345 offences in the previous 12 months. Reoffending data for this cohort are not finalised, but it is expected that the number of offences in the following 12 months will be in the range of 204 and 289.

During 2012/13 in Brighton and Hove 76% of offenders successfully completed their community orders and licences, against a nationally set target of 75%. 94 offenders completed an Alcohol Brief (course) against a local target of 74, whilst 23 offenders completed a Drugs Brief against an internal target of 15.

The Citizens Panel were asked in 2010 about how worried they were about different types of crime. 32% reported being worried about their bicycle being stolen, 24% about their home being broken into, 20% were worried about bogus callers and

¹ Ministry of Justice and Department for Children, Schools & Families. Reducing Re-offending: Supporting families, creating better futures. 2009

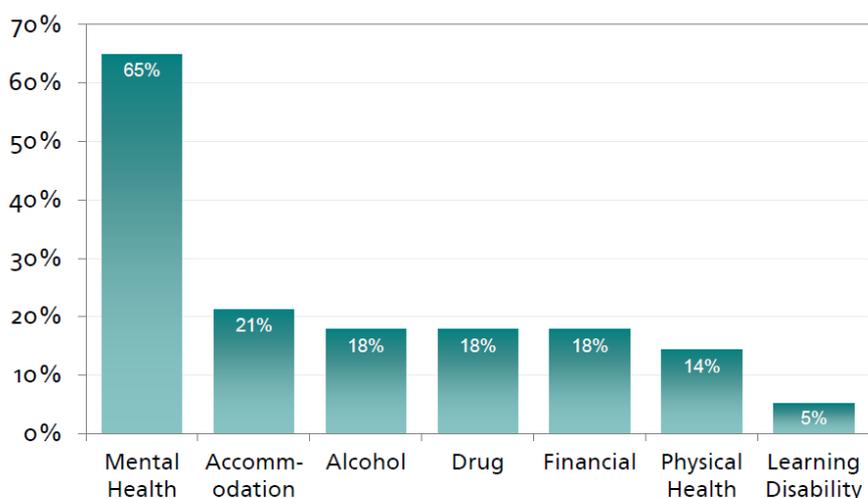
² Farrington, DP et al. Family factors in the intergenerational transmission of offending. Criminal Behaviour and Mental Health, 19: 109–124 (2009)

6.3.3 Offenders and offending

between 15% and 20% of respondents were worried about being mugged/physically attacked, vehicle crime and vandalism.

The Sussex Criminal Justice Liaison and Diversion Scheme bases Criminal Justice Liaison Nurses in courts and custody suites. The nurses identify offenders with needs across a number of categories and direct them towards services that can help meet these needs. The scheme has been operational in Brighton & Hove since August 2012 and between then and March 2013 the nurses screened 1,819 cases and carried out assessments on 465 individuals. Out of the cases assessed 65% had a mental health need, 14% a physical health need, 18% an alcohol need and 18% a drug need. The chart below shows the needs identified.³

Figure 1: Types of needs for offenders assessed in custody or at court, Aug 2012 to Mar 2013 (n=465)



Source: Sussex Criminal Justice Liaison and Diversion Scheme

Where we are doing well?

There is a strong local partnership of statutory and voluntary agencies focused on addressing the needs of individual offenders. For some years the Safe in the City Partnership has been operating a Priority and Prolific Offender (PPO) scheme, working most intensively to address the particular needs those offenders at highest risk of offending. There are usually about 70 or 80 PPOs being

worked with at any one time and monitoring of the offences of PPO cohorts in 2011 has shown that their offending has reduced by 23% compared with the previous year.

The PPO partnership approach has more recently been extended to working with a broader range of offenders through 'Integrated Offender Management', particularly those who have served short term prison sentences and who would not normally be subject to statutory probation supervision. From April 2013 there have been developments around community reintegration providing bespoke support for these individual offenders through the wider use of volunteers.

The criminal justice system has also been used to support the health needs of drug users. Police drug enforcement activities through 'Operation Reduction' provide an opportunity to access those engaged in drug offences and offer support to address their misuse of substances.

This work has been recognised as good practice in Brighton & Hove for a number of years and now other areas have also adopted similar approaches.

Other preventative initiatives include:

- Stronger Families, Stronger Communities (Troubled Families) work which works with families to provide a holistic approach to disadvantaged families
- Break4Change which addresses child to parent/carer violence
- A Band of Brothers mentoring project which develops skills, emotional intelligence and enhances confidence in young men who are experiencing difficult life situations
- Living Without Violence programme for perpetrators of domestic violence
- INSPIRE project to address the particular needs of women offenders.

Local inequalities

A literature review carried out for West Sussex in 2011 concluded that different offender populations, eg. women, minority ethnic groups,

³ NB. The court and custody offender population does not represent the population of offenders as a whole.

6.3.3 Offenders and offending

older offenders, mentally disordered offenders, drug users have different health needs. For example, research showed that females have higher levels of mental health and relationship problems; while male offenders have higher levels of alcohol problems.⁴

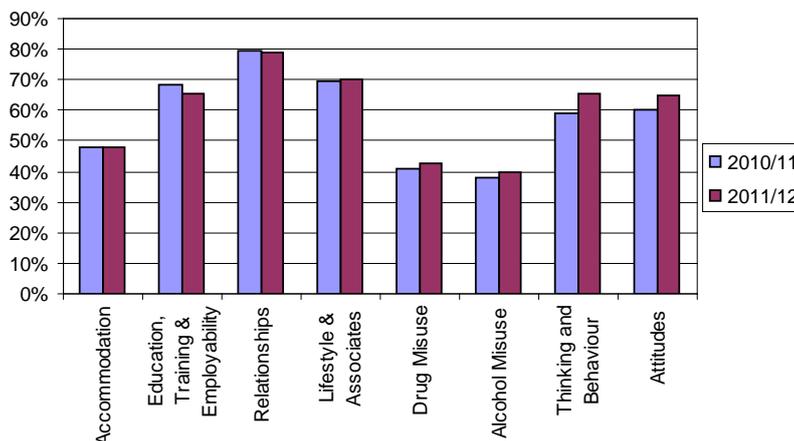
Police offender data⁵ for 2011-12 shows that:

- 81% of violent crimes⁶ have a male offender, and 19% have a female offender. Offenders peak in the 18-24 age group for males, and the 10-17 age group for females (although overall numbers are low).
- 70% of acquisitive crimes⁷ have a male offender, and 30% have a female offender. Offenders peak in the 10-17 age group for both males and females. Both violent crime and acquisitive crime showed an ethnic breakdown of offenders similar to that of the population as a whole.
- 89% of criminal damage offences have a male offender, and 11% a female offender. The rate of offenders per 1,000 population is elevated in the 10-17 age group, peaks in the 18-24 age group for males, and subsequently drops off in older age groups. Criminal damage offences showed a slightly lower proportion of offenders who were BME than seen in the population as a whole.

The probation service carries out assessments of criminogenic need for high risk offenders⁸ they are working with and the findings of these over the last two years for which data are available are provided in the bar chart. Around 40% of these offenders had needs related to drugs misuse and about the same percentage for alcohol misuse.

There is a slight increase in needs around ‘thinking and behaviour’ and in ‘attitudes’, although the need for education, training and employment has decreased slightly between 2010/11 and 2011/12.

Figure 2: Offender criminogenic needs identified in Brighton & Hove, 2010/11 and 2011/12 (OASys assessments)



Source: Probation Service

Probation data for those on their caseload as of March 2010 showed that the demographic profile of offenders was similar to that of the whole of the Surrey and Sussex Probation Trust area in respect of gender and age profile, but that there were more offenders with a disability than in other areas.

The Corston Report⁹ identified nine additional barriers that women offenders face and in 2011/12 of the 169 women accessing Inspire:

- 60% had accommodation needs
- 71% had mental health needs
- 68% had alcohol and substance needs.
- 64% had skills and employment needs
- 65% had finance, benefit and debt needs
- 60% had children, family and relationship needs
- 96% had attitude, thinking and behaviour needs

⁴ An assessment of the needs of offenders in West Sussex, Institute for Criminal Policy Research, 2011

⁵ Please note that offender data is listed by crime, not by individual offender and therefore analysis is likely to contain multiples.

⁶ Violent crimes include violence against the person offences, sexual offences and robbery.

⁷ Acquisitive crime includes burglary, theft of and from a motor vehicle, and theft other.

⁸ Full OASys assessments are only carried out for offenders who are deemed to be a higher risk of serious harm and those with certain types of offences. Results are not necessarily representative of the whole offending population or all those on the probation caseload.

⁹ The Corston Report. A report by bAroneSS JeAn Corston of A review of women with pArtiCulAr vulneRAbilities in the CriminAl JustiCe system 2007. Available at <http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf>

6.3.3 Offenders and offending

- 66% had been raped, abused or experienced domestic violence
- 40% were involved in sex work.¹⁰

Predicted future need

The Welfare Reform Act 2012 will bring into law the biggest changes to the benefits system since the 1940s. Areas affected include housing benefits, disability and employment related benefits and council tax benefits. There will also be changes in how benefits are received. Welfare reform could have an adverse impact on offenders as individuals become affected by the changes. This will need to be closely monitored and addressed in a way which ensures that individuals affected receive appropriate support to manage their affairs, retain their health and wellbeing and avoid homelessness.

What we don't know

While local work to obtain reoffending data for individual clients has been carried out for some projects (eg. the PPO scheme), this is a time-consuming task and is not carried out for all offenders who receive services and so information on the impact of projects in reducing offending is not always available. Developments with the national Justice Data Lab may assist in this regard.

Aggregated reoffending data for different groups of offenders (eg. PPOs, adults/young people, drug misusers) are available through a national data release, but this is subject to a time delay of up to 22 months. Ways are being explored on how to gain a better and more timely understanding of the impact of local projects on a more consistent basis.

Key evidence and policy

- Integrated Offender Management is a national approach based on the importance of inter-agency working to successfully identify and meet the needs of offenders and reduce reoffending.

- The Bradley Report (2009) drew attention to the health and learning disability needs of offenders and provided recommendations for improving the way in which issues are identified and managed.
- The Corston Report (2007) drew attention to the particular needs of women offenders, who may include those who have been subject to domestic or sexual violence or abuse, or may have been involved in prostitution.
- The 'Reducing reoffending: supporting families, creating better futures' report by the Ministry of Justice and Department for Schools, Children and Families (2009) looked at how services can be provided around the children and families of offenders and at how these relationships can be an important influence on likelihood of future offending.
- The last few years have seen a government move towards the 'recovery approach' to substance misuse treatment, focussing on getting more people leaving treatment successfully

The Ministry of Justice 'Transforming Justice' programme, which is likely to be implemented during 2013, makes key changes to offender management services and will result in lower risk offenders (about 80% of offenders) who are currently managed by the probation service being supervised by private or voluntary sector organisations. They will be paid in part according to their success in reducing reoffending (Payment by Results).

Recommended future local priorities

1. Develop our understanding of the extent to which services meet the needs of offenders and reduce reoffending
2. Take forward work on the Health Hub which connects offenders with suitable community interventions
3. Expand Restorative Justice conferencing to increase victim satisfaction and deal more effectively with perpetrators

¹⁰ Brighton Women's Centre. Inspire and Women's Counselling Service data and feedback. June 2013.

6.3.3 Offenders and offending

4. Tackle intergenerational crime through the Stronger Families, Stronger Communities work programme
5. Extend the reach of services into communities through enhancing Community Reintegration Team by a greater use of volunteers.
6. Manage the transition to the restructuring of offender services in line with the government's 'Transforming Justice' programme

Key links to other sections

- Youth offending
- Crime, anti-social behaviour and safety
- Domestic and sexual violence
- Alcohol and substance misuse

Further information

Further information can be found in the Brighton & Hove Community Safety, Crime Reduction and Drugs Strategy 2011-14 and annual Strategic Assessment which are available on the website of the Safe in the City Partnership:

www.safeinthecity.info

Last updated

May 2013

6.4.1 Volunteering and the voluntary and community sector

Brighton & Hove JSNA 2013

Why is this issue important?

There is increasing evidence that high levels of social capital promote health and lower morbidity and mortality. Social capital, trust and participation in decision-making are strong indicators of resilience in local communities.¹ People involved in voluntary and community activities are reported to have higher levels of subjective wellbeing and areas with high levels of involvement increase the wellbeing of people living in the area who are not themselves involved.² Communities reporting higher levels of trust in each other also report higher levels of wellbeing. Participation in local decision-making increases wellbeing, in part due to decisions being more likely to reflect the wishes of local people.³

Volunteering is defined locally as:

An activity that involves spending time, unpaid, doing something that aims to benefit the environment or individuals or groups other than, or in addition to, close relatives⁴.

Interest in volunteering peaks following retirement and can help with the transition from working life to retirement. Nationally, nearly a quarter of people aged 50 or over are engaged in volunteering. Older people derive greater mental health benefits from volunteering than younger people. It reduces the likelihood of experiencing depression and increases life satisfaction by improving self-esteem and creating larger social networks.⁴ Participation and volunteering in the community also raise children's educational achievements, improve behaviour and help develop social networks and foster a sense of belonging.⁵

Both statutory and voluntary organisations can facilitate opportunities for local decision making.

The previous government's strategy to build social capital promoted greater investment by statutory organisations in the 'Third Sector' (not for profit businesses, including the voluntary and community sector (VCS)). The current coalition government is championing the concept of a 'Big Society', whereby the VCS and its volunteers play a pivotal role in providing key local and national services.

However, the recession has had a negative impact on the voluntary sector and volunteering. Nationally, volunteering rates, particularly informal volunteering, have been falling since the onset of the recession, from 43% of people formally volunteering once a year in 2007/08 to 39% of people in 2010/11.⁶ Whilst rising unemployment offers people more time (lack of time being a significant barrier to volunteering), those out of work are generally less likely to volunteer than those in work (34 per cent compared to 42 per cent for formal volunteering).

The voluntary sector has also not fared well. At the beginning of 2010, 59% of charities reported that they were affected by the recession. In each quarter of 2011, the majority of voluntary sector leaders surveyed reported that the financial situation of their organisation had worsened over the previous year. Charity Commission research suggests that larger charities – defined as those with incomes over £100,000 – have been hit hardest with 79% affected. The very smallest charities, whilst facing their own set of challenges, appear to have been more insulated from changes in the wider economy.⁷

Key outcomes

- ***Social isolation (Placeholder) (Public Health Outcomes Framework)***
- ***People are able to find employment when they want, maintain a family and social life and contribute to community life and avoid loneliness or isolation (Adult Social Care Outcomes Framework)***

¹ NHS Brighton and Hove & Brighton & Hove City Council. Annual Report of the Director of Public Health – Resilience. 2010.

² Helliwell J. Well-being and Social Capital Harvard University: Conference on wellbeing and social capital; 2003 cited in Bell D. Annexes in Quality of Life and Well-being: Measuring the benefits of culture and sport: Literature review and thinkpiece. Edinburgh: Scottish Executive; 2005.

³ Research based on referenda in Switzerland, in Donovan N and Halpern D. Life Satisfaction: The state of knowledge and implications for government. London: Cabinet Office Strategy Unit; 2002.

⁴ Impetus. Joining the Dots: a triple impact volunteering strategy for Brighton and Hove. 2010-2015; 2010.

⁵ Bacon N, Brophy M, Mguni N, Mulgan J, Shandro A. The State of Happiness. Can public policy shape people's wellbeing and resilience? London: The Young Foundation; 2010.

⁶ Institute for Volunteering Research. Volunteering and the recession. 2011. Available at: <http://www.ivr.org.uk/images/stories/Institute-of-Volunteering-Research/Migrated-Resources/Documents/T/Think-piece-on-volunteering-rates-and-the-recession-D3.pdf> [Accessed 23.05.2013]

⁷ <http://data.ncvo-vol.org.uk/a/almanac12/finance-the-big-picture/what-impact-did-the-recession-have-upon-the-voluntary-sector/> [Accessed 23.05.2013]

6.4.1 Volunteering and the voluntary and community sector

- *Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services (Complementary indicators in Public Health, NHS and Adult Social Care Outcomes Frameworks)*
- *Self reported wellbeing (Public Health Outcomes Framework)*
- *A strong and thriving third sector (Local)*

Impact on health and wellbeing of the population in Brighton & Hove

Brighton & Hove has the second largest voluntary and community sector in England with a broad range of organisations concerned with issues of both people and/or place. New ways of commissioning services, with a real decrease in resources has resulted in VCS providers and statutory agencies working together to provide creative solutions. Increasingly the VCS is working in partnership with providers in the wider statutory and for-profit sector to minimise gaps in service.

The NHS and Brighton & Hove City Council both fund 'gateway' organisations to ensure user voices inform decision making: public sector funding for VCS providers is dependent on evidence of user involvement in design and delivery of services; the council and NHS Commissioning Prospectus approach builds in user voice from the outset; increasingly volunteers are helping to improve the quality of statutory services such as speech and language, falls prevention, and occupational therapy. There are specific funding streams which support residents to address health issues at very local level.

Healthwatch Brighton & Hove, one of the first new local independent consumer champions for health and social care in England, 'opened for business' on 1 April 2013, replacing the Local Involvement Network (LINK). Volunteers have a key role, providing advice on health and social care issues, capturing case studies, representing Healthwatch at meetings and supporting "enter and view" teams⁸.

Approximately 8,000 people work in VCS organisations in the city, 7% of total employee positions, with around half of these employees living in Brighton & Hove.⁴

VCS services help save the NHS at least £985k a year by reducing use of mental health medication by young people as well as saving up to £2,000 a year from reduced one-to-one support sessions and need for GP visits.⁹

Where we are doing well

The city has a significant third sector with a large number of volunteers producing key sustainability and health outcomes. There are around 19,200 volunteer positions giving 57,600 volunteer hours a week: 24% of residents report having volunteered (informally) at least once a month during the past 12 months, similar to volunteering levels in England.⁶ If volunteers were paid the same rate as workers in the third sector their annual salary bill would be worth £24 million - a huge donation of time and effort.

Local voluntary and community groups are currently supported by the Community and Voluntary Sector Forum (CVSF), with a membership of over 500 local organisations. A new infrastructure organisation is being developed in 2013 to improve support to and co-ordination of the community and voluntary sector, improve cross-sector partnership working and maximise the impact and engagement of volunteers.

The city's third sector income is approximately £55 million per year, much of which is spent on local projects. The community and voluntary sector contributes £96 million to the Brighton & Hove economy each year.⁴

In the 2013 City Tracker Survey,¹⁰ 95% of respondents felt that local charities and community groups use money wisely, up by 3% on the previous year, the third highest level of satisfaction across all services. Satisfaction levels are broadly similar across all sub-groups, highest among those aged 45-54 years (70%).

⁸ Trained volunteers who assess health and social care adults services, report on findings and make recommendations.

⁹ Evidencing the added value of not for profit organisations in Brighton & Hove – A Taking Account follow-on report.

¹⁰ Brighton & Hove Strategic Partnership City Tracker, 2013 www.bhlis.org/surveys [Accessed on 13/08/2013]

6.4.1 Volunteering and the voluntary and community sector

The City Council has four grant schemes which contribute to the overarching aim of supporting a thriving third sector that promotes engagement and equality by encouraging cohesive communities to have active voices.

Strengthening communities and involving people is a priority theme in Brighton & Hove Local Strategic Partnership's *Sustainable Community Strategy*.

A local Social Returns on Investment pilot found that 90% of those volunteering 21+ hours a month felt they could influence local decision-making and all gained skills, confidence and knowledge.

The successful *Better Futures Project* is a 3-year programme providing high-quality, well-supported volunteering opportunities to people with learning disabilities, physical disabilities and/or mental health issues alongside tailored brokerage that ensures the best match of individual to opportunity.

Investment in and continuation of the Skills Exchange volunteering programme generated £43,000 of pro bono support to voluntary sector organisations in six months.

The prioritisation of employer-supported volunteering has begun to deliver results with a rise in supported volunteers in surgeries, team challenges and training.

A new online resource for younger volunteers is to launch in June 2013 to mark Volunteer's Week.

Volunteering has had an increasingly high profile in city-wide plans and agendas and is included in the development of citywide strategies, e.g. advice provision.

Most schools have a school council or forum, many have student governors and citywide there is an elected Youth Parliament which gives young people, including those from vulnerable groups, the chance to contribute to decisions made about services.¹

A number of organisations facilitate older people's participation including the Older People's Council, LifeLines, AgeUK Brighton & Hove, Hangleton and Knoll 50+ Group, Tarner Health Action Group.¹

Local inequalities

Many VCS organisations specialise in supporting people at increased risk of inequalities. A greater proportion of statutory funding is directed towards those supporting children and young people and BME groups.

Gender: In Brighton & Hove, 66% of volunteers are women and 34% men, in contrast with national data which shows no significant difference by gender. Locally, 68% of those in paid work in the sector are women and 32% men compared with the general Brighton & Hove population of 51% women and 49% men.⁴

Age: VCS volunteers have a similar age profile to the working population, with the vast majority of volunteers (69%) and management committee members (73%) being between 25 and 59 years.⁴

LGBT: LGBT people are more likely to volunteer than heterosexual people in the city. Over a third of LGBT people volunteer for an LGBT group, and almost half regularly participate in national LGBT groups. There are also high levels of young volunteers across the Allsorts LGBT volunteering Programme.^{11,12,13}

Place: In East Brighton there are higher rates of volunteering but a low reported rate of involvement in decision-making organisations.¹

Predicted future need

There was an assumption that volunteering and would flourish in the recession. However, national statistics show the opposite and volunteering rates, particularly informal volunteering, have been falling since the onset of the recession.¹⁴

Locally, as far back as 2008, VCS organisations were identifying a drop in funding from their usual sources. National figures suggest that this is the case across the country, and any increase in funding has been wiped out by rising inflation.

¹¹ Browne K. *Count Me in Too. LGBT lives in Brighton & Hove, initial findings: Academic report.* University of Brighton and Spectrum LGBT Community Forum: 2007

¹² Brighton & Hove City Council. *The Place Survey 2008.*

¹³ Allsorts Youth Project. *Allsorts Annual Report 2009-10. Brighton & Hove*

¹⁴ Hill M. *Volunteering and the recession.* 2011. IVR

6.4.1 Volunteering and the voluntary and community sector

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What we don't know

Statutory funding to VCS organisations has not been audited to compare need to investment, so it is not possible to identify if there are inequities.

We do not have information on the impact of the voluntary sector and volunteering across equalities groups apart from gender, age, LGBT and some information on place.

Key evidence and policy

Taking Account: an economic and social audit of the community and voluntary sector in Brighton & Hove (2008) and Evidencing the added value of not for profit organisations in Brighton & Hove – A Taking Account follow-on report (2010).

www.cvsectorforum.org.uk/sites/cvsectorforum.org.uk/files/TAKING%20ACCOUNT%20FINAL%203.pdf

Hill M. Volunteering and the recession. 2011. IVR

Recommended future local priorities

More work is needed to develop engagement with local populations, in particular young people.

It would be useful to undertake an equity audit of statutory funding to VCS organisations to compare need to investment.

Key links to other sections

- Social connectedness
- Community resilience
- Community assets
- Employment

Further information

Brighton & Hove volunteering strategy for 2010-2015. www.box.com/shared/yfxvh8c43i

Brighton & Hove Annual Report of the Director of Public Health 2010: Resilience. Available from: <http://www.bhlis.org/needsassessments/publichealthreports>

Brighton & Hove Strategic Partnership City Tracker, www.bhlis.org/surveys

Last updated

June 2013

6.4.2 Excess winter deaths and fuel poverty

Why is this issue important?

People living in cold homes during the winter months are at increased risk of negative health outcomes, including winter deaths.¹ Excess winter deaths (EWDs) are defined as the difference between the number of deaths from December to March and the average number during non-winter months. In winter 2010-11, there were about 23,700 EWDs, or 1,300 more deaths per week in the winter months in England.² Most of the difference is due to respiratory and circulatory deaths, such as stroke and coronary heart disease. Other health conditions associated with, or exacerbated by, cold housing are mental ill-health, arthritis and rheumatism.¹

Under the '10 per cent' ratio indicator, if a household needs to spend more than 10% of its income to maintain an adequate level of warmth, it is said to be fuel poor. The main contributing factors of fuel poverty are energy efficiency of the home; fuel costs; and household income.³

In 2011, the number of fuel poor households in the UK was estimated at around 4.5 million, representing approximately 17% of all UK households. This is a fall of around 0.25 million compared with 2010, due to rising incomes and a reduction in energy use through improvements in the energy efficiency of housing. These two elements combined to offset energy price increases in 2011.⁴

Fuel poor households must choose either to spend more than 10% of their income on heating, which has a detrimental impact on other aspects of health and well-being, or to under-consume energy and live in a cold home to save money.¹

EWDs are almost three times higher in the coldest quarter of housing than in the warmest quarter, with an estimated 21.5% of all EWDs being attributable to cold housing. There is a relationship between EWDs, low thermal efficiency of housing

and low indoor temperature. Countries that have more energy efficient housing have lower EWDs.¹ Poorly insulated housing also contributes to carbon emissions and improving the energy efficiency of local homes and buildings is a priority in the Brighton & Hove Sustainability Action Plan.⁵

Indirect health impacts of cold housing and fuel poverty include a negative affect on: children's educational attainment, emotional wellbeing and resilience; adult and children's dietary choices; and the risk of accidents and injuries in the home.¹

Key outcomes

- **Fuel poverty (Public Health Outcomes Framework)**
- **Excess winter deaths (Public Health Outcomes Framework)**

Impact in Brighton & Hove

The EWD Index is excess winter deaths as a percentage increase of the expected deaths based on non-winter deaths. For 2008-11 the EWD Index in Brighton & Hove was 20% (equivalent to an average of 135 EWDs per year). This is the same as the South East (20%) and similar to England (19%).⁶ In the recent past, the rate of EWDs in England was twice the rate observed in some colder northern European countries, such as Finland.² Countries with the poorest housing in terms of thermal efficiency demonstrate the highest level of excess winter mortality.⁷

Brighton & Hove has an old housing stock with 66% of houses built before 1945 (compared with 43% in England)⁸ and many private sector properties labelled 'hard to treat' (e.g. those with solid walls) in relation to standard energy efficiency measures.⁹ According to 2011 estimates, 12% of households (14,500 households) in the city were fuel poor; a

¹ Marmot Review Team. The Health Impacts of Cold Homes and Fuel Poverty; 2011

² Department of Health. Cold Weather Plan for England: 'Protecting health and reducing harm from severe cold'; 2012.

³ Department of Energy and Climate Change. The UK Fuel Poverty Strategy; 2001.

⁴ Department of Energy and Climate Change. Annual Report on Fuel Poverty Statistics 2013

⁵ Brighton & Hove City Council. Sustainability Action Plan. Available at: <http://www.brighton-hove.gov.uk/content/environment/sustainability-city/city-sustainability-partnership> [Accessed 11/08/2013]

⁶ West Midlands Public Health Observatory. Excess Winter Deaths Trend, 1990-2009 www.wmpho.org.uk/excesswinterdeathsineotlandatlas [Accessed on 25/08/2012].

⁷ World Health Organisation. Environment and health risks: a review of the influence and effects of social inequalities; 2010

⁸ Brighton & Hove City Council. Private Sector House Condition Survey; 2008.

⁹ Internal Brighton & Hove City Council reporting (2009). Cited in Brighton & Hove State of the City Report; 2011.

6.4.2 Excess winter deaths and fuel poverty

drop of 1.3% from 2010. This is lower than England (15%) but higher than the South East (10%).¹⁰

Local inequalities

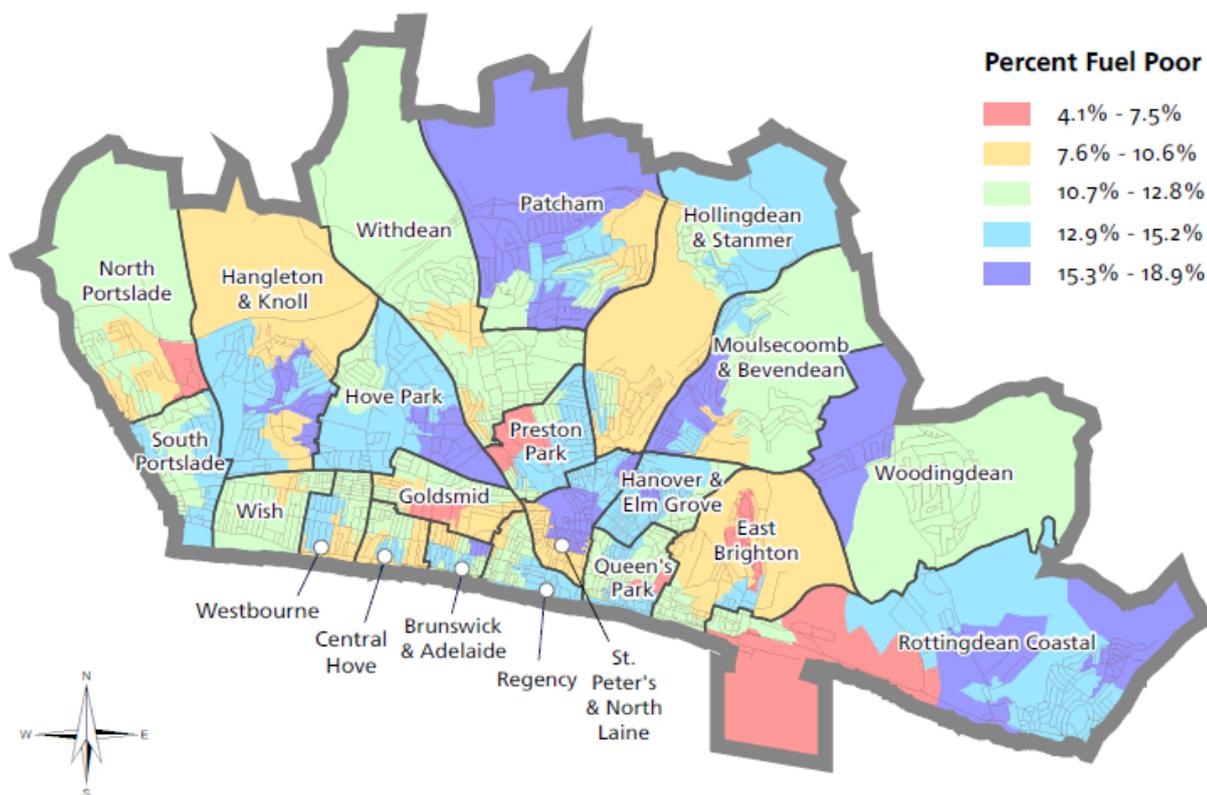
Older people, very young children and people with pre-existing medical conditions, are most at risk of ill-health from cold weather.² With the exception of households where the oldest member is under 25, fuel poverty also increases linearly with age of the oldest member. In 2011, around a fifth of households where the oldest person was aged 60-84 were fuel poor.⁴ Gypsies and Travellers may face higher heating costs and be unable to claim winter

of respondents said they could not keep their home warm enough in the winter 'quite often' or 'most of the time'. The survey also showed that inability to keep homes warm enough 'most of the time' increased with deprivation.¹³

The wards with the estimated highest fuel poverty are Patcham; Hanover and Elm Grove; South Portslade; Hove Park and Rottingdean Coastal (all 14%). Sub ward analysis identifies areas most affected (Figure 1).

Figure 1: Estimated fuel poverty distribution, 2011

Source: Department of Energy and Climate Change, 2013



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fuel allowance without a permanent address.¹¹

The vast majority of EWDs (87% for England and Wales, 2009-2010) were in those aged 75 or over, and 59% of EWDs were in those aged 85+.¹² In the Brighton & Hove Health Counts Survey 2012, 16%

Where we are doing well

Following successful bids to the Department of Health for Warm Homes Healthy People funding, multi-stranded programmes were run in the city during 2011/2012 and 2012/2013 winters to prevent winter death and illness. Together, the programmes delivered: 269 fuel poverty awareness training sessions to front line workers; 150 winter home checks to make homes safer and warmer; 23 emergency home visits to check welfare and

¹⁰ Department of Energy and Climate Change. Sub-regional fuel poverty levels, England, 2011; 2013.

¹¹ Office for Public Management. Health and social care needs of Gypsies and Travellers in West Sussex: Report to NHS West Sussex and West Sussex County Council; 2010.

¹² ONS, Excess Winter Mortality in England and Wales, 2010/11 (Provisional). <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-235062> [Accessed on 25/08/2012].

¹³ NHS Brighton & Hove. Health Counts 2012.

6.4.2 Excess winter deaths and fuel poverty

deliver 55 warm packs; 75 warm packs to rough sleepers; 198 home energy advice and assessment visits; 17,500 information leaflets and 3,500 room thermometers to residents; 11 community outreach workshops and two information events on keeping warm and saving energy in the home; 92 winter warmth grants totalling £18,100 and 382 financial inclusion checks, resulting in £604,193 in confirmed and likely annual income increases for residents.

In April 2013, a Brighton & Hove Winter Debrief was held to gather views from local statutory, community and voluntary organisations on how the city coped with winter 2012/13 and what improvements could be made in protecting vulnerable people in future cold weather. Relevant recommendations are included below.

Predicted future need

Over the next 40 years, global temperatures are set to rise. Despite the warming climate, it is predicted that we may still experience very cold winters, although they are likely to become less frequent.⁵

Increasing fuel costs relative to income have contributed to greater fuel poverty and this is predicted to continue. In July 2013, the government accepted an alternative measurement of fuel poverty, known as the 'Low Income High Cost' (LIHC) measure.¹⁴ Under this definition, a household is considered to be fuel poor if they have required fuel costs that are above average (the national median level) and, were they to spend that amount, they would be left with a residual income below the official poverty line. Under the LIHC definition, an estimated 2.6 million households were fuel poor in England in 2011. Even under this measure, numbers are set to rise by 2016; Parliament's previously agreed date for the eradication of fuel poverty as far as reasonably practicable.⁴

The 2010 Spending Review and the end of previous energy company obligations has reduced grant funding for energy efficiency measures. Energy efficiency improvements, and any available subsidy

for vulnerable residents, will now be delivered through the Green Deal and the Energy Company Obligation (ECO). Green Deal is a market-led framework that will allow individuals/businesses to make energy efficiency improvements to buildings at no upfront cost. Central to the Green Deal is a finance mechanism that will allow access to the finance needed with repayment attached to future electricity bills. Underpinning delivery is the ECO where energy suppliers are obligated to provide funding for measures that, through the installation of energy efficiency measures, generate an amount of heat or carbon credit in qualifying homes.

Concerns have been raised from a number of quarters that this national programme will not necessarily benefit the most vulnerable and financially disadvantaged households. Brighton & Hove City Council are working with other local authorities, public bodies, local businesses and organisations in Sussex to design a model that is able to address some of these issues.

What we don't know

There is no local data on levels of fuel poverty by equality groups. With the exception of age, there is also no local data for EWDs.

Key evidence and policy

- Department of Energy and Climate Change. Annual Report on Fuel Poverty Statistics 2013.
- Department of Health. Cold Weather Plan for England 2012: Protecting health and reducing harm from severe cold.
- Hills J. Getting the Measure of Fuel Poverty: Final Report of the Fuel Poverty Review. 2012.
- Marmot Review Team. The Health Impacts of Cold Homes and Fuel Poverty. 2011.
- Brighton & Hove City Council. Private Sector House Condition Survey. 2008.

Recommended future local priorities

1. An over-arching strategic group with an identified lead to set the scope for and to drive year round seasonal planning, reporting to the Health and Wellbeing Board.

¹⁴ Hills J. Getting the Measure of Fuel Poverty: Final Report of the Fuel Poverty Review; 2012.

6.4.2 Excess winter deaths and fuel poverty

2. An agreed plan to protect and support vulnerable people during winter months, bringing together the national cold weather plan, potential future Warm Homes Healthy People Programmes and other Brighton & Hove linked arrangements.
3. Coordination of local assets and resources available to support vulnerable people in the city during the winter, including local statutory and Community and Voluntary Sector organisations and volunteer networks.
4. Focus action on those most at risk of fuel poverty and ill health caused by cold living conditions.
5. More health professionals and other front-line staff and volunteers trained on the risks of cold housing, what practical and financial support can be offered and how to refer clients locally.
6. Develop 'winter warmth champions' in a range of organisations and settings to raise awareness of the WHHP Programme and encourage referral of patients / clients.
7. Further work on increasing appropriate referrals from GPs, health and other relevant professionals to the Council Private Sector Housing Team for advice and assistance with fuel poverty and cold homes, including work to increase use of the online referral system 'Refer-all'.
8. Explore and maximise opportunities to reduce energy bills of most vulnerable residents, for example, collective buying of energy; progressing solar photovoltaic cells and solar thermal, district heat networks and supporting the roll out of the Green Deal and ECO.
9. Revive the work involved in planning the Brighton & Hove Transport Hub, including involving transport providers more fully and considering broader issues such as delivery of food and essential supplies to areas cut off during adverse weather conditions.
10. Further promotion to the general public, particularly older people, on the health risks of living in a cold home and work to tackle perceptions that people should simply endure

cold living conditions and not 'bother' the support services.

11. Further outreach work to ensure marginalised and minority populations are supported (e.g. BME; people who speak little or no English; rough sleepers).
12. Local community networks and individuals to be fully informed of the risks of cold weather and engaged in efforts to protect themselves and their neighbours.
13. Wider dissemination of Met Office Cold Weather Alerts.

Key links to other sections

- Ageing well
- Climate change
- Housing
- Childhood poverty
- Long term conditions

Further information

- Department for Energy and Climate Change Fuel poverty statistics.
http://www.decc.gov.uk/en/content/cms/statistics/fuelpov_stats/fuelpov_stats.aspx
- West Midlands Public Health Observatory.
www.wmpho.org.uk/excesswinterdeathsinenglandatlas

Last updated

July 2013

6.4.3 Rough sleeping & single homeless Brighton & Hove JSNA 2013

Why is this issue important?

This section summarises the needs of people who are sleeping rough on the streets and includes those in insecure, temporary accommodation such as hostels.

Homelessness and rough sleeping have been increasing nationally in recent years. Between Autumn 2010 and Autumn 2011 the national rough sleeper snapshot count rose 23% with numbers rising most rapidly in London and the South of England.¹

Health and wellbeing needs are high among rough sleepers. In particular, there is a high prevalence of mental ill-health and drug and alcohol dependency. Other common problems include physical trauma (especially foot trauma), skin problems, respiratory illness and infections (including hepatitis A, B and C).²

Nationally, it is estimated that the use of inpatient hospital care by people who are sleeping rough or living in insecure accommodation (such as hostels) is eight times higher than in the general population aged 16-64.²

The average age of death for a homeless person is 47 years old compared to 77 for the general population, with death from drugs and alcohol being particularly common.³

Key outcomes

Rough sleeping is not included as an indicator in NHS, Public Health, or Adult Social Care Outcomes Frameworks. There are a number of related indicators including suicide and alcohol hospital related admissions.

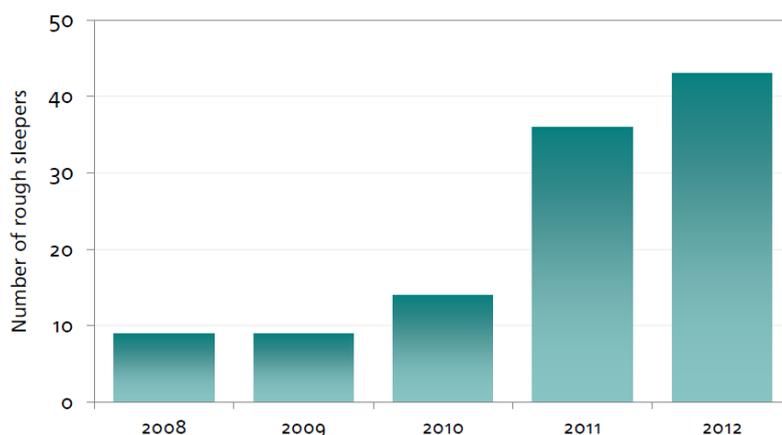
The Common Data Framework (formerly the 'Supporting People Outcomes Framework') enables local authorities to monitor outcomes for vulnerable adults accessing housing-related support. Key outcomes measure how client needs have been met across key areas of economic wellbeing, work and learning, health, accommodation and enabling choice and control.

One of the key performance indicators for Band 2 hostel accommodation is planned moves to greater independence. Of those leaving hostels in 2011/12 53% moved on to greater independence, an increase of 3% on the previous year. In Supported Band 3 accommodation 89% moved on to greater independence, this was also an increase of 3% on the previous year.

Impact in Brighton & Hove

Locally there has been a sharp increase in the number of recorded rough sleepers in the city. In November 2010 the official rough sleeper street count figure was 14, in 2011 it was 37 and in 2012 this figure had risen to 43 (figure 1).

Figure 1: Total rough sleepers found on the annual street count



Source: Department for Communities and Local Government

A group of partner agencies, led by the council, took part in an estimate exercise in March 2013. The aim of the exercise was to estimate the number of people sleeping rough on one 'typical' night in Brighton & Hove. The final estimate figure was 90 individuals. CRI, who deliver services to this group locally, worked with 588 rough sleepers in 2010/11, 732 in 2011/12 and 1,163 in 2012/13 a 98% increase over three years.

This increase in rough sleepers places pressures on health, housing support services and other statutory partners.

Evidence from Housing Commissioning monitoring data indicates that rough sleepers have high levels of complex needs including mental health issues, substance misuse issues and physical health issues.

¹ Crisis, Homeless Monitor, England 2012

² Wright NMJ and Tompkins. How can health services effectively meet the health needs of homeless people? Br J Gen Pract. 2006 April 1; 56(525): 286-293.

³ Crisis. Homelessness Kills. 2012

6.4.3 Rough sleeping & single homeless Brighton & Hove JSNA 2013

This results in higher mortality rates and A&E attendances as highlighted by the following data from Brighton Homeless Healthcare, the GP practice in Morley Street that provides a specialist primary care service for homeless people.

Table 1: Comparison of health outcomes between Brighton Homeless Healthcare practice population and Brighton & Hove GP registered population

Mortality rates from coronary heart disease are twelve times greater than patients registered with the practice with the 2nd highest rate

A&E attendance rates are five times higher than the local average

Emergency hospital admissions are four times higher than the local average

Planned inpatient admissions are a third lower than the local average

Hospital readmission rates (at 28 days after discharge) are twice the local average.⁴

Source: Annual Report of the Director of Public Health 2012

A local audit at the Royal Sussex County Hospital confirmed the high level of emergency admissions in homeless people.⁵

Current Housing Commissioning strategies⁶ include priorities that aim to improve outcomes by:

- Helping clients to move on to more independent accommodation through the Brighton & Hove Integrated Support Pathway⁷
- Increasing accommodation options for locally connected rough sleepers
- Increasing housing and support options for people with no local connection to find accommodation and support outside of the city
- Developing psychological intervention support
- Developing personalisation in support packages
- Focusing on the recovery and reintegration agenda

⁴ NHS Brighton and Hove and Brighton & Hove City Council. Vital: Annual Public Health Report of the Director of Public Health. 2011.

⁵ www.bsuh.nhs.uk/EasySiteWeb/GatewayLink.aspx?allId=387306 [Accessed 25/08/2012].

⁶ Single Homeless Strategy 2009-2014 and Commissioning Strategy for Housing-Related Support, 2011-2015.

⁷ For more details see the Brighton & Hove Homelessness Strategy.

- Improving support and access for those with a Dual Diagnosis or multiple complex needs
- Preventing unplanned hospital admissions.

Where we are doing well

Local commissioned services working with this client group are well co-ordinated within a successful local partnership structure which includes commissioned and non commissioned services.

The local area has successfully been awarded homeless transitions funding to operate a 'No Second Night Out' project. This aims to target those new to rough sleeping and move them off the streets before they become entrenched. In 2012/13 this project saw 76 individuals supported with 98% being accommodated. Within CRI rough sleeper services 1163 individuals were supported with 90% of these having a positive accommodation, treatment or care outcome. Less than 1% of those who were supported to leave the streets by CRI returned within 2 weeks.

At First Base Day Centre in 2011/12 an average of 52 rough sleepers were seen per day of these 397 had a planned support programme, 225 accessed sport and fitness programmes, 308 were seen by St Johns Ambulance and 313 were seen by an oral hygienist.

Brighton & Hove operates a severe weather shelter (SWEP) to ensure that rough sleepers are housed when the temperature drops below 0 degrees for three nights in a row. The provision run by Brighton Housing Trust has coped with increasing demand in 2012/13

- In 2011/12 SWEP was open for 21 nights and provided 541 bed spaces between January and February 2012.
- In 2012/13 SWEP was open for 44 nights providing a total of 1714 bed spaces from November 2012 to April 2013.
- The average (mean) number of individuals accommodated each night during SWEP was 26 in 2011/12 and 40 in 2012/13.

Within Housing services 352 individuals exited Band 2 hostels in 2011/12 with 53% moving to greater independence, this included 17% into supported accommodation, 11% into substance

6.4.3 Rough sleeping & single homeless Brighton & Hove JSNA 2013

misuse detox services and 10% into their own tenancy. This was an increase of 3% on the previous year.

For the 63 individuals that exited Band 3 supported accommodation in 2011/12 89% achieved greater independence including 66% who moved into their own tenancy.

The alcohol nurse was introduced to work intensively with hostel residents with alcohol dependency issues. Between May 2011 and May 2012 the cohort of clients worked with reduced their emergency call outs (Ambulance) by 37%, their presentations at A&E by 29% and their hospital admissions by 18%. Evictions from hostel accommodation were also greatly reduced for this client group.

The Pathway Homeless Research Trial has been carried out at the Royal Sussex County Hospital in 2012/13. It has examined the effect of a GP-led homeless team monitoring the care and discharge of homeless people admitted to the hospital. Results will be published later in 2013/14.

As part of the JSNA programme for 2013/14, the Homeless Link Health Needs Audit, a survey of the health needs of single and vulnerable homeless was conducted in Brighton and Hove in Summer 2013. Results will be made available before the end of 2013.

Local inequalities

Current monitoring data suggests that rough sleepers and single homeless people in Brighton & Hove in 2011/12 were:

- Rough Sleepers: 90% Male
- Hostel Residents: 84% Male

Rough sleepers and hostel residents are:

- predominantly aged between 25 and 44 years old, with higher levels of under 25's and over 45's in hostel accommodation.
- 7-9% Lesbian, Gay, Bisexual and Transgender (including 0.4% transgender)
- 52% have no religion with 20% self classifying as Christian, 3% Muslim, 2% Buddhist and less than 1% Jewish.

84% of those in hostels were White British.

The rough sleeper and single homeless population is not representative of the wider population of Brighton & Hove.

Rough sleepers fall within several of the main equalities social inclusion key target groups: homeless people; people with mental health needs; people with substance misuse issues; unemployed people; people employed on a part-time, temporary or casual basis; refugees and asylum seekers; ex-offenders and people with unrelated convictions; and people experiencing domestic violence.

Predicted future need

The impact of the Welfare Reform Bill is still being felt with reductions in council tax relief, changes to Disabled Living Allowance, the reduction of Housing Benefit to over occupiers, the cap on overall benefits payments and the introduction of Universal Credit still being rolled out in England and Wales.⁸ We predict that these changes will increase the number of individuals unable to sustain their accommodation in the coming year.

The significant increase in numbers of rough sleepers which we have witnessed in recent years has placed unprecedented pressure on existing services and we expect this to continue at a time of decreasing funding.

What we don't know

We don't know about many of the hidden homeless in our city who may be living in squats, sleeping on sofas, and staying with friends and family, and are therefore not captured in local needs data. Nationally one study has shown that of 437 single homeless individuals 62% were hidden homeless and a quarter had never accessed any accommodation provided by a homeless or housing organisation.⁹

We cannot estimate the number of people affected by welfare reform who will subsequently have an episode of rough sleeping.

⁸ Homeless Link response to Welfare Reform Bill 2011 <http://homeless.org.uk/news/homeless-link-response-welfare-reform-bill> [Accessed on 25/08/2012].

⁹ Crisis, K Reeve with E Batty, The Hidden Truth about Homelessness – Experiences of Single Homelessness in England, May 2011

6.4.3 Rough sleeping & single homeless Brighton & Hove JSNA 2013

Key evidence and policy

Vision to end rough sleeping: No Second Night Out nationwide, 2011. Department for Communities and Local Government

<http://www.communities.gov.uk/publications/housing/visionendroughsleeping>

Making every contact count – a joint approach to preventing homelessness August 2012

www.gov.uk/government/publications/making-every-contact-count-a-joint-approach-to-preventing-homelessness

Recommended future local priorities

1. Commission services and resources to support the No Second Night Out strategy and a refreshed Homelessness Strategy in 2013.
2. Use Government funding (awarded March 2012) to develop further rough sleeping prevention initiatives across Sussex with neighbouring authorities.
3. Use the findings from the Homelessness Pathway trial and the Homeless Link Health Audit to inform action to improve health service provision for homeless people.

Key links to other sections

- Housing
- Mental health
- Substance misuse
- Alcohol
- Dual diagnosis
- Urgent care

Further information

Brighton & Hove City Council homelessness webpage

<http://www.brighton-hove.gov.uk/index.cfm?request=c306>

Last updated

September 2013

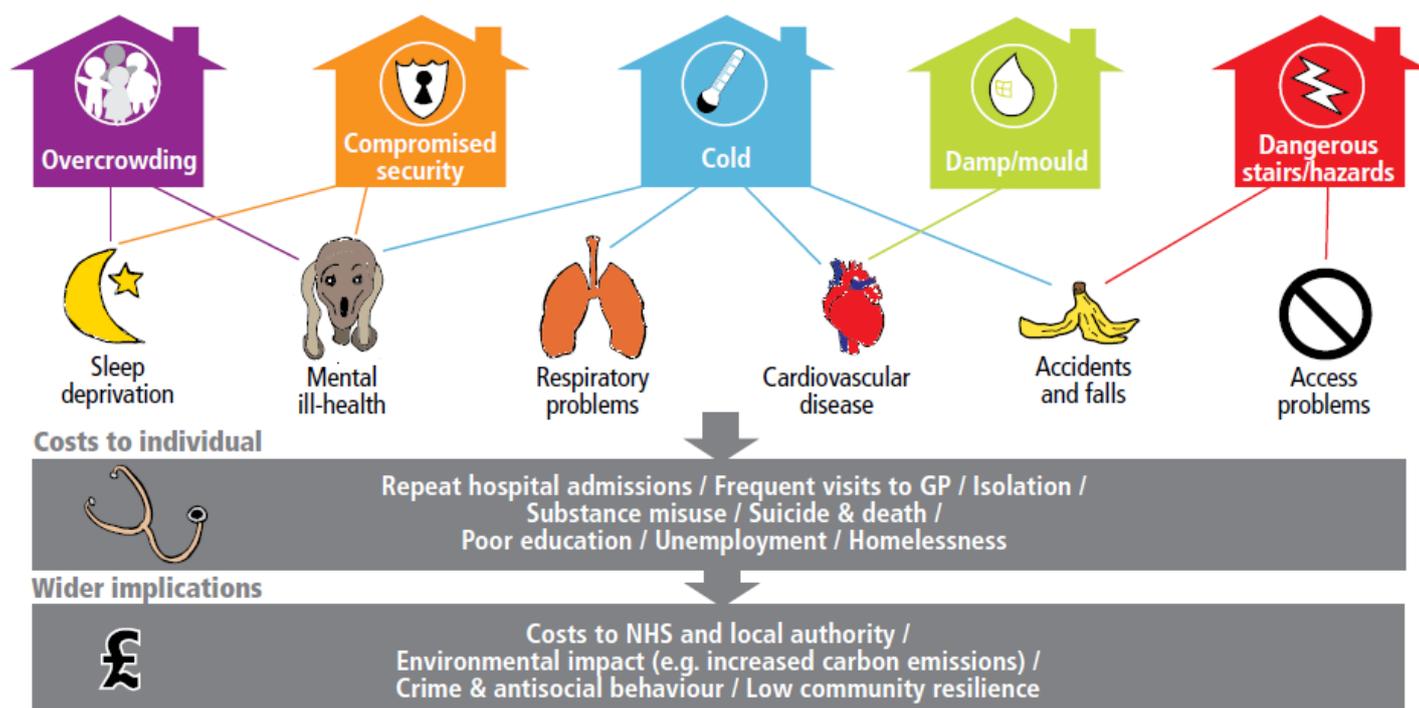


Figure 1: the relationship between poor housing and health outcomes

Source: Annual Report of the Director of Public Health 2011

Why is this issue important?

Poor housing conditions arising from homelessness, living in unsuitable temporary accommodation, overcrowding, housing insecurity and housing in poor physical condition present risks to health.¹ Figure 1 illustrates the impact over a wide range of health and related outcomes.

Key outcomes

The Strategic Housing Partnership works through the city's Housing Strategy 2009² to tackle our housing challenges by focusing on:

- **Improving housing supply**
- **Improving housing quality**
- **Improving housing support**

These strategic priorities contribute to achieving a number of aims in the Public Health, NHS and Adult Social Care Outcomes Frameworks on issues such as: homelessness; suitable housing for those with a mental illness, disability or learning disability; domestic abuse; noise; fuel poverty; excess winter deaths; social contentedness; falls and injuries; mortality; helping older people regain independence after illness or injury.

Impact in Brighton & Hove

Brighton & Hove has 126,827 homes and is one of the most densely populated areas in the region and has the smallest household size in the South East averaging at 2.1 people.³

Our owner occupier rate is low at 53.3%, compared to 67.6% in the South East and the private rented sector increased by 45.7% between 2001 and 2011 with 28.0% of households now renting their home from a private landlord. Limited land supply restricts new housing development putting additional pressure on housing costs.

8,168 (6.7%) of Brighton & Hove's households are considered to be overcrowded (fewer bedrooms than needed). 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 key housing issues reported by residents are:

- **Housing Supply:** restricted supply leading to high cost of owner occupation and private renting and a need for benefit support to compensate for low wages to meet costs

¹ Fair Society, Healthy Lives: The Marmot Review; 2010

² Brighton & Hove Housing Strategy 2009: healthy homes, healthy lives, healthy city: www.brighton-hove.gov.uk/index.cfm?request=c1188834

³ Office for National Statistics. Census 2011

6.4.4 Housing

- Housing Quality: poor quality housing in the private sector and fuel poverty
- Housing Support: high levels of vulnerable households with high care support needs
- Increased numbers of people rough sleeping (see Section 6.4.3)

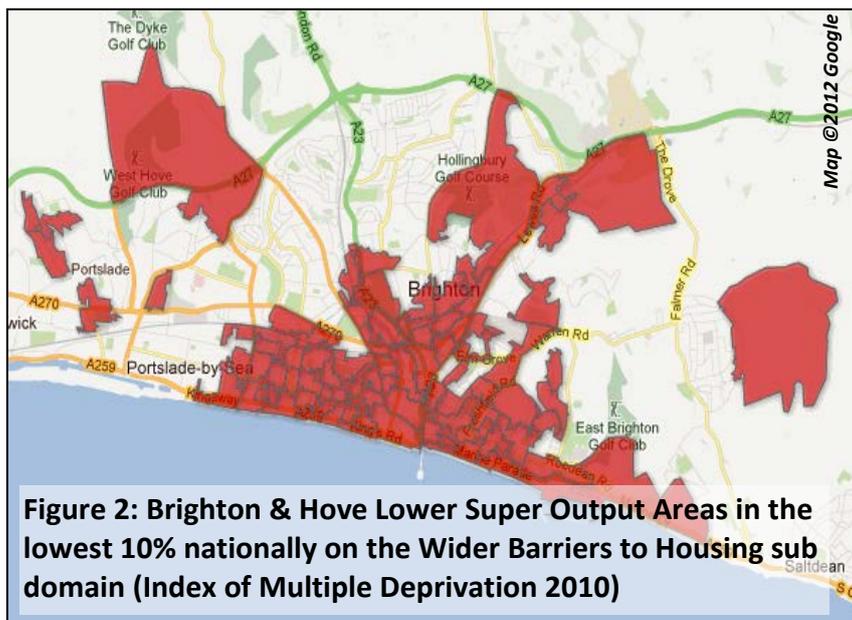
In the Index of Multiple Deprivation 2010 (IMD2010) wider barriers to housing sub-domain (affordability, overcrowding and homelessness), almost half (49%) of the city's Lower Super Output Areas (LSOAs) are in the bottom 10% nationally, with all 164 of the city's LSOAs in the bottom 41% (Figure 2).

The Council's Assessment of Affordable Housing Need Report 2012 identified that the minimum household income required to afford market housing (whether owner occupied or private rented) is £42,000 per annum against an average (median) household income of £28,240.⁴

The Assessment estimates that almost 88,000 households (72%) can not afford market housing without spending a disproportionate level of their income on housing costs or some form of subsidy.

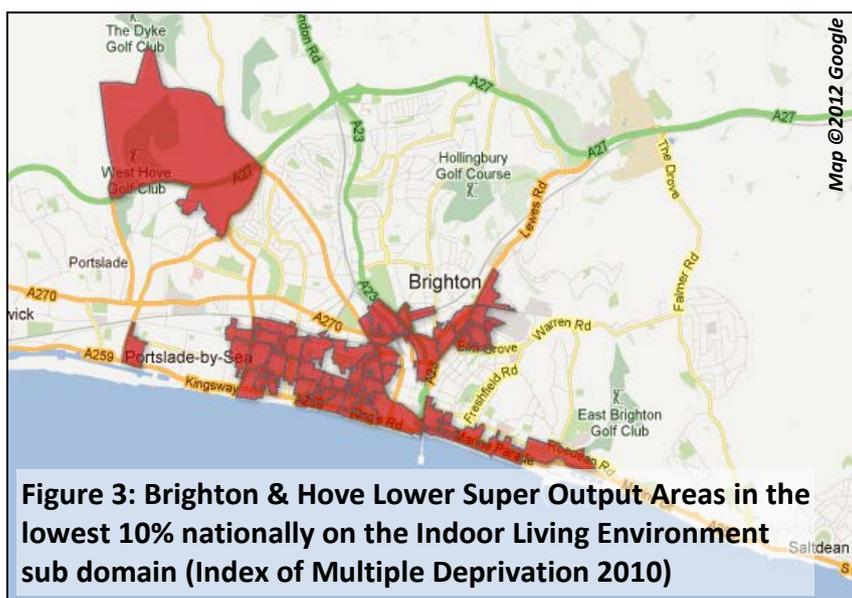
The Report has identified demand for 17,403 new affordable homes (3,481 per annum) in the period 2012-2017 above that already planned.

Housing pressures have seen homelessness increase by 38% over the last three years (506 households in 2012/13) with the most common reasons being eviction by parents, family or friends (38%) and loss of private rented accommodation (30%). In 2012/13 intensive prevention work with young people and families ensured that only 13 people ages 16 and 17 were accepted as homeless.⁵ 32.4% of those accepted as homeless in 2012/13 were in priority need due to physical disability or mental illness⁵ with rates generally running around double the England average.



Housing condition is known to have a major impact on health particularly around issues such as damp, disrepair and poor energy efficiency. The IMD2010 shows that on the indoor living environment sub-domain (housing quality) almost half (48%) of the city's LSOAs are in the bottom 20% nationally with more than a quarter in the bottom 10% (Figure 3).

A third of the city's housing stock (up to 40,000 homes) is considered to be non-decent with the vast majority (92%) being in the private sector; 42.5% of all vulnerable households in the private sector are living in non-decent accommodation.⁶



⁴ Brighton & Hove Assessment of Affordable Housing Need Report 2012: www.brighton-hove.gov.uk/downloads/bhcc/ldf/Assessment_of_Affordable_Housing_Need.pdf

⁵ Brighton & Hove City Council Housing Statistics Bulletin:

www.brighton-hove.gov.uk/index.cfm?request=c1202854

⁶ Brighton & Hove City Council: Private Sector Stock Survey 2008

6.4.4 Housing

The CIEH and BRE developed a toolkit to estimate the cost of poor housing. For Brighton & Hove it suggests that there are more than 1,200 excess colds and falls in the home each year that impact on quality of life and cost society £20 million per annum (£8 million NHS costs and £12 million in lost work and the need for benefits and support). The cost to adapt and improve this housing is estimated at £2million.⁷

As older people age and their needs change, responding effectively to these changes can enable them to maintain a good quality of life and maintain independent living. Spending £2,000-£20,000 on adaptations to support an older person at home can save £6,000 per year in care costs.⁸ The 2001 census indicated that half of local residents aged 85 and over still owned their own home.

Where we are doing well

The 2011-2015 Affordable Housing Programme will see 527 new affordable homes developed in partnership between the Council, Registered Providers, developers and the Homes and Communities Agency.⁹ This includes completion of the first new Council homes in a generation at Balchin Court. Over 400 new affordable homes are currently in development on sites across the City, all are built to Lifetime Homes Standard, including over 40 new wheelchair adapted homes. All are built to at least level 4 on Code for Sustainable Homes Standard.

The Council is also working with owners of empty homes and have brought more than 1,750 back into use since 2001. During 2012/13 - 157 long term empty private sector homes were brought back into use in the City including 34 brought back on long term leases for homeless families. £900k funding has been secured from the Homes and Communities Agency to fund a programme of empty home loans to 2015.

During 2012/13 we continued to invest in improving homes in the private sector, including installing 342 energy efficiency measures to the homes of vulnerable private sector residents with

197 tonnes of carbon dioxide saved. We were also successful in securing funding through DECC (Fuel Poverty and Green Deal Pioneer Places) and Warm Homes Health People bids, attracting an additional £750,000 investment to delivering home energy efficiency measures.

With more people with complex needs living at homes for longer we continue to improve assessment times and investment in housing adaptations across all tenures. During 2012/13 we completed 149 Disabled Facilities Grants to private sector households and 850 adaptations to council properties to help residents maintain their independence at home.

We have leased over 1,000 flats and houses of good quality so as to minimise our use of B&B type accommodation and also to provide quality housing solutions for Adult Social Care and Children's Services which reduces the impact on those services. There is a strong correlation between B&B type accommodation and poor health and so by providing alternatives we are mitigating the potential impact.

We have also leased accommodation to provide young people with supported housing projects.

Government funding for private sector renewal ceased in 2011 however the council was able to fund its own programme for the last 2 years. Unfortunately budget pressures have meant that this support has come to an end and we are exploring alternative sources for this investment. We are working with West Sussex County Council developing a model for delivery of Green Deal / Energy Company Obligation funding for local residents, businesses and the community through the Sussex Energy Saving Programme.

A long term maintenance partnership with Mears has not only provided apprenticeships for 50 local people but has also helped reduce the number of non-decent Council homes to less than 5%. The Council has also leased 355 poor quality homes to Brighton & Hove Seaside Community Homes since 2011 which has now refurbished and let the 250th home to a household in need.

The last 5 years has seen the Council's Housing Options service and partner organisations prevent more than 12,000 households from becoming homeless (2,981 in 2012/13).

⁷ Chartered Institute of Environmental Health / Building Research Establishment: Good Housing Leads to Good Health. A Toolkit for Environmental Health Practitioners

www.cieh.org/policy/good_housing_good_health.htm

⁸ Audit Commission: Building Better Lives; 2009

⁹ Brighton & Hove Local Housing Investment Plan 2012-2015

Brighton & Hove City Council fund the provision of support for more than 4,500 residents to either maintain their independence or help them return to independence through targeted services such as hostels for rough sleepers, the domestic violence refuge and special projects working with a range of groups such as those with learning disabilities or mental health problems. It has been calculated that every £1 spent on support services saves an additional £3.24 across the public sector.

Local Inequalities

Older People: The 2008 Private Sector Housing Condition Survey identified that homes where the head of the households was aged 85 or over had the highest rates of housing non-decency.

Young People: a new Childrens and Young Peoples Joint Commissioning Strategy is being developed to improve support to young people, help prevent homelessness and develop pathways to independence for those in our care.

Disability: historically we have topped-up the government's funding for Disabled Facilities Grants from Private Sector Housing capital budgets to assist more households and fund larger more complex adaptations. There is currently no new Private Sector Housing capital budget available from 2013-14 onwards so unless funding is available from other sources there is likely to an adverse impact on our ability to fund private sector housing adaptations.

Race: a BME needs assessment is being carried out to identify any unique housing needs of these communities.

Lesbian, Gay, Transgender and Bisexual communities: a specialist LGBT Housing Options Officer ensures the needs of these groups are more effectively supported with their housing needs.

People experiencing domestic violence: specialist Housing Options staff ensure the needs of these households are more effectively supported.

Gypsies and Travellers: a Traveller Commissioning Strategy is helping to meet the needs of these focussing on improving site availability, education, health and community cohesion.

Predicted future need

Welfare Reform changes are projected to take £102m per annum from residents and the city's economy, an average of £528 per working age adult each year. However, the annual loss for some households is expected to be in the £1,000's.¹⁰ This is resulting in a higher demand for our housing advice services and increasing homelessness.

Access to private rented housing for those on benefits is getting harder, with fewer properties available within housing benefit limits. Monitoring of the Rightmove website has identified that on average there were fewer than three 3-bedroom homes advertised within benefit limits at any time. Households are having to move out of Brighton & Hove along the coast to less expensive areas.¹¹

In the longer term, household growth and an ageing population will increase pressures on the housing supply, housing costs and support services.

The draft City Plan shows that the city has the capacity to develop 11,300 homes in the period 2010 to 2030 (565 per annum), far less than projected household growth of 22,840 households (914 per annum) in the period 2008 and 2033.^{12,13}

In addition, the Council's Assessment of Affordable Housing Need Report 2012 identified demand for 17,403 new affordable homes (3,481 per annum) in the period 2012-2017 above that already planned. The City Plan housing target suggests that there could be up to 3,600 new affordable homes built up to 2030 however this only meets 1 year of the current excess demand.

The city has a large proportion of people aged 85 and over (2.6% of the city's population compared to 2.1% in the UK) and projections to 2035 suggest this population will increase more than two thirds to 3.6%.¹⁴ This will increase the need for housing, support and care and we are actively looking to increase the supply of extra care housing and other accommodation to maintain resident's quality of life and reduce the need for institutional care.

¹⁰ Centre for Regional Economic Social Research and Sheffield Hallam University, *Hitting the poorest places hardest, the local and regional impact of welfare reform*, April 2013

¹¹ Brighton & Hove Local Housing Allowance Comparison Report: www.brighton-hove.gov.uk/index.cfm?request=c1202875

¹² Brighton & Hove City Plan (submission draft): www.brighton-hove.gov.uk/index.cfm?request=b1163744

¹³ DCLG 2008 household projections

¹⁴ Office of National Statistics 2010 Subnational Population Projections

6.4.4 Housing

What we don't know

Welfare Reform: The extent to which households will cope and the subsequent impacts on homelessness, other support services and risks around securing delivery of new affordable housing.

Spending Review 2013: The impacts from 2015 on welfare benefits, council funding and funds to support new affordable housing development.

BME Households: a BME needs assessment is being carried out which will also identify any unique housing needs of these communities.

Key evidence and policy

Chartered Institute of Housing: www.cih.co.uk

Chartered Institute of Environmental Health: www.cieh.org

UK Public Health Association: www.ukpha.org.uk

Homes and Communities Agency: www.homesandcommunities.co.uk

National Housing Federation: www.housing.org.uk

Joseph Rowntree Foundation: www.jrf.org.uk

Shelter: www.shelter.org.uk

Recommended future local priorities

1. Development of new affordable housing to lifetime homes standard.
2. Joint housing, health and care commissioning of Investment in energy efficiency and adaptation works to reduce fuel poverty and promote independence.
3. Joint housing, health and care commissioning of investment in housing support to sustain and promote independence.
4. Joint housing, health and care commissioning of increased provision of extra care and other supported housing options.

Key links to other sections

- Rough sleeping
- Fuel poverty

Further information

www.brighton-hove.gov.uk/housingstrategy

Last updated

May 2013

Why is this issue important?

Transport is an important determinant of health. 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.¹

Many car-based journeys are for short distances and are amenable to transfer to alternative modes (walking, cycling, and public transport).

Active travel refers to an approach to travel and transport that focuses on physical activity.

Regular physical activity of moderate intensity, such as walking or cycling, can bring about major health benefits and an improved quality of life. People who are physically active reduce their risk of developing major chronic diseases – such as coronary heart disease, stroke and type II diabetes – by up to 50%, and the risk of premature death by about 20–30%.²

The estimated annual cost of physical inactivity to the NHS alone is estimated to be £0.9 billion. This would be much higher if taking into account indirect costs to the health service.³

Active travel is a great way for people to incorporate physical activity into their daily lives. Improving the walking and cycling environment can dramatically improve local accessibility with positive benefits for growth and the local economy.⁴

Promoting active travel can bring important health benefits but also contributes to objectives in relation to sustainability and congestion and air pollution.⁵ To convert to active travel, people need to be persuaded of the benefits of such change.

¹ Marmot M. Fair Society, Healthy Lives: The Marmot Review – strategic review of health inequalities in England post 2010.

² Department for Transport and Department of Health. Active Travel Strategy, 2010; London.

³ Scarborough et al. The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs Journal of Public Health; 2011.

⁴ Department for Transport. Creating growth, cutting carbon: making sustainable local transport happen. London; 2011.

⁵ Department of Health. A Call To Action On Obesity 2011. London.

Creating conditions which encourage people to walk and cycle is necessary, as is access to good quality public transport.

Key outcomes

- ***Killed and seriously injured casualties on England's roads (Public Health Outcomes Framework)***
- ***Proportion of physically active and inactive adults (Public Health Outcomes Framework) – (see section 7.3.3)***

Impact in Brighton & Hove

The local rate of people killed or seriously injured is significantly higher than the national average: between 2009 -11 the rate was 59 per 100,000 resident population compared with 42.2 per 100,000 for England.⁶

Between 2006 and 2010 there was a downward trend in the number of people seriously injured on local roads. The number of people seriously injured increased in 2011 and fell slightly in 2012 (Table 1). The number of people slightly injured is also collected: in 2011 there were 819 people slightly injured (down from 937 in 2011 and 975 in 2010). In total during 2012 there were 979 casualties.

Table 1: Number of people killed or seriously injured in Road Traffic Collisions in Brighton & Hove, 2006-2011

Year	Killed	Seriously injured	Total
2006	9	162	171
2007	6	158	164
2008	5	136	141
2009	2	143	145
2010	8	128	136
2011	6	166	172
2012	5	155	160

Source: Department for Transport

⁶ Public Health England. Public Health Outcomes Framework Data Tool. Available at: <http://www.phoutcomes.info/> [Accessed 07/05/2013]

These figures are based on data collected by the police. It is known that this is not a complete record of all injury accidents and resulting casualties. However, this source remains the most detailed, complete and reliable single source of information on road casualties covering the whole of Great Britain.⁷

The journey to school is a significant contributor to local congestion particularly in the morning peak. Sustainable, active travel for journeys to school when replacing vehicle trips can reduce local congestion and carbon emissions.⁴

58% of pupils in years 4-6 walk to school on a regular basis; 3% cycle; and 34% travel to school by car.⁸

Just 24 secondary school pupils out of 3,000 plus surveyed in 2011 cycled to school, the highest number at any one school being six (Cardinal Newman School). However, 10% of all children surveyed, just over 300 pupils, live within one mile of their school and do not walk or cycle. A third (32%) travel by bus and a fifth (19%) by car.⁹ The average car journey is just over 2 miles.

Children (especially boys) who walked to school were more physically active the rest of the day than those who were driven.¹⁰

In the 2012 City Tracker Survey respondents were asked about a number of issues which could affect the street where they lived. Of these issues, respondents were most dissatisfied with road safety (21% very or fairly dissatisfied).¹¹

Where we are doing well

Data from the 2011 Census showed that many residents choose an active means of getting to work. In fact almost double the national and regional averages of residents walk to work in Brighton & Hove, with 20.6% travelling on foot. A further 4.9% cycle to work, which is also higher

than the national and regional average, both being 3%.¹²

Although still the most popular way of getting to work, less than two out of five of Brighton & Hove residents drive a car to work (37.2%). This is considerably less than in the South East (60.8%) and in England (57.0%). Use of cars to travel to work has decreased since the 2001 census when 43.2% reported driving a car to work.¹²

Automated cycle counters located across Brighton & Hove showed a 27% increase (relative to the baseline) in cycling over the period 2006 – 2009.¹³

The Brighton & Hove 'Local Transport Plan 3' (LTP3) supports measures to improve road safety and security and improve health by removing barriers to, and increasing uptake of, active travel.¹⁴

Out of 70 Local Authorities who participated in the National Highways and Transport Network Public Satisfaction Survey in 2011, Brighton & Hove was ranked 7th overall for walking and cycling. There were 21 benchmarking indicators for walking and cycling, and for Brighton & Hove seven were judged excellent, ten good, and four poor. The highest scoring indicator was 'the provision of pavements where needed' and the lowest was 'pavements being kept clear of obstruction'.¹⁵

20mph is now the legal speed limit on most roads in central Brighton & Hove. Following Phase 1, the programme is then proposed to be rolled out city wide, with further consultation on the later phases, over the next two to three years.

An Active Travel Forum, to promote, support and encourage active travel, was launched in June 2012 and is open to any public organisation with a role in supporting active travel.

Major improvements for cyclists and pedestrians on Old Shoreham Road were completed in June 2012.

In March 2013 Work began on a scheme to significantly improve Seven Dials; a major road

⁷ Department for Transport 2011: Reported Road Casualties in Great Britain: 2010 Annual Report.

⁸ Brighton & Hove Safe and Well at School Survey; 2010.

⁹ Brighton and Hove Safe and Well at School Survey; 2011.

¹⁰ Cooper AR, Page AS, Foster LJ and Qahwaji D. Commuting to School: Are Children Who Walk More Physically Active? American Journal of Preventative Medicine. 25(4):273-276; 2003.

¹¹ Brighton & Hove Strategic Partnership City Tracker, First Wave April-May 2012. Available at: www.bhlis.org/surveys [Accessed 07/05/2013]

¹² Brighton & Hove City Council. Census transport briefing. 2013. Available at: www.bhlis.org/census2011 [Accessed 07/05/2013]

¹³ Department for Transport. Analysis and synthesis of evidence on the effects of investment in six cycling demonstration towns; 2009.

¹⁴ Brighton & Hove City Council. Local Transport Plan 3. 2011. Available at: <http://www.brighton-hove.gov.uk/index.cfm?request=c1146323> [Accessed 25/08/2012].

¹⁵ National Highways and Transport Network Public Satisfaction survey 2011 www.nhtsurvey.org [Accessed 25/08/2012].

junction to the northwest of the city centre. The scheme aims to address the very serious road safety issues that exist here - 41 collisions resulting in 44 people injured have been recorded over the last five years, with 18 of these involving cyclists.

Local inequalities

There are links between road traffic collisions and socio-economic status. For children and for men aged 20-64 years, mortality rates for motor vehicle traffic accidents are higher in lower socioeconomic groups.⁶ In Brighton & Hove, of 2,730 hospital attendances between 2007/08 and 2010/11 where road traffic collision was indicated as a cause:

- 25% were in the most deprived population quintile and 18% were in the least deprived
- 55% were female and 45% were male
- 17.5% were aged 0 to 19 years¹⁶

17% of male respondents to the 2012 Health Counts self-report survey had cycled in the last seven days compared to 13% of females. There was little difference between males and females in the number of days cycled.¹⁷

Nationally, cyclists are more likely to be young, middle class, male and white.¹⁸

Predicted future need

Further shift from petrol/diesel based private cars will be required to meet carbon reduction targets set within the city's carbon reduction strategy and increased take up of active travel could contribute.

Improvements to infrastructure are needed where speed and volume of traffic have been identified as a growing problem. Priority areas include: Valley Gardens, the station gateway, Lewes Road and Edward Street/Eastern Road.

What we don't know

There is a lack of reliable local data on:

- The modal share (the percentage of travelers using a particular type of transportation)
- Information on equalities groups

- Barriers to active travel

Key evidence and policy

In 2012 the National Institute for Health and Clinical Excellence (NICE) produced public health guidance on 'local measures to promote walking and cycling as forms of travel or recreation'.¹⁹

The public health benefits of increasing cycling are considerable – evaluation of Department for Transport's Cycling Demonstration Towns initiative show these to outweigh the costs of the programme by three times.⁴

A systematic review of the economic benefits of cycling interventions, including economic benefits of health impacts from more physical activity, found a median benefit-cost ratio of 5:1.²⁰

Recommended future local priorities

1. Improvements in walking and cycling connections including in the city centre, other key routes and South Downs National Park to remove barriers to, and encourage uptake of, active travel.
2. Improvements to infrastructure where speed and volume of traffic have been identified as a problem. Priority areas include: Valley Gardens, the station gateway, Lewes Road and Edward Street/Eastern Road.
3. The public health guidance issued by NICE is the model towards which public health and transport bodies should work. Effective implementation of NICE recommendations could lead to major positive changes in the built environment and the way it is planned, implemented and managed.
4. LTP3, which funds local delivery projects from 2011/12 to 2014/15, will be refreshed in 2013.
5. Ensure the Safe and Well at School survey continues in its present form and includes the travel to school question in order to continue to monitor children's travel behaviours.

¹⁶ Secondary User Service data analysis; Public Health.

¹⁷ Health Counts 2012 <http://www.bhlis.org/>

¹⁸ NICE. Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation: Consultation on the draft guidance; 2012.

¹⁹ <http://publications.nice.org.uk/walking-and-cycling-local-measures-to-promote-walking-and-cycling-as-forms-of-travel-or-recreation-ph41>

²⁰ Cavill N, Kahlmeier S, Rutter H, Racioppi F, Oja P. Economic analyses of transport infrastructure and policies including health effects related to cycling and walking: a systematic review. *Transport Policy* 2008;15:291-304.

6. Improvements to data collection and analysis to support the evaluation of outcomes.

Key links to other sections

- Green and open spaces
- Air quality
- Noise pollution
- Physical activity (child and adult)
- Healthy weight (child and adult)

Further information

Brighton & Hove City Council: LTP3 2011.

<http://www.brighton-hove.gov.uk.LTP3>

Department for Transport. White Paper: Creating Growth, Cutting Carbon: Making Sustainable Local Transport Happen. 2011.

<http://assets.dft.gov.uk/publications/making-sustainable-local-transport-happen.pdf>

Department for Transport/ Department of Health. Active Travel Strategy. 2010.

<http://www.dh.gov.uk/active-travel>

Last updated

May 2013

6.4.6 Good nutrition and food poverty Brighton & Hove JSNA 2013

Why is this issue important?

Good nutrition supports both mental and physical health. A poor diet is characterised by excessive intake of saturated fat, salt, sugar and insufficient consumption of fruit, vegetables and dietary fibre.¹ Evidence demonstrates the impact of nutrition on educational attainment in children.²

It has been estimated that malnutrition costs UK health services up to £7.4 billion a year.³

Poor diet is associated with conditions such as obesity, coronary heart disease, diabetes, stroke and cancers.⁴ Evidence demonstrates the contribution of food and nutrition to mental wellbeing and the development, prevention and management of some specific mental health problems.⁵

Data related to premature deaths in England shows that Brighton and Hove ranks 98th worst out of 150 local authorities.⁶ Cancer, liver disease and heart disease are key contributors to premature deaths (2,185 deaths of under 75s). Poor diet and obesity are key factors in the causes of these deaths.

Data related to many aspects of nutrition and diet illustrate the inadequacies of the nation's diet and that dietary inequalities contribute to inequalities in health. In 2010, the average UK household purchased four portions of fruit and vegetables per person per day but in lowest income families this fell by 20% between 2006 and 2010 (to 2.7 portions).⁷ Food poverty is described as "the inability to afford, or have access to, food to make up a healthy diet."⁸

Key outcomes

- Health Improvement – Diet: The proportion of the population meeting the recommended 5 A Day on a "usual" day (Public Health Outcomes Framework)
- The Brighton & Hove Food Strategy is based around nine aims, one of which is for people in the city to eat a healthier and more sustainable diet.⁹

Impact in Brighton & Hove

The 2012 Health Profile for Brighton & Hove indicates that 30% of adults are eating a healthy diet, this is comparable to the England average of 29%.¹⁰ However, this data should be treated with caution as it is based on modelled estimates.

The Safe and Well at School Survey 2012 found that 18% of students aged 11-16 years had eaten five or more portions of fruit or vegetables the previous day, the same as the previous year.¹¹

Research in Brighton and Hove suggests that cost is a major constraint informing choice when shopping for food,¹² with those growing their own food motivated to have access to food that is fresh and healthy but importantly affordable.¹³

The 2011 community consultation for the city's food strategy identified the need for information and support on good diet and nutrition to be available to people living with long-term mental and physical health conditions.

The effects of austerity and welfare reform have contributed to food poverty in the city, with a rise in people turning to food banks and other emergency help. The city is seeing an increase in Crisis Food Poverty (e.g. financial crisis means they're unable to buy food at that moment in time) and On-going Food Poverty¹⁴. There are 5 Food

¹ National Heart Forum. Nutrition and food poverty: a toolkit; 2004.

² Feinstein et al. Dietary patterns related to attainment in school: the importance of early eating patterns J Epidemiol Community Health 2008;62:734-73.

³ Elia et al. The cost of disease-related malnutrition in the UK and economic considerations for the use of nutritional supplements (ONS) in adults. Health Economic Report on Malnutrition in the UK. 2005.

⁴ WCRF/AICR's Second Expert Report, Food, Nutrition, Physical Activity, and the Prevention of Cancer: a Global Perspective

http://www.dietandcancerreport.org/expert_report/index.php [Accessed on 25/08/2012]

⁵ Mental Health Foundation; Feeding minds: the impact of food on mental health; 2006.

⁶ Public Health England. Mortality rankings.

<http://longerlives.phe.org.uk/area-details#are/E06000043/par/E92000001> [Accessed 18.06.2013]

⁷ <http://www.defra.gov.uk/statistics/files/defra-stats-foodfarm-food-pocketbook-120402.pdf> [Accessed on 25/08/2012].

⁸ Department of Health. Choosing a Better diet: a food and health action plan; 2005.

⁹ Spade to Spoon: Digging Deeper <http://www.bhfood.org.uk/food-strategy> [Accessed on 25/08/2012].

¹⁰ Department of Health. Health Profile 2012, Brighton and Hove. <http://www.apho.org.uk/resource/view.aspx?RID=50215®ION=50158&LA=50148&SPEAR=>

¹¹ Brighton & Hove City Council. Safe and Well at School Survey (Secondary) Summary Results 2012. Available at <http://www.bhllis.org/surveys> [Accessed 11/08/2013]

¹² Harvest Brighton and Hove Evaluation Report – Bevenden Street Survey, Food Matters; 2011.

¹³ Brighton & Hove Community Supported Agriculture Feasibility Study, Food Matters; 2011.

¹⁴ Brighton & Hove Food Partnership. April 2013

6.4.6 Good nutrition and food poverty Brighton & Hove JSNA 2013

Banks in the city. Food banks report a lot more families, including working families are turning to them for support.¹⁵ A FareShare survey of its Community Food Members (CFM) in Brighton & Hove in 2011 found that the 18 CFM projects that responded served 1,600 clients. The CFMs reported that 30% of clients had gone without food for a day in the last month and 60% had gone without a square meal for a day or more in the past year. 42% of clients were unable to buy food on a regular basis. 25% of the CFMs had seen an increase in demand for their services since the start of the recession.¹⁶

There are strong links with other areas including fuel poverty (fuel and food both put increasing pressures on household budgets). Evaluation of the Brighton and Hove Warm Homes Healthy People Programme 2012/13 indicated that 115 people accessing the programme avoided buying essential items – which may include food. The Marmot Review¹⁷ drew attention to the need to address the food environment in tackling health inequalities, including the value of local sustainable food.

Where we are doing well

Between 2003 and 2012 there has been a statistically significant improvement in the proportion of respondents to the Health Counts Survey, eating five portions of fruit and vegetables a day – increasing from 43% to 52%.¹⁸

The latest Health Related Behaviour Survey found that the eating habits of local children aged 10-14 are improving.¹⁹

Thirty five schools have achieved Healthy School status and have food policies that consider and engage the whole school community. 48 local nurseries and childminders have adopted a Healthy Early Awards including the Healthy Choice Award, which ensures children are served food that is age-appropriate and nutritious. 19 Breakfast Clubs and 23 residential care homes in the city have also achieved the Healthy Choice Award for their setting.

In 2012 the Shadow Health and Wellbeing Board adopted healthy weight and good nutrition as one of the Health and Wellbeing Strategy priority areas for the city.²⁰

The Brighton & Hove City Council Financial Inclusion Policy 2013-2016 includes addressing food poverty as one of the aims of the Community Banking Partnership.²¹

There is a vibrant network of more than 100 food projects across the city providing education, opportunities to participate in community activity, and access to healthy, sustainable food. There are community-based cookery and nutrition programmes that are addressing health inequalities associated with poor diets. However these are not necessarily accessible to all those in need.

Allotments and community growing projects are one way of increasing access to good quality affordable food. The city has one of the largest allotment services in the country with 36 sites and approximately 3,000 tenants. Plots are provided for individuals, disabled people and community plots. A reduction of 25% on annual fees is available for people over 60, full time students, those on long term disability allowance and some benefits recipients. There are 32 community plots on allotments and 48 community food growing spaces on other public and private land in the city. Of the 80 plots, 66% are based in deprived neighbourhoods and half work with vulnerable client groups.

Local inequalities

There are many neighbourhoods in the city where access to fresh fruit and vegetables is limited. This is a particular issue for residents who are reliant on public transport or have limited mobility. Access to good quality food is not just about location, but includes other factors such as cost; opening and delivery times; acceptability and awareness.

¹⁵ O'Brien E. Food Poverty Affecting Many More Families. Brighton and Hove Food Partnership. 2013

¹⁶ FareShare National Impact Survey 2011. Results for FareShare Brighton.

¹⁷ Marmot et al. The Marmot Review: Fair Society, Healthy Lives; 2010.

¹⁸ Health Counts 2012. Diet.

¹⁹ Brighton and Hove City PCT, Health Related Behaviour Survey; 2007.

²⁰ Draft Brighton & Hove Joint Health and Wellbeing Strategy.

<http://present.brighton->

[hove.gov.uk/Published/C00000687/M00004093/AI00029519/\\$20120903105223_002717_0009306_JHWSworkingdraft3008125.docA.ps.pdf](http://present.brighton-hove.gov.uk/Published/C00000687/M00004093/AI00029519/$20120903105223_002717_0009306_JHWSworkingdraft3008125.docA.ps.pdf)

²¹ Brighton & Hove City Council Financial Inclusion Strategy, 2013-2016.

http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/downloads/equalities/Appendix_One_Financial_Inclusion_Strategy_-_Final.doc

6.4.6 Good nutrition and food poverty Brighton & Hove JSNA 2013

More than one in five children in the city lives in poverty.²² This is similar to the England average but significantly worse than the South East average. Work to improve children's diet should be targeted at those most at risk including children living in areas of deprivation. Children from poor working families are often not entitled to free school meals and may be at particular risk. Families with children who are entitled to free school meals are at higher risk of food poverty within school holidays.

Nationally it has been identified that those most likely to experience food poverty are: people on low incomes or unemployed; households with dependent children; older people; people with disabilities; and members of BME communities.¹

The Brighton and Hove Learning Disability Partnership Board has recognised the need to support adults with learning disabilities around food and nutrition choices. The Brighton and Hove Food Partnership and Speak Out have run Cooking Together cookery skills and healthy eating courses for people with learning disabilities.

The Safe and Well at School Survey 2012 found that younger students aged 11-12 years are significantly more likely to eat five a day (20%) than those aged 15-16 years (13%) and there is a significant reduction in the consumption of five or more portions of fruits and vegetables associated with increasing age. Girls are significantly less likely to eat five a day (16%) compared with boys (19%). There was little difference in consuming five or more portions of fruits or vegetables between BME students (18%) and White British students (17%).¹¹

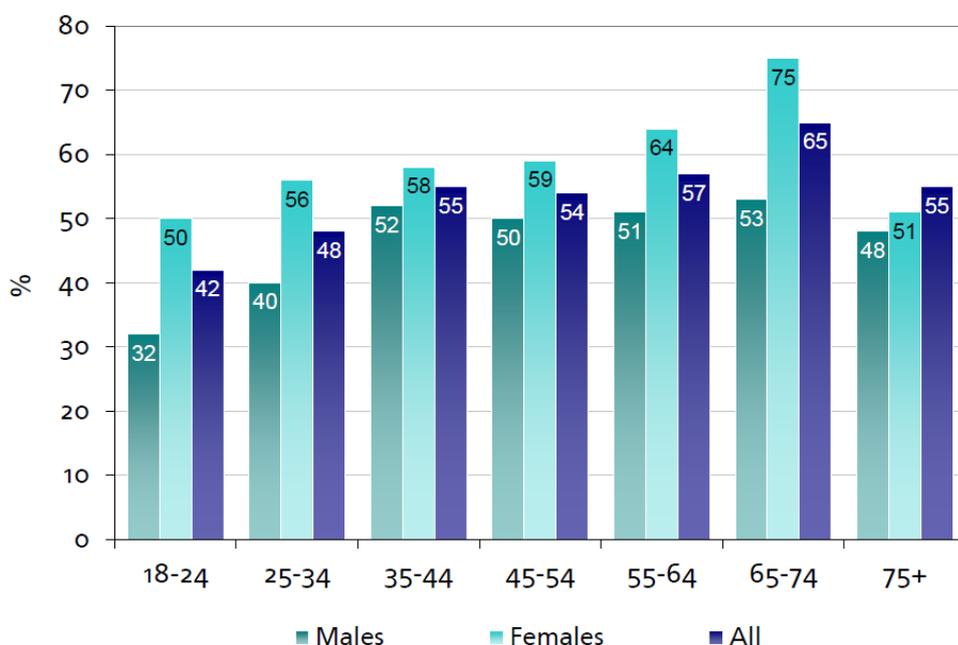
The Health Counts Survey 2012 (2,035 respondents) found eating five a day is significantly more common in females (59%) than males (46%) and is considerably higher for women in all age groups (Figure 1).¹⁴

People living in the most deprived quintile have the lowest consumption of five a day (48%), with the highest consumption in quintiles 3 and 4 (55%).¹⁴

Single people responding to the Health Counts Survey were significantly less likely to eat five a day or more (44%). Those who were widowed were significantly more likely (66%).¹⁴

Home owners are more likely to eat five a day (58%) compared with those renting from local authority or housing associations (41%).¹⁴

Figure 1: Percentage of respondents eating five or more portions of fruit and vegetables per day by gender and age



Source: Brighton & Hove Health Counts Survey 2012

Unemployed people are less likely to eat five a day (40%) and those with a degree or higher level qualification are significantly more likely (59%) to eat five a day than those without qualifications (46%).¹⁴

Predicted future need

The cost of food has been rising significantly over the past few years. Between June 2007 and June 2011 food prices increased by 26% (more than 12% in real terms) and healthy food such as fruit has increased even more.²³ It is expected that fluctuations in food prices will continue: lower

²² ChiMat Child Health Profiles Brighton & Hove; 2012. <http://www.chimat.org.uk/resource/view.aspx?RID=101746®ION=101636> [Accessed on 25/08/2012].

²³ <http://www.defra.gov.uk/statistics/files/defra-stats-foodfarm-food-pocketbook-120402.pdf> [Accessed on 25/08/2012].

6.4.6 Good nutrition and food poverty Brighton & Hove JSNA 2013

income families are most affected by rising food prices.²⁴

The national Welfare Reform programme may have an additional impact as benefit levels are set with no account of food costs or other needs.

What we don't know

We do not have any data on the differential impact of food poverty on specific groups. Nor do we know how the implementation of welfare reform will affect people's access to healthy food.

Key evidence and policy

The city's food strategy and action plan sets out a long-term vision for the city's food system that is healthy, sustainable and fair.

<http://www.bhfood.org.uk/food-strategy>

The Brighton and Hove Food Partnership held an event in November 2012, at which several recommendations for addressing food poverty were made.

<http://www.bhfood.org.uk/food-poverty>

The local Biosphere Reserve Bid supports the development of locally produced and sustainable food sources.

<http://biospherehere.org.uk/>

A Zero Hunger City – Tackling food poverty in London calls for a more coherent approach to emergency measures such as food banks and better long-term support for those at risk of food poverty.

<http://www.london.gov.uk/mayor-assembly/london-assembly/publications/a-zero-hunger-city-tackling-food-poverty-in-london>

Recommended future local priorities

1. Support individuals to gain skills and knowledge to shop and cook to make the most of their food budgets, minimise food waste and avoid products very low in nutritional value.
2. Support schemes that improve access to affordable, healthy food such as Healthy Start vouchers, breakfast clubs and food projects

that provide opportunities for volunteering and access to fresh produce.

3. Improve understanding of food poverty in the city; establish baseline data through the use of standardised food poverty questions to be included in agencies data monitoring tools and agree an action plan. Ensure work on debt advice, child poverty and food poverty is better linked.
4. Improve information and support on diet and nutrition for people living with long-term mental and physical health conditions (initially prioritising people with HIV).
5. Provide hands-on food education (cooking and growing) alongside education about healthy and sustainable diets, so that young people can make confident food choices now and when they become adults. Schools should be supported to include the whole school community in promoting and offering healthy food choices.
6. Large public sector organisations (schools, universities, hospitals etc) should lead by example to ensure that the food they serve is of a high standard of sustainability and nutrition.

Key links to other sections

- Coronary heart disease
- Stroke
- Diabetes
- Cancer
- Healthy weight
- Child poverty
- Climate change
- Excess winter deaths and fuel poverty
- Green and open spaces

Further information

Brighton and Hove Food Partnership
<http://www.bhfood.org.uk/>

Last updated

June 2013

²⁴ Food Standards Agency (2007) Low Income and Diet Survey. London: Food Safety Authority.
<http://www.food.gov.uk/science/dietarysurveys/lidnsbranch/> [Accessed on 25/08/2012].

Why is this issue important?

Being physically active in the outdoors is good for health, reducing the risk of developing conditions such as diabetes and heart disease, tackling obesity and supporting recovery after illness. It also supports good mental health and emotional wellbeing. The Marmot Review recognises that nationally there is inequity in access to green and open spaces, with more socially deprived groups more likely to experience barriers. The Review recommended that in order to reduce health inequalities a key policy objective should be to improve the availability of good quality open and green spaces across the social gradient.¹

The Marmot Review also noted the indirect health and wellbeing benefits. Green spaces encourage social contact and integration, provide space for physical activity and play, improve air quality and reduce urban heat island effects.

Key outcomes

- **Utilisation of outdoor space for exercise/health reasons (Public Health Outcomes Framework)**

Impact in Brighton & Hove

Our city is bounded by green and open space: the South Downs National Park and the seafront. Overall there are 1,279 hectares of open space in the city (5.1 hectares per 1,000 population), including:

- 98 parks and green open spaces, including 36 parks and recreation grounds of significance
- eight nature reserves spanning 7.4% of the land within the city
- two sites of Special Scientific Interest (Castle Hill and Marina to Newhaven cliffs)

Brighton & Hove owns about 6,000 hectares (14,000 acres) of countryside around the city: most of the land from Saltdean to Ditchling Beacon and around Hove towards Southwick Hill. Most of this land is in the South Downs National Park,

¹Marmot M. Fair Society, Healthy Lives: The Marmot Review – strategic review of health inequalities in England post 2010. 2010. Available at: <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report> [Accessed 12/08/2013]

amounting to over 40% of the city. This includes a portfolio of farmland.

The Health Counts Survey 2012 reported that 54% of the survey population used parks and open spaces in the city at least once a week.²

The way people access open spaces is influenced by a range of social and physical factors. Roads and railways are significant barriers to accessing green and open space³ (e.g. the A27 limits pedestrian access between the City and the National Park). The Local Access Forum⁴ advises the Council where rights of way and road crossings can be improved to increase access to the countryside.

In 2012 two Brighton & Hove beaches were awarded Blue Flag status: Hove Lawns and West Street.⁵ This is based on compliance with 32 criteria covering environmental education and information; water quality; environmental management; and safety and services.

Allotments have great potential to contribute to health and wellbeing. Allotment gardening enables people to be physically active, provides access to healthy and affordable food, has a wide range of social benefits and supports sustainability by reducing 'food miles'. In June 2013 there were 3,032 plots in the city (an increase of 4% compared with January 2011) and 1,716 people on the waiting list. In May 2013, 12 waiting lists were closed, so demand for a plot is likely to be higher than the number of people on the waiting list.⁶

Respondents to the Biosphere consultation said they most valued accessibility to the local environment; nature conservation of varied features and promotion of health and wellbeing through nature.⁷

² NHS Brighton & Hove and University of Kent Centre for Health Service Studies. Health Counts 2012.

³ Open Space Study Update report; 2011 <http://www.brighton-hove.gov.uk/index.cfm?request=c1187994> [Accessed by 25/08/2012].

⁴ <http://www.brighton-hove.gov.uk/index.cfm?request=c1238738> [Accessed by 25/08/2012].

⁵ Blue Flag status <http://www.blueflag.org/> [Accessed by 25/08/2012].

⁶ Brighton & Hove City Council. Allotments Service. City Parks. Waiting list 1.05.13.

⁷ Howarth R. Biosphere Project. http://www.brighton-hove.gov.uk/downloads/bhcc/sustainability/CSP_16_05_13_biosphere_report.pdf

Where we are doing well

Provision of parks and gardens is generally good.⁸ In 2008, 91% of residents reported having used a local park or open space in the previous six months.⁹ This is higher than reported for the South East and England (83% and 81% respectively). Furthermore, 82% were satisfied with local parks and open spaces, compared with 73% for the South East and 69% for England (Brighton & Hove was ranked 14th out of 352 local authorities and 2nd out of 55 unitary authorities).

Brighton & Hove has an above average number of parks with Green Flag awards, a scheme which recognises and rewards the best examples in the country. In 2011 six flags were awarded for Easthill Park; Hove Park; Preston Park; Kipling Gardens; Stoneham Park and St Ann's Well Gardens.¹⁰

Effective management is important to maintain, and where necessary improve, the quality of local green spaces. The city has many active 'friends' groups who work with the council Ranger Service to manage green spaces across the city.

Friends groups can also provide healthy volunteering opportunities. Other opportunities include Brighton Conservation Volunteers, Sussex Wildlife Trust, Health Walks, Green Gym and various community gardens, allotments and farm volunteering.¹¹ In September 2012 the Community and Voluntary Sector Forum and Groundwork supported the development of Brighton & Hove Green Spaces Network for community groups and voluntary organisations in the city with an interest in parks and green spaces.¹²

The local Health Walks programme is designed to help people get the most out of walking for their physical and mental health.¹³ Walks are led by Volunteer Walk Leaders and groups targeted include those who are getting little or no exercise, recovering from illness, or lacking in confidence.

Education can play an important role in encouraging engagement with local environment. The Sussex Wildlife Trust Forest Schools Programme offers children, young people and participating schools opportunities to enjoy their local woodlands.¹⁴

Brighton & Hove is on track to become the world's first designated One Planet City. This will be achieved by implementing the ten One Planet Living principles. These include reducing the carbon footprint of the city, an area in which green and open spaces can play an important part in reducing "greenhouse gases" through the uptake of CO₂ by mature trees.¹⁵

Local inequalities

At the city-wide level, current provision of natural and semi-natural green space is judged to be relatively good. However the majority of green space is located on the edges of the city, and at the more local level there is unequal access to green and open space.

In 2006, access to natural and semi-natural green space was measured by Natural England using the ANGst model.¹⁶ The majority of residents' access does not meet the ANGst standard at the most local level (the local picture was similar or slightly better than the South East average).

In 2008, people living in more deprived areas, especially around East Brighton, and residents renting from the council, were less likely to have used a park in the previous six months, at 79% and 75% respectively, compared with 91% across the city.¹⁷ The Health Counts Survey 2012 found people from areas of deprivation continued to be less frequent users of parks and open spaces, with 46% of the sample using them. This is despite the relatively good physical access to green and open spaces in East Brighton.

⁸ Brighton & Hove City Council: Open Space Study Update 2011.

⁹ Brighton & Hove City Council. Place Survey 2008. Available at www.bhlis.surveys [Accessed 12/08/2013]

¹⁰ BHCC Green Flag Parks <http://www.brighton-hove.gov.uk/index.cfm?request=c1249659> [Accessed on 25/08/2012].

¹¹ <http://www.harvest-bh.org.uk/volunteering>

¹² Terms of Reference Brighton & Hove Green Spaces Network September 2012

<http://www.cvsectorforum.org.uk/sites/cvsectorforum.org.uk/files/Green%20Spaces%20Network%20-20Terms%20of%20Reference%20Sep%202012.pdf>

¹³ <http://www.brighton-hove.gov.uk/index.cfm?request=c1115507> [Accessed 25/08/2012]

¹⁴ <http://www.sussexwildlifetrust.org.uk/education/page00023.htm> [Accessed on 25/08/2012].

¹⁵ Faculty of Public Health. Great Outdoors: How our natural health service uses green space to improve wellbeing. 2010.

¹⁶ Mckernan and Grose. An analysis of accessible natural greenspace provision in the South East. 2006 <http://www.forestry.gov.uk/forestry/inf-d7d4mgd> [Accessed on 25/08/2012].

¹⁷ Brighton & Hove City Council. Place Survey. 2008 reported in the State of the City Report. Available at: <http://www.bhlis.org/needsassessments/stateofthecityreport> [Accessed 12/08/2013]

6.4.7 Green and open space

The Health Count Survey also found that:

- Men and women were equally likely to use parks or open spaces at least once a week. However, women aged 18-44 years were more likely than men of the same age to use parks and open spaces at least once a week. Those aged 65 years or over and men were more likely than women to use these spaces at least once a week.
- There was no difference in use for White British and BME residents, however only 8% of the 26 Black or Black British respondents had used a park or open space in the last week.
- Similarly there was no difference in use between heterosexual and LGB, unsure or other respondents.
- Those renting from a Housing Association or council were less likely to have used parks or open spaces in the last week (38%).
- Use was similar for carers (56%) and non carers (55%).
- Those who are unable to work due to disability or ill health are less likely to have used parks or open spaces in the last week (32%).
- As are those without qualifications (33%) compared with 64% of those with a degree level qualification or higher.²

Evidence shows that people from BME communities can feel disengaged from the natural environment.¹⁸ Despite representing 10% of the national population, ethnic minorities represent only 1% of visitors to National Parks.¹⁹ The Mosaic III project tried to address this in the South Downs National Park between 2009 and 2012, by training BME volunteer Community Champions to organise and lead visits to the park. Legacy from this project has included three Community Champions trained in Brighton & Hove.²⁰

¹⁸ Black Environment Network, 2005. Engaging Ethnic Communities in Natural and Built Heritage. Llanberis:Black Environment Network

¹⁹ The Mosaic Model. Engaging BME communities in National Parks. Natural England.

²⁰ Private communication. Mosaic May 2013.

Predicted future need

Modelling indicates that the City will need to increase the amount of open space by approximately 108 hectares by 2030 to maintain current levels of access (based on a ratio of residents to hectares) (Table 1).

Table 1: Brighton & Hove open space: 2006 provision & future requirements

	2006 provision (hectares)	Approx additional space required (hectares) by 2030 applying recommended standards
Natural / semi-natural	709	60
Parks and gardens	232	20
Amenity green space	149	11
Outdoor sport	118	10
Allotments	59	4
Children and young people	12	3
Total	1,279	108

Source: PMP 2009 and applying the 2030 population forecast (i.e. 274,165) indicated in the Housing Requirements Study and Supplementary Papers (GL Hearn) (2011 and 2012)

Having green space available doesn't necessarily mean people will use it – the challenge is to promote behaviour change by helping people to become actively involved in their local environment. This should focus on the least active and/or those with poor access to green space.

One the aims of the city's Biosphere Reserve bid is to increase health of residents and visitors by increased use of the outdoors. The Biosphere covers the South Downs National Park, a marine conservation area, the City itself and parts of Wealden. Its functions include conservation, development and knowledge.²¹

²¹ Biosphere Project Brighton & Hove City Council <http://www.brighton-hove.gov.uk/index.cfm?request=b1159364> [Accessed 15 May 2013]

6.4.7 Green and open space

What we don't know

We don't know a great deal about how parks and open spaces are being used by some equalities groups - marital status, religion, carers, disability or sexual orientation.

Key evidence and policy

NICE has produced guidance on physical activity and the environment (PH8); this is targeted at professionals who have a direct or indirect role in, and responsibility for, the built or natural environment.

<http://publications.nice.org.uk/physical-activity-and-the-environment-ph8/recommendations#public-open-spaces>

The Defra White Paper is the first on the natural environment for over twenty years.

<http://www.defra.gov.uk/environment/natural/whitepaper/>

The Faculty of Public Health published a report in 2010 on "Great Outdoors: How our natural health service uses green space to improve wellbeing," highlighting the physical and mental health benefits of using green spaces.

http://www.fph.org.uk/uploads/bs_great_outdoors.pdf

Recommended future local priorities

1. Use healthy urban planning principles to build green and open space into new developments.
2. Increase access to existing green and open spaces across the city through partnership working.
3. Improve connectivity between different green and open spaces (encouraging walking and benefiting wildlife).
4. Incorporate use of green and open spaces (including the new South Downs National Park) into design of initiatives to improve health, particularly focusing on the least active.
5. Consider health and wellbeing benefits and equity of access for deprived groups in the development of the local Allotments Strategy.
6. The health and wellbeing benefits of good access to, and use of, green and open spaces

should be taken into account when planning to improve local access and provision.

Key links to other sections

- Transport and active travel
- Good nutrition and food poverty
- Air quality
- Climate Change
- Happiness and wellbeing
- Volunteering and the community and voluntary sector
- Physical activity (children and young people)
- Healthy weight (children and young people)
- Physical activity (adults and older people)
- Healthy weight (adults and older people)
- Diabetes
- Coronary heart disease

Further information

Brighton & Hove State of the Local Environment report <http://www.bhlis.org/environment/>

Brighton & Hove Parks and Countryside <http://www.brighton-hove.gov.uk/index.cfm?request=b1161284>

City Wildlife: Council website for wildlife in Brighton & Hove <http://www.citywildlife.org.uk/>

South Downs National Park Authority <http://www.southdowns.gov.uk/>

Brighton & Hove Healthwalks <http://www.brighton-hove.gov.uk/index.cfm?request=c1115507>

Open Space Access Study 2008/09 and 2011 Update <http://www.brighton-hove.gov.uk/index.cfm?request=c1187994>

Last updated

May 2013

Why is this issue important?

Climate change presents a threat to life, health and wellbeing.¹ The magnitude of the health impacts within the UK will be less than in many parts of the world but still significant. The Faculty of Public Health has identified that these impacts will be of two major types²: global impacts affecting the UK, for example crop failures causing food insecurity through rising food prices and possibly shortages; and direct impacts within the UK including an increase in deaths, disability and injury from:

- extremes of heat and cold
- floods and storms
- food poisoning
- respiratory problems from the damaging effects of surface ozone during the summer and mould growth in housing
- skin cancer and cataracts
- insect-borne disease.

Action is required both to reduce the contribution our city makes to climate change and to adapt our city to the changing climate.

Effective action to tackle climate change could improve health and reduce health inequalities. Adopting low carbon behaviour (such as active travel, low waste, local food, efficient energy use) and developing a low carbon infrastructure and economy can support:

- improvements in air quality
- increased levels of physical activity
- improvements in household ventilation and insulation
- a healthier urban environment
- the development of a more sustainable food system.

In turn, this will have positive impacts on the health and wellbeing of our population, including reducing obesity, hypertension, respiratory conditions, premature winter deaths, coronary

heart disease, diabetes and mental health problems.

Key outcomes

Brighton & Hove is committed to reducing the city's carbon emissions by 42% by 2020 and 80% by 2050.³ This is consistent with the Climate Change Act (2008).

The public sector is a major contributor to carbon emissions (the NHS contributes the largest proportion). Reflecting this, the following national outcome indicator has been agreed:

- ***Proportion of Public Sector Organisations with a Board-approved sustainable development management plan (Public Health Outcomes Framework).***

Reporting against this indicator at the Local Authority level currently relates to NHS organisations only. The figure for 2011/12 for Brighton and Hove is 85.7% compared to the England figure of 84.1%

Impact in Brighton & Hove

Carbon Dioxide (CO²) makes up 83%⁴ of greenhouse emissions driving the UK contribution to global warming.

Government figures published in July 2013⁵ show that Brighton and Hove's estimated CO₂ emissions have fallen in recent years. Since 2005, estimated local emissions have reduced by 24% in total and 17% per capita resident.

The State of the Local Environment Report summarised local indicators showing the impact of climate change including these historic trends:

- Reducing average rainfall in spring and summer, contributing to greater "water stress" on the city's environment. This is important because the local groundwater supply has been

³ From the 2005 baseline. See <http://www.bandhsp.co.uk/climatechangestrategy/>

⁴

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210491/1_GHG_Inventory_Overview.pdf [Accessed 04/09/2013].

⁵ Official statistics: Local Authority carbon dioxide emissions <https://www.gov.uk/government/publications/local-authority-emissions-estimates> [Accessed 04/09/2013].

¹ Department of Health. 2009 Annual Report of the Chief Medical Officer. 2010.

² Faculty of Public Health. Sustaining a healthy future: Taking Action on Climate Change. 2008.

6.4.8 Climate change

assessed as “poor” due to quantity issues (the amount of water abstracted).⁶

- Upward trend in average temperatures.
- Increasing sea levels, with an estimated 1,100 local properties at significant risk of coastal flooding.

Where we are doing well

As highlighted above there is a downward trend in local CO² emissions. Continuing this trend will present a considerable challenge.

In April 2013 Brighton & Hove became the world’s first designated One Planet City. The city’s Sustainability Action Plan has received independent accreditation from BioRegional for its plans for the city to using just one planet’s worth of resources rather than the current three and a half.

This embeds an approach to sustainability built upon ten guiding principles, including aiming for zero carbon and zero waste.

For more details, including case studies of action impacting on carbon emissions, see <http://www.brighton-hove.gov.uk/content/environment/sustainability-city/one-planet-city>

Local inequalities

There is no data quantifying the impact of climate change on health inequalities. Climate change affects everyone but impacts are likely to be greater on vulnerable groups, for example, older people, people with long-term conditions, infants and people living in poor housing conditions. Supporting those most affected by climate change will be required to ensure that action to tackle climate change does not increase health inequalities.

Predicted future need

The State of the Local Environment identified that the most likely scenario is that by 2050 (in comparison with the 1969-90 baseline) Brighton & Hove will experience:

- a 26% decrease in summer rainfall (and 14% increase in winter rainfall)
- a 3.2°C increase in average maximum daily summer temperatures and a 1.9°C increase in winter

Altering our behaviour to respond to the impacts of climate change is known as ‘adaptation’. It means not only protecting the city, its residents and businesses against negative impacts, but also making us better able to take advantage of any benefits.

What we don’t know

The State of the Local Environment Report identified information gaps including publication of CO² emission monitoring data is lagged and this makes it difficult to attribute changes to specific interventions.

Projections of impact of climate change on UK health and wellbeing are uncertain.

Key evidence and policy

UK Climate Change Act (2008)
http://www.decc.gov.uk/en/content/cms/legislation/cc_act_08/cc_act_08.aspx

Brighton & Hove City Climate Change Strategy (2011)
<http://www.bandhsp.co.uk/climatechangestrategy>

Saving Carbon, Improving Health: NHS Carbon Reduction Strategy (2009)
<http://www.sdu.nhs.uk/publications-resources/3/NHS-Carbon-Reduction-Strategy/>

Recommended future local priorities

1. City-wide implementation of the Brighton and Hove Sustainability Action Plan.
2. Local resilience planning should reflect the increased risk of episodes of extreme cold and hot weather and consider how the risks for the most vulnerable can be reduced.
3. Local NHS organisations to consider the new NHS Sustainability Strategy when it is published in January 2014
4. The Health and Wellbeing Board should consider how its priorities can contribute

⁶ Water Framework Directive <http://www.environment-agency.gov.uk/research/library/data/97343.aspx> [Accessed 25/08/2013].

6.4.8 Climate change

towards carbon reduction, climate change adaptation and promotion of sustainability.

5. Brighton & Hove should continue to build on good practice around healthy urban planning principles, for example encouraging low carbon new builds and more trees and greenery generally to reduce the urban heat island effect.

Key links to other sections

- Air quality
- Transport and active travel
- Good nutrition and food poverty
- Fuel poverty
- Green and open spaces
- Physical activity
- Groups most affected by climate change (e.g. older people; specific long term conditions)

Further information

State of the Local Environment: Chapter 1 Climate Change <http://www.brighton-hove.gov.uk/index.cfm?request=c1256214>

Last updated

August 2013

Why is this issue important?

Air pollution has short and long-term health effects including worsening the condition of those with cardiovascular¹ and respiratory disease (COPD Chronic Obstructive Pulmonary Disease) potentially inhibiting the growth of lung tissue in infants; aggravating asthma in those already diagnosed with the condition and in the longer term, reducing life expectancy at a population level.² Some people with cardiovascular and respiratory diseases (especially older people) can be adversely affected by day-to-day changes in air pollutants, including an increased risk of hospital admission and mortality.³

Long-term exposure to air pollution has a lasting effect on health, though the effects vary depending on where people live and the type of pollutant mixture that people are exposed to. Across the UK as a whole it is estimated that for those born in 2008 the average loss of life expectancy from man-made air pollution is approximately six months.⁴ The impact of long-term exposure on vulnerable groups is likely to be more significant. Exposure to local airborne pollutants is more prevalent at recognised roadside locations that are recommended for designation in a new Air Quality Management Area (AQMA),

Key outcomes

- ***Air pollution (Public Health Outcomes Framework).***

Impact in Brighton & Hove

Airborne fine particles (PM_{2.5}) are monitored in Preston Park as part of the UK monitoring network. The site is classed as urban background and is therefore not a roadside monitoring location.

Observed annual concentrations of PM_{2.5} have not exceeded target levels defined by Defra (however there were some daily spikes in measured concentrations). Policy to monitor and reduce regional PM_{2.5} is made at a national and international level. Compared with background concentrations mapped by Defra, higher

concentrations of fine particulate are expected within the AQMA in close proximity to diesel emissions.

The Public Health Outcomes Framework assesses all-cause adult mortality attributable to long-term exposure to recent levels of anthropogenic particulate air pollution.⁵ This relates the fraction (%) of all-cause adult mortality attributable to long-term exposure to levels of anthropogenic particulate air pollution. The indicator is an estimated proportion that takes account of Defra background monitors, but not local roadside concentrations. It represents the estimated annual mortality attributable to fine particles in the population aged 30+, as a proportion of total deaths of those aged 30+.

The value of the indicator for Brighton & Hove for 2010 is 5.40%.

PM₁₀ (particulate matter with diameter less than ten microns) is monitored adjacent to the A23 in Brighton. The average value during 2011 and 2012 was close to 27µg/m³ compared with a limit value of 40 µg/m³. In 2013 new PM₁₀ monitoring started on North Street and results are expected in 2014.

Our local monitoring locations are currently under review in accordance with the needs of Local Air Quality Management Duties (LAQM) and those of our transport partners.

Ground level ozone concentrations are monitored against limit values at Stanmer and Preston Parks. Higher concentrations of ozone are most likely to be recorded in rural areas during sunny conditions.

Concentrations of Nitrogen Dioxide (NO₂) continue to exceed national limits in certain streetscapes⁶ in Brighton, Portslade and Rottingdean High Street. NO₂ monitoring records suggest that average concentrations were higher in 2011 and 2012 than 2008 and show little improvement during the past ten years. However, a longer-term improvement is indicated by monitors outside of worse-case streets⁷ e.g. at Hove Town Hall, Preston Park and South Downs.

¹ COMEAP. Cardiovascular Disease and Air Pollution; 2006.

² Health Protection Agency. Health Protection in the 21st Century; 2005.

³ COMEAP. The Mortality Effects of Long-Term Exposure to Particulate Air Pollution in the United Kingdom; 2010.

⁴ DEFRA. Valuing the Overall Impacts of Air Pollution; 2010.

⁵ Public Health Outcomes Framework <http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000043/par/E12000008/ati/102/page/6/>

⁶ Area immediately parallel (10m either side) of an urban transport corridor.

⁷ Refers to levels 40 to 80 µg/m³ NO₂ as a long-term mean. Between one and two times the legal limit under EU and English Law.

Within the city, road transport is the primary cause of breaches of the NO₂ limit value, but commercial and domestic heating such as wood and coal burning could be increasingly important contributors. Roadside breaches of the NO₂ limit value occur predominantly within nine metres of certain road carriageways. At many locations the residential façade is one to seven metres from the road kerb. Stop-start traffic, heavy vehicles, acceleration of diesel vehicles and the proximity of building enclosure adjacent to traffic are factors which can result in the air quality limit value being exceeded.

Recent work carried out by Brighton & Hove using 2013 address gazetteer data in combination with dispersion model results estimates the number of people affected by traffic related air pollution. A tally of: 21.6 km of road length exceed the NO₂ standard at the parallel building line. It is estimated that between 2,000 and 2,500 residential dwellings are exposed to concentrations above the standard of 40 µg/m³ over durations of a year or more.

It is estimated that private cars contribute no more than half of roadside NO₂ pollution in the most affected transport corridors, with trucks, vans, taxis and buses contributing up to three quarters. There is considerable variability between different roads, and on some streets the contribution from one vehicle type can be negligible to small, e.g. there are no bus routes along Viaduct Road and few private cars on sections of North Street and Western Road.

The council has approved in principal a smaller Air Quality Management Area (AQMA) in which it is considered that English and EU limits for NO₂ are not likely to be met. The new AQMA includes a small section close to the junction between Preston Road and The Drove and a separate area along Rottingdean High Street. Three quarters of the 2008 AQMA is to be revoked. A new air quality action plan will target the remaining AQMA (243 hectares).

Where we are doing well

After an increasing trend in traffic for many years, decreases in traffic numbers have been recorded

on some road links since 2007/08.⁸ It is thought this is influenced by active measures to reduce traffic and a slowdown in the economy. A notable shift towards cycling and walking can be attributed to both. However, there is an increasing trend in the number and proportion of diesel vehicles and older petrol cars on the road and this is unlikely to be beneficial for roadside air quality in most affected areas.

The airAlert service provides real time information on pollution episodes across Sussex with messages relating to the potential for predicted pollution levels to impact on population health, targeted at those with asthma and other respiratory conditions.

The Local Sustainable Transport Fund has given Brighton & Hove City Council £4 million to invest in improving the Lewes Road, an area affected by air quality issues. The primary aims are carbon reduction and job creation; it is also hoped that the project will benefit local air quality at the roadside.

Local inequalities

National research⁹ has shown that higher relative concentrations can be observed in the most deprived populations in England. For NO₂ and PM₁₀, this distribution can largely be explained by road transport sources in urban areas, and the proportion of deprived communities in some urban areas.

An equalities impact assessment was submitted with the 2011 Brighton & Hove Air Quality Action Plan. The AQMA includes a mix of land use at roadside including a high proportion of flats above commercial premises, town house conversions, houses in multiple occupation, accommodation for students and private sector housing. We do not know for sure how some groups are affected more than others. Some parts of the city centre are desirable well connected areas to live in with high rental/purchase prices, so areas of poorer air quality locally are not always concurrent with deprived neighbourhoods.

⁸ Brighton & Hove City Council. Air Quality Action Plan. 2011. Available at: <http://www.brighton-hove.gov.uk/index.cfm?request=b1000293> [Accessed 12/08/2013]

⁹ DEFRA. Air Quality and Social Deprivation in the UK: an environmental inequalities analysis; 2006.

Predicted future need

Recent monitoring suggests little or no improvement in NO₂ levels at most affected locations over longer durations.

What we don't know

We do not have a local estimate of the attributable impact on health from air pollution in the city that takes account of roadside concentrations and the mixture of multiple pollutants.

The air quality action plan is to explore alternative vehicle technologies in order to reduce emissions where reduction is needed most. Uncertainties exist regarding future emission performance in the AQMA where stop-start drive circuits with hill climbs are the norm.

Key evidence and policy

The key objective in the city's Local Air Quality Action Plan is to reduce the number people living in the area above NO₂ limit values. The improvement needed is challenging and the measures multifaceted. They are not listed in their entirety but include:

- actions to encourage switches to alternative fuels (including bio-gas and electric) and vehicles with lower emissions in urban settings
- improvements in traffic flows and road surfaces
- educational initiatives to encourage behaviour change, supported by measures such as car clubs and providing information on traffic flow

Other national evidence includes:

- Committee on the Medical Effect of Air Pollutants <http://www.comeap.org.uk/>
- COMEAP (2010) The Mortality Effects of Long-Term Exposure to Particulate Air Pollution in the United Kingdom and COMEAP (1998) The quantification of the effects of air pollution on health in the United Kingdom <http://comeap.org.uk/documents/reports.html>
- DEFRA (2008) UK Air Quality Strategy for <http://www.defra.gov.uk/environment/quality/air/air-quality/approach/>

Recommended future local priorities

1. Determine the contribution to poor air quality from different vehicle categories at various locations
2. Establish a new air quality action plan
3. Influence bus, taxi, waste, council and emergency vehicle fleet procurement and look to reducing dependence on diesel
4. Discussion and shared information with the bus companies regarding emission improvement of oxides of nitrogen and particulate
5. Ongoing discussions with taxi licensing policy regarding oxides of nitrogen and particulate emission improvement and checks in place to insure good upkeep of abatement kit; exhaust particulate filters and catalysts
6. Development Control linked with National Planning Policy Framework (NPPF) and Sussex Guidance; architecture, design and ventilation strategy encouraged to mitigate residential exposure to ambient pollution

Key links to other sections

- Transport and active travel
- Coronary heart disease
- Respiratory disease
- Maternal and infant health

Further information

Brighton & Hove City Council Air Quality Action Plan <http://www.brighton-hove.gov.uk/index.cfm?request=b1000293>

Sussex Low Emission Strategy http://www.lowemissionstrategies.org/sussex_region.html

Sussex-Air <http://www.sussex-air.net/>

Last updated

July 2013

6.4.10 Noise pollution

Why is this issue important?

Noise is defined as “unwanted sound”. Sources of noise can be occupational (in the workplace), neighbourhood (including noise related to antisocial behaviour), and environmental (including road traffic).

The health effects of noise can include annoyance; sleep disruption; a small increase in risk factors associated with cardiovascular disease and; negative impact on children’s learning and cognitive performance.¹

Exposure to constant or very loud noise can cause temporary or permanent damage to hearing.

Key outcomes

- **The percentage of the population affected by noise (Public Health Outcomes Framework).**

The National Noise Policy Statement² states the long-term vision to promote good health and quality of life through the management of noise.

Impact in Brighton & Hove

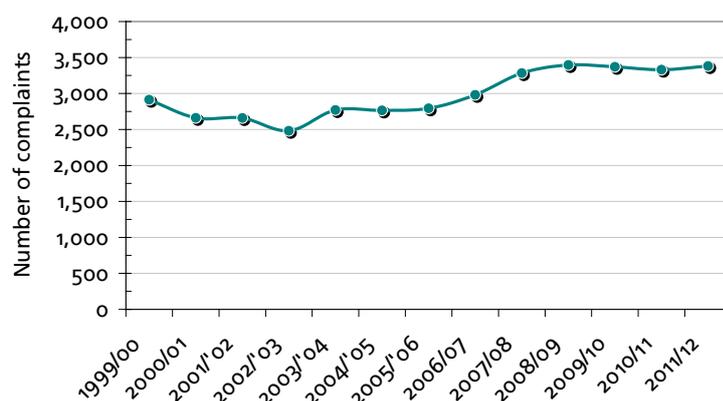
Data for 2011/12 provided by 226 out of 326 local authorities in England show that Brighton & Hove has significantly higher complaints about noise (12.1 complaints per 1,000 population) than England (7.5 complaints per 1,000 population).³

However, Brighton & Hove is a large cosmopolitan city and receives a cross section of complaints in relation to noise from domestic dwellings, construction sites, events held around the city, and noise from licensed premises. This character and make up of complaints received is more comparable with London Boroughs than fellow local authorities outside London in the South East. The average noise complaints for London local authorities is 19.7 complaints per 1,000 population, higher than for Brighton & Hove.³

The City Council receives over 3,300 noise complaints a year, relating to noise from both domestic and commercial sources including construction sites, air handling units, plant and machinery, pubs and clubs, neighbours and parties.

The number of complaints has increased since 2000/01, but has been stable since 2007/08. Over time the character of complaints has changed e.g. more noise complaints are received about home entertainment systems and stag/hen parties.

Figure 1: Number of noise complaints per year 1999/00 to 2010/13



Source: Brighton & Hove City Council

Where we are doing well

The City Council continues to work closely with local schools in raising awareness of various noise-related issues. National Noise Action Week (held in May of each year) provides an opportunity to raise awareness in children and young people of the risk from exposure to loud music from MP3 players.

Local inequalities

There are limited local data on the impact of noise on different population groups. Groups who may be particularly vulnerable to the effects of noise include children, older people and people with hearing impairments.⁴ The Defra mapping predicts that households most affected by traffic noise are those closest to major roads: London Road, Lewes Road and the seafront.

National research has reported that noise problems are worse in areas of high density housing, rented accommodation (both social and private sectors), areas of deprivation and areas which are highly urbanised.⁵

¹ Health Protection Agency. Environmental Noise and Health in the UK; 2010.

² <http://www.Defra.gov.uk/environment/quality/noise/npse/> [Accessed 25/08/2012].

³ Public Health England. Public Health Outcomes Framework Data Tool. July 2013. Available at: <http://www.phoutcomes.info/> [Accessed 06/08/2013]

⁴ World Health Organisation. Guidelines for Community Noise; 1999.

⁵ Cited in Royal Commission on Environmental Pollution; 2007.

6.4.10 Noise pollution

What we don't know

The impact of noise pollution on local people's health and wellbeing is not known. There is limited knowledge of the impact of noise across different population groups.

Key evidence and policy

Health Protection Agency (2010) Environmental Noise and Health in the UK

<http://www.hpa.org.uk/ProductsServices/ChemicalsPoisons/Environment/Noise/>

Defra webpages, including national policy and legislation.

<http://www.defra.gov.uk/environment/quality/noise/>

National Environment White Paper (2011)

<http://www.defra.gov.uk/environment/natural/whitepaper/>

Various legislation and guidance exists to manage noise in the environment, homes and workplaces:

- The statutory nuisance provision under the Environmental Protection Act 1990 is a primary tool for preventing and abating noise nuisance. Where a noise nuisance exists, or is likely to exist, there is a statutory duty to serve a noise abatement notice on the person responsible, owner and/or occupier.
- The Noise Act 1996 introduced the concept of the night time noise offence, and a fixed penalty provision that enables fixed penalties to be issued to domestic and licensed premises.
- The Control of Pollution Act 1974 provides specific provisions to manage noise from construction sites and has been a valuable tool when preventing noise from major construction sites around the city.
- The Licensing Act 2003 defines one of the licensing objectives as 'prevention of public nuisance'. Noise from city centre licensed premises is a factor in our special licensing policy covering the cumulative impact zone. Assessment and review of noise complaints in relation to licensed premises is carried out whenever licensing policy is reviewed.

The planning regime provides an opportunity to prevent and manage noise where new developments are proposed. Local and national planning policy helps influence the statutory decision-making process on whether a

development goes ahead, its character and design, and/or any planning conditions that can be imposed to minimise noise, and thereby minimise the impact. The National Planning Policy Framework (March 2012) removed guidance specific to managing noise. This has been a key tool for protecting new residential developments proposed near significant noise sources.

Since May 2013 The Town and Country Planning (general Permitted Development) Order 2013 allows the office accommodation to be converted to residential without needing planning permission. This deregulation could result in a sector of our housing stock having a poor standard of sound insulation and residential accommodation being introduced into areas where the surrounding noise climate is unacceptably high.

Recommended future local priorities

1. Following recent changes in planning legislation and planning policy we have been formulating guidance and pre validation advice for developers and customers submitting planning applications. We have been working with other Sussex authorities to make this guidance and advice Sussex wide. Training is being implemented for both planning and environmental health staff to ensure future changes are implemented consistently.
2. In relation to addressing the issue of noise complaints from accommodation rented by students we are proposing to review how we engage with the student population, letting agents, and landlords to ensure all parties have advice and guidance on how to prevent noise nuisance and how not to disturb neighbours.

Key links to other sections

- Transport and active travel; Coronary heart disease; Children; Physical and sensory impairment

Further information

Brighton & Hove City Council <http://www.brighton-hove.gov.uk/index.cfm?request=b1124404>

Last updated

August 2013

Why is this issue important?

To measure wellbeing it is important to not only rely on indicators of economic and social progress, but also to collect information from people themselves about how they assess their wellbeing.

The Annual Report of the Director of Public Health 2012/13 "Happiness: the eternal pursuit"¹ focuses on the associations between health and happiness in Brighton & Hove. It sets out the evidence for the links between happiness and health:

- There is increasing evidence showing the links between positive emotions, happiness and our state of health. A recent review by the Harvard School of Public Health summarised the issue, "A vast scientific literature has detailed how negative emotions harm the body. Serious, sustained stress or fear can alter biological systems in a way that, over time, adds up to wear and tear and, eventually, illnesses such as heart disease, stroke, and diabetes."
- It's not just that there are damaging effects from low mood or adverse life events. A positive outlook in itself may be helpful and lead to improved health. A study of nearly 8,000 men and women followed for five years showed that emotional vitality (a sense of enthusiasm, hopefulness, engagement in life, and emotional balance) and optimism were associated with a reduced risk of developing heart disease.

From April 2011 the Office for National Statistics (ONS) introduced four subjective wellbeing questions in their household surveys:

- Overall, how satisfied are you with your life nowadays?
- Overall, to what extent do you feel the things you do in your life are worthwhile?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?

All were asked on a 0 to 10 scale, where 0 is 'not at all' and 10 is 'completely'.

Key outcomes

- **Self reported wellbeing (Public Health Outcomes Framework)**

Impact in Brighton & Hove

Experimental data on these measures of subjective wellbeing at local authority level were published by the Office for National Statistics in June 2012.

In Brighton & Hove:

- 82% of people had medium or high life satisfaction compared with 76% in the UK.
- 84% of people had medium or high 'worthwhileness' compared with 80% in the UK.
- 73% of people had medium or high happiness yesterday compared with 71% UK.
- 40% of people had high or very high anxiety yesterday compared with 40% in the UK.

Satisfaction with life and how happy you were yesterday were higher in Brighton & Hove than England. However how worthwhile people feel the things they do are was lower in the city than England, levels of very low or low anxiety were the same (Table 1).

The 2012 Health Counts survey² asked these same questions to allow production of sub Brighton & Hove level results, and results for particular population groups. Results from the Health Counts survey showed lower levels of satisfaction with life and feeling the things you do are worthwhile but results for how happy and how anxious people felt yesterday were similar to the Brighton & Hove results from the Office for National Statistics survey.

Satisfaction and worthwhile are significantly higher in the ONS Annual Population Survey (APS) for Brighton & Hove than the Health Counts Survey. However it is worth noting that the APS is a mixed mode survey and uses both face-to-face and telephone interviews. Different collection methods can affect responses, for example, ONS found that higher average ratings for the 'life satisfaction', 'worthwhile', 'happy yesterday' questions and a slightly lower average for the 'anxious yesterday' question were provided by respondents interviewed via the telephone compared with those

¹ NHS Brighton and Hove and Brighton & Hove City Council Annual Report of the Director of Public Health 2012/13. Happiness: the eternal pursuit. Available at: <http://www.bhlis.org/needsassessments/publichealthreports> [Accessed 17/08/2013]

² NHS Brighton and Hove and Brighton & Hove City Council. Health Counts Survey. 2012. Available at www.bhlis.org/surveys

6.5.1 Happiness and wellbeing

who are asked subjective well-being questions face-to-face.

Table 1: Happiness and wellbeing measures, Health Counts and Office for National Statistics Annual Population Survey 2012

	Health Counts Brighton & Hove	ONS Brighton & Hove	ONS England
Medium to high satisfaction with life	71%	81%	76%
Medium to high feeling things you do are worthwhile	74%	80%	84%
Medium to high how happy you felt yesterday	72%	73%	71%
Very low or low anxiety yesterday	61%	60%	60%

Source: ONS (<http://www.ons.gov.uk/ons/guide-method/user-guidance/well-being/publications/index.html>) and Health Counts 2012.

Local inequalities

The 2012 Health Counts survey² showed that:

- Females are significantly more likely to have to have medium to high satisfaction with life and to feel the things they do are worthwhile. Males however are significantly more likely to have had very low or low levels of anxiety on the previous day. There was little difference in how happy people felt on the previous day by gender.
- There is no clear pattern seen between happiness and age. Respondents aged 65-74 years were most happy: 78% for men and 77% for women. Though respondents aged over 75 years were least likely to feel that things in their life were worthwhile (65%).
- There is a significant association between all four happiness and wellbeing questions and deprivation.
- Heterosexual respondents were more likely to be more satisfied with their life, feel the things they do are worthwhile, have higher levels of happiness and be less anxious than LGB and unsure respondents, however none of these differences were significant. There were also no

significant difference results for any LGBU group.

- Those who are single are significantly less likely to have high wellbeing across any of the measures, as were those who are separated or divorced, with the exception of anxious. However, those who are married, in a civil partnership or living as a couple had significantly higher levels of wellbeing across all measures than all respondents.
- There was no significant difference in any of the measures for BME respondents. Although, respondents with Mixed ethnicity showed significantly worse results for satisfaction (54%), happiness yesterday (57%) and for being less anxious (41% in the less anxious category).
- There were no significant differences by religion in the broad groupings. More detailed analysis shows that Buddhists were most likely to be satisfied with their lives (88%), feel that life was worthwhile (94%) and were most happy (82%). By contrast, Muslim residents reported lower levels of satisfaction with life (55%), were significantly less likely to feel that the things they did in life were worthwhile (57%), were less happy with their lives (54%), and were also significantly less likely to have low levels of anxiety (40%).
- There was no significant difference in levels of happiness and wellbeing for carers.
- Respondents who own their own homes did significantly better across all measures, and those who are employed significantly higher for satisfaction with life and feeling the things they do are worthwhile. However, those who rent from a housing association or local authority or council fare significantly worse across all four measures.

In the 2012 Safe and Well at School Survey³:

- 94% of secondary school pupils reported they are happy often (62%) or sometimes (32%), 48% reported they are anxious often (11%) or sometimes (37%).

³ Brighton & Hove City Council. Safe and Well at School Survey 2012. Available at <http://www.bhlis.org/surveys> [Accessed 17/08/2013]

6.5.1 Happiness and wellbeing

- The percentage of pupils who are often or sometimes happy falls from 96% in 11-12 year olds to 93% in 15-16 year olds.
- The percentage who are often or sometime anxious increases from 41% in 11-12 year olds to 58% in 15-16 year olds (7% to 17% for often anxious).
- As well as being age related, the following groups of students were significantly less likely to be happy: those who need extra help, LGB and unsure pupils, students who had truanted, been bullied, and those who have tried alcohol, taken drugs, or are current smokers, and students who have had sex.
- There was little difference between males and females and by ethnic group, with exception of Chinese pupils (79%) who were significantly less likely to be happy (94% for both White British and all BME pupils). Although, it should be noted that the number of Chinese pupils is small.

The 2009 local carers' survey found that most carers do not feel in control of their lives, with those looking after their son or daughter or caring for over 50 hours a week being almost twice as likely to report that their caring role has a significant impact on lifestyle and stress levels.⁴

Predicted future need

As this is a relatively new area of study there is little evidence of the likely future need. The strong association with unemployment could mean that happiness/wellbeing might fall given increasing unemployment rates.

What we don't know

Although there is data on the happiness of looked after children, these are not currently collated in a way that can be assessed.

There are no data available on life satisfaction of disabled children and young people in Brighton and Hove.

Key evidence and policy

Annual Report of the Director of Public Health 2012/13. Happiness: the eternal pursuit.

<http://www.bhlis.org/needsassessments/publichealthreports>

Recommended future local priorities

Analysis of the subjective wellbeing questions which have been included in the local 2012 Health Counts Survey is now available and the Annual Report of the Director of Public Health 2012/13 sets out recommendations.

Key links to other sections

- Social connectedness
- Community resilience
- Community assets

Further information

ONS measuring wellbeing guide

<http://www.ons.gov.uk/ons/guide-method/user-guidance/well-being/index.html>

Annual Report of the Director of Public Health 2012/13. Happiness: the eternal pursuit.

<http://www.bhlis.org/needsassessments/publichealthreports>

Health Counts 2012. www.bhlis.org/surveys

Last updated

August 2013

⁴ Brighton & Hove City Council. Carers Centre, NHS Brighton and Hove. Brighton & Hove Carers' Survey; 2009.

Why is this issue important?

There is evidence from studies of a 'buffering' effect of having positive social support in the face of shocks such as divorce, ill-health, bereavement, or unemployment. Having strong, positive social connections provides an important source of this support in life and has been associated with better psychological and physical health as well as positive health and other behaviours.¹

Contact between individuals living in close proximity and the creation of local identity help build successful communities. Participation in local decision-making processes is also beneficial and has been shown to increase wellbeing and trust, and areas with high levels of public involvement perform well in these areas. Participation in the community in general allows for the development of a well connected population and can improve children's educational achievements and behaviour and help them develop social networks and foster a sense of belonging.

Key outcomes

- **Social isolation (Public Health Outcomes Framework)**
- **Self reported wellbeing (Public Health Outcomes Framework)**

Impact in Brighton & Hove

The evidence presented in this section is drawn mainly from the Health Counts Survey 2012² and the Brighton & Hove City Tracker Survey³, both of which included a number of items relevant to the concept of social connectedness.

A sense of belonging to one's surroundings is fostered by strong connections with other individuals in the community and in the Health Counts Survey, over half of respondents (58%) felt that they belong very or fairly strongly to their immediate neighbourhood. However, this is somewhat lower than nationally, where according to the 2010/11 Citizenship Survey,⁴ 78% of adults

felt that they belong very or fairly strongly to their immediate neighbourhood.

Another important factor related to social connectedness is the feeling that someone would be able to help during times of difficulty. Three quarters of respondents (76%) in the Health Counts Survey felt they could call for help from a friend or neighbour at home if needed² which can be compared to just over 90% of adults in the British Household Panel Survey⁵ in 2007/08 who reported that there was someone who they could depend upon to help them in a crisis. Although caution is required when comparing these two figures directly, this could be explained partly by the fact that the 2011 Census showed that Brighton & Hove has above the national average of single person households: 36% compared to 30% for England.⁶

The frequency with which an individual sees their neighbours is also a good indicator of social connectedness and over two-thirds of residents in Brighton & Hove see or speak to their neighbours at least once or twice a week, with 15% of these people seeing or speaking to neighbours on a daily basis.²

Analysis of the Health Counts survey data showed that there were consistently strong associations between each of these three factors (people feeling they belong to their immediate neighbourhood, how often they see or speak to their neighbours and confidence that they can ask for help if they need it) and whether people feel satisfied with their lives and have a belief that things they do in their lives are worthwhile.²

Where we are doing well

Many people choose to come and study, live and work in Brighton & Hove, and satisfaction rates with living here are high. Unsurprisingly, the area scores highly on a number of key aspects of social connectedness in numerous different surveys conducted across the city. For example, in the City Tracker survey almost 20% of respondents indicated they have had involvement as a member of a group that makes decisions in their local community, usually as a member of a regeneration

¹<https://www.understandingsociety.ac.uk/research>

² NHS Brighton & Hove and Brighton & Hove City Council. Health Counts. 2012. Available at www.bhjis.org/surveys [Accessed 13/08/2013]

³ Brighton & Hove Strategic Partnership. City Tracker. 2013. Available at www.bhjis.org/surveys [Accessed 13/08/2013]

⁴<http://webarchive.nationalarchives.gov.uk/20120919132719/http://www.co>

munities.gov.uk/publications/corporate/statistics/citizenshipsurveyq420101

⁵ British Household Panel Survey 2007/2008

⁶ Office for National Statistics. Census. 2011.

or tenants group. In the same survey, approximately 40% of residents indicated that they volunteer and give their time on an unpaid basis to a local group, club or organisation which is an important means of connecting with the community. Furthermore, 90% of people agreed that people from different backgrounds get on well together in the local area, which is higher than a national figure of 87% from quarter three of the 2012/13 Community Life Survey.⁷

Health Counts data shows that older people in the City have a particularly strong sense of belonging with 78% of those aged 75 years or over feeling very or fairly strongly that they belong to their neighbourhood compared to 46% in 18-24 year olds. Those aged 75 years or over are also more likely to speak to their neighbours regularly although less likely to feel able to ask someone for help at home if needed.²

Poor social connectedness can often be a problem for minority groups in a community who may find it harder to integrate into the local community and face real or perceived discrimination and racism. However, Black and Minority Ethnic residents in Brighton & Hove are no less likely to feel fairly or very strongly that they belong to their neighbourhood compared to White British residents.²

Good friendships and participation in group activities foster belonging in children and young people. According to the Brighton & Hove Safe and Well at School Survey 2012, 97% of students agreed or strongly agreed that they have one or more good friends at school while over two-thirds stated that they take part in group activities outside school (69%). Furthermore, only 6% of students stated that they often felt lonely or isolated and 16% sometimes.⁸

Local inequalities

There was evidence in the Health Counts Survey that people living in the most deprived wards in Brighton and Hove have poorer social connectedness than the rest of the city. For example, people who are in the most deprived quintile are significantly less likely than the

population as a whole to feel that they belong to their immediate neighbourhood (50% compared to 58%). They are also less likely to feel able to ask someone for help when ill and needing help at home (69% compared to 76%). Conversely, people in the most affluent quintile are significantly more likely than the population as a whole to feel that they belong to their immediate neighbourhood (70% compared to 58%) and also to feel they are able to ask for help when ill at home (83% compared to 76%).²

Although the 2002 Health Counts Survey showed an overall trend between deprivation and being less likely to have regular contact with neighbours, this was not the case in the most recent survey. However, residents living in Withdean, one of the least deprived wards reported significantly higher confidence that they could ask for help if they were ill and needed help at home while those in Brunswick and Adelaide, East Brighton and Queens Park were significantly less confident.²

Lesbian, gay, bisexual and unsure residents were less likely than heterosexual residents to feel they belong to their immediate neighbourhood (48% compared to 59%). This is also the case for females aged 18-24 who are considerably less likely than men of the same age to feel fairly or very strongly that they belong to their immediate neighbourhood (36% compared to 57%).²

Many carers are known to feel lonely and detached from society and the Brighton & Hove Adult Social Care - Caring for Others Survey (2012) identified increased social contact as one of three key themes that carers wanted improvement on locally.

Children and young people of Asian/Asian British (56%) and Chinese (54%) ethnic groups are less likely to participate in out-of-school group activities than the population as a whole (69%). Similarly, students identifying as lesbian, gay and bisexual were also less likely (59%).⁸

Predicted future need

The current economic situation is testing the resilience of individuals and communities as the number of people whose jobs are being threatened or lost has increased. The UK as a whole is also experiencing its' highest level of youth unemployment and changes to benefits have

⁷<http://communitylife.cabinetoffice.gov.uk/explore-the-data.html>

⁸ Brighton & Hove City Council. Safe and Well at School Survey. 2012. Available at: www.bhlis.org/surveys [Accessed 13/08/2013]

6.5.2 Social connectedness

started to hit the vulnerable hard. These factors are likely to impact on individual and community resilience and community cohesion.

What we don't know

The evidence base for social connectedness is in its infancy as is evidence on how to measure it. A wide range of factors needs to be considered. Some factors may be unknown, unmeasured or difficult to measure and there is debate as to what constitutes suitable outcome/s. Current tools all have issues around definition, measurement and mapping. Assets and vulnerabilities of groups other than age, lesbian, gay, bisexual and trans and carers have not been mapped.

Key evidence and policy

The 2012 Health Counts Survey provides the most comprehensive and up-to-date source of information on social connectedness in the Brighton & Hove population and is discussed in the Annual Report of the Director of Public Health 2012/13. The Annual Report of the Director of Public Health 2010 also brought together the key evidence and policy around community resilience.

Recommended future local priorities

Initiatives which help communities to embrace diversity by establishing links within and between communities create a sense of belonging. There is a need for more investment in this area, including:

1. Developing ways of engaging local populations, in particular young people, to foster a sense of belonging to the community, including volunteering via local universities and third sector organisations.
2. Using the regeneration of London Road and the redevelopment of the open market to develop a sense of belonging and increase satisfaction in St Peter's and North Laine.
3. Greater efforts in East Brighton to involve residents in decision-making.
4. Tackling barriers to participation by children and young people such as lack of local activities and the expense of taking part.
5. Helping carers to have time to themselves, time to socialise and practical support from others.

6. Enabling LGBT communities to address equality and public health issues.

Key links to other sections

- Community resilience
- Community assets
- Volunteering and the voluntary and community sector
- Happiness and wellbeing
- Transport and active travel
- Green and open space

Further information

Health Counts Survey 2012.

<http://www.bhlis.org/surveys>

City Tracker Survey 2013

<http://www.bhlis.org/surveys>

Brighton & Hove. Annual Report of the Director of Public Health 2010: Resilience and 2012/13 Happiness: The Eternal Pursuit.

<http://www.bhlis.org/needsassessments/publichealthreports>

Last updated

July 2013

6.5.3 Community resilience

Why is this issue important?

Resilience is the defining characteristic of communities that do better than expected in the face of adversity. Recent years have seen a growing body of academic research, plus support for building the resilience of individuals, families and communities from across the public health, social, economic and political arenas. Greater resilience has the potential to benefit physical and mental wellbeing, as well as economic development. At a time of growing financial pressure, increasing resilience is very attractive to the public and voluntary sectors, business and governments.

Community resilience is influenced by social relationships, networks and social capital, which affect a community's ability to cope during difficult times. Strengthening this resilience involves recognising strengths or assets within that community, building on these, and using them to help address the vulnerabilities that hamper a community's capacity and capability to do well in difficult times. This differs from traditional approaches to assessing and assisting communities which focus on deficits.

Key outcomes

- **Social connectedness (Public Health Outcomes Framework)**
- **Self-reported wellbeing (Public Health Outcomes Framework)**

Impact in Brighton & Hove

The evidence presented here is drawn from the 2010 Annual Report of the Director of Public Health¹ which used the Young Foundation's Wellbeing and Resilience Measure (WARM)² to map community resilience in Brighton & Hove. WARM uses available data to look at communities in a new way and assumes that boosting local assets while tackling vulnerabilities is the key to building resilience. As such this section of the report has not been updated in 2013.

¹ NHS Brighton and Hove & Brighton & Hove City Council. Annual Report of the Director of Public Health; 2010.

<http://www.bhlis.org/needsassessments/publichealthreports> [Accessed 25/08/2012].

² Mguni N, Bacon N. Taking the Temperature of Local Communities. The Wellbeing and Resilience Measure. The Young Foundation. 2010. http://www.youngfoundation.org/files/images/WARM_website_copy.pdf [Accessed 25/08/2012].

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WARM identifies and rates (red/amber/green) a community's strengths (social capital, confidence, quality of local services or proximity to employment) as well as its vulnerabilities (isolation, crime and unemployment) to enable more informed decisions about where to direct limited resources.

Where we are doing well

Life satisfaction: In Brighton & Hove, 96% of people were very or quite satisfied with their local area³ compared with 86% in England.⁴ In 2008, the highest satisfaction was seen in Hove Park, Wish, Rottingdean Coastal and South Portslade. Brighton & Hove is perceived as a lesbian, gay, bisexual and transgender-friendly city.

Education: As levels of education increase, so does wellbeing. Brighton & Hove has a low proportion of adults without any qualifications and a high proportion with high qualification levels.

Health: Health, both physical and emotional, greatly enhances resilience. Self-reported health in the city is good, and arguably better than expected given the measures of objective health and wellbeing. In 2008, 80% of people reported they were in good or very good health compared with 76% in England. LGBT people report good health.

Material wellbeing: The city has a relatively low exposure to debt and generally residents are unemployed for short periods (less than a year).

Economy: Employment, strong local networks and low commuting times all contribute to resilience. The city scores well, benefiting from its small size, accessibility, low travel times, relatively good public transport links and high vacancies. The LGBT population has above average economic activity.

Public services: The quality of public service responses to people facing problems is a key factor. The city scores well on accessibility by foot or public transport to GP practices, primary schools and further education. Services in the city facilitate carer engagement and involvement.

Infrastructure: Infrastructural resilience comprises features such as transport, schools and hospitals as

³ Brighton & Hove Strategic Partnership City Tracker, First Wave. April-May 2012.

⁴ Citizenship Survey 2010/11.

6.5.3 Community resilience

well as community facilities. Residents express high levels of satisfaction with parks and green spaces.

Local inequalities

Education: The city has poor results at GCSE level - it ranked 128 of 150 local authorities in 2010/11. It has the second greatest gap in England between high working age qualifications and low GCSE results. There are indications of significant bullying relating to sexual/gender identity. Young carers have educational difficulties and school absence due to their caring responsibilities.

Health: The city has high rates of tobacco, alcohol and substance misuse and higher rates of sexual health and mental health problems. Queen's Park, Goldsmid, Moulsecoomb and Bevendean, East Brighton and Hangleton and Knoll all have red (WARM) ratings for self-reported health. LGBT people are at higher risk of drug misuse, mental ill health and suicide. One in four carers reports that caring has a significant impact on their health.

Material wellbeing: The city has a high level of claimants for income support and incapacity benefit. When exposed to debt, it is at higher levels than nationally. Moulsecoomb and Bevendean, Queen's Park, East Brighton, Westbourne and Hangleton and Knoll all have red ratings. In Westbourne, some older people experience relatively high deprivation. There are significant pockets of children in poverty, particularly in East Brighton and among those with lone parents.

Social relationships: Wards with red ratings in the east of the city have vulnerabilities in terms of lone parents, divorced residents and households with dependent children with no adults in employment. Large proportions of elderly people live alone and are potentially socially isolated. Hollingdean and Stanmer, East Brighton, Westbourne and Moulsecoomb and Bevendean show most vulnerability. LGBT people and particularly bisexual and transgender people are at a high risk of domestic violence.

Belonging: This is the only component where the city as a whole scores a red rating. Younger adults in particular feel less involved in the community. Residents of Portslade, Withdean and Rottingdean feel the greatest sense of belonging, and those in St Peter's and North Laine the least. Many carers and certain LGBT groups feel lonely and isolated.

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Infrastructure: Housing conditions affect all ages and many who are vulnerable. The central, coastal area - Central Hove, Brunswick and Adelaide and Regency - has high barriers to housing and services. Residents of outer areas have more assets. LGBT residents are least likely to be satisfied with council services.

Predicted future need

The recent global economic situation and subsequent fiscal policy are testing the resilience of individuals and communities. The number of people whose jobs are being threatened or lost has increased, the UK is currently seeing its highest level of youth unemployment and there are changes to the benefits system which are likely to hit the vulnerable hard. These factors are likely to impact on individual and community resilience.

What we don't know

The evidence base for community resilience is in its infancy. The concept is used more for individuals than populations, or to explore how communities respond to events/disasters. Measuring community resilience is complex, and there are issues with definition and measurement. A wide range of factors needs to be considered, some of which may be unknown, unmeasured or difficult to measure.

There is little information on the assets and vulnerabilities of groups other than LGBT and carers.

Key evidence and policy

The Annual Report of the Director of Public Health 2010 brings together the key evidence and policy.

Recommended future local priorities

The recommendations from the Resilience report include:

1. When deciding funding priorities, the statutory sector should take into account the lasting impact of community initiatives versus short term 'service reconfiguration'.
2. To help raise the academic achievements and aspirations of children, local universities should play a greater role with local secondary schools.

6.5.3 Community resilience

3. Programmes to build health resilience should adopt an integrated approach rather than address groups individually.
4. Families should be supported to create and engage with social networks and contribute to economic activity.
5. There is a need to consider how students living in the city might become more engaged with the communities in which they live.
6. Attracting other large private employers to the city would help balance the dominance of the service and small business sector.

Key links to other sections

- Social connectedness
- Happiness and wellbeing
- Community assets

Further information

Brighton & Hove Annual Report of the Director of Public Health 2010: Resilience.

<http://www.bhlis.org/needsassessments/publichealthreports>

Last updated

Reviewed July 2013

6.5.4 Community assets

What are community assets?

*'Assets are, in this context, any factor that enhances the ability of individuals, groups, communities, populations, social systems and institutions to maintain health and wellbeing and reduce health inequalities.'*¹

Examples of assets include:

- Skills and knowledge of local residents
- Passions and interests that motivate change
- Networks and connections in a community
- Resources of public, private and third sector organisations that are available to support community development
- Physical and economic resources of a place that enhance wellbeing

It is important to note that assets are defined from the perspective of the local community.

Organisational-driven lists can provide a starting point, but an asset-approach demands real community engagement.

Stakeholders working at all levels need to buy into the concept for it to be effective. It represents a significant shift from the traditional deficit-based approach and requires an acceptance of moving decision-making power to the local community.

Why is this issue important?

*'Communities have never been built upon their deficiencies. Building communities has always depended on mobilising the capacity and assets of people and place.'*²

Community assets are offered as a way for local councils to reduce health inequalities and promote sustainable change. In the current financial climate, with reductions in public sector funding, it is more important than ever to ensure efficient use of available resources. Furthermore, recognising and strengthening assets is an opportunity to address the vulnerabilities that hamper a community's ability to do well in face of adversity.

Figure 1 illustrates how assets can contribute to increased community resilience.

Figure 1: How assets can contribute to community resilience



Individual assets – skills, talents, networks, knowledge, interests, time, positive values, self-esteem and a sense of purpose which people are willing to contribute

Community assets – family and friendships, networks, intergenerational links, community cohesion, religious groups, associations, creative arts and opportunities for people to express themselves and come together

Organisational/Institutional assets – land, buildings, transport, local business/organisation spending, people's knowledge-based assets³

By identifying capacity, skills, connections and potential in a community, an asset-approach seeks to mobilise all available resources, build social capital and promote community resilience.

There are several defined techniques to an asset approach:

- **asset mapping** (communities map resources and skills)
- **asset based community development** (build up community and voluntary groups/organisations and share knowledge/power)
- **Appreciative enquiry** (appreciate the current situation, think about what could happen and collectively deliver this)

¹ Improvement & Development Agency. 'A glass half full: how an asset approach can improve community health and wellbeing.' 2010.

² Kretzmann J & McKnight J. Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets; 1993.

³ NHS North West and Department of Health (2011) Development of a method for Asset Based Working

6.5.4 Community assets

- **Participatory appraisal** (Local people are trained to collect and analyse information about their own community)
- **Open space technology** (A meeting of representatives of all stakeholders is held with an “open” forum for the agenda to be decided within the meeting)

These community-led, long term and open-ended techniques specifically aim to discover and mobilise what people have to offer to maintaining and building the health and wellbeing of their communities.

The Localism Act (2011)⁴, sets out a series of proposals intended to shift power away from central government, towards local people, to allow people to:

- be more involved in their local area and identify opportunities for community action
- raise issues that need addressing and develop local solutions
- be actively involved in the decisions that are taken about their area
- be empowered to develop local services and groups

Key outcomes

While there are no outcomes relating directly to assets, there is a national recognition of the importance of identifying and valuing local assets to improve and maintain health and wellbeing, particularly in relation to the harnessing of social capital.^{5,6,7,8,9}

Impact in Brighton & Hove

The 2010 Annual Report of the Director of Public Health¹⁰ used the Young Foundation’s Wellbeing and Resilience Measure (WARM) to map

⁴ The Stationary Office (2011) The Localism Act 2011

⁵ Marmot (2010) Fair Society, Healthy Lives and A Glass Half Full

⁶ NHS Northwest/DoH (2012) Development of a Method of Asset Based Working

⁷ NHS Northwest/DoH (2012) What makes us healthy? The asset approach in practice: evidence, action, evaluation

⁸ DoH (March 2013) Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies March 2013

⁹ National Collaboration for Integrated Care and Support (May 2013) Integrated Care and Support: Our Shared Commitment

¹⁰ NHS Brighton and Hove & Brighton & Hove City Council. Annual Report of the Director of Public Health – Resilience. 2010

<http://www.bhlis.org/needsassessments/publichealthreports> [Accessed on 25/08/2012].

community resilience in Brighton & Hove. This used existing data to look at communities in a new way.

Introducing an asset-approach gives an opportunity for the local community to participate more meaningfully in decision-making by creating a safe space for individuals to identify solutions to their problems and determine funding priorities.

Where we are doing well

The concept of community assets is relatively new and yet there are examples of strategic, citywide, local work towards recognising assets in Brighton & Hove.

Strategic assets work includes:

The **Brighton & Hove Strategic Partnership** brings together different parts of the public, private and third sector and provides a local structure for coordinated action. The Partnership developed a **Community Engagement Framework** setting out the strategic aims and key principles for community engagement, and examples of good practice.

The City Council’s **Community Development strategy** acknowledges the need for an asset based model and the communities and equality team have supported the implementation of programmes that build on an asset based model including work led by the CVSF and communities through neighbourhood governance work.

Citywide assets work includes:

The Brighton & Hove FED Centre for Independent Living launched the **It’s Local Actually Project** which has gathered information about 250 groups and clubs and 950 social activities on offer in the local area. The resource is available online, allows searching by service or by area of the city and is seen as a benchmark for mapping community assets in Brighton and Hove.

The Community and Voluntary Sector Forum (CVSF) is an independent charity that facilitates advocacy and networking between local community organisations. In partnership with the University of Brighton and Brighton & Hove City Council, CVSF produced ‘Taking Account: a social and economic audit of the third sector in Brighton and Hove’. The report provides an overview of the community and voluntary sector and demonstrates

6.5.4 Community assets

the social and economic benefits of these local assets. An update of this is currently underway.

Between November 2011 and January 2012 the Council asked residents' opinion of neighbourhood decision making. 90% of respondents felt they wanted more influence over their area and 68% said they would get involved in this. Since then local initiatives are already mapping assets and employing an asset-approach in their community work. A few examples are given here:

Neighbourhood governance is an initiative in Brighton & Hove to explore the mechanisms through which decision making in particular areas can be devolved to local communities. Two pilot projects in Whitehawk (neighbourhood) and Hollingdean and Stanmer (ward) use an assets approach to increase communication between service providers and users so services can meet needs better and where appropriate handing those services over to the community. Participatory budgeting has meant that funding is available for local residents to allocate to community projects chosen by themselves.

Two **Coldean and Hollingdean asset mapping workshops** formed part of the Neighbourhood Governance Project trialled in Brighton & Hove and were run between October 2012 and March 2013 to chart all the resources and assets identified and valued by the local communities, and to provide opportunities for ideas on how to build on these resources. A customised Google map was created for each area plotting local assets and is intended as a live source of community information that can be accessed and added to by community members.

Predicted future need

An asset-approach provides an opportunity for the local community to become equal partners in co-production and has the potential to bring about real and sustainable change in health outcomes. In the current financial climate, maximising the use of available resources is more important than ever.

What we don't know

National guidance encourages an asset approach but does not define how this should be implemented at a local level. It is likely that 'no one size fits all' and Brighton & Hove needs to decide what tools are best suited to the local community.

To date, asset-based approaches have been small-scale and exploratory in nature. From these pilot projects, there is emerging evidence on different tools, but little is known, either locally or nationally, about how to introduce an asset-approach on a larger scale.

Key evidence and policy

The Brighton & Hove Annual Report of the Director of Public Health 2010

<http://www.bhlis.org/needsassessments/publichealthreports>

'What makes us healthy? The asset approach in practice: evidence, action, evaluation' is a follow up document to 'A glass half full'.

<http://www.scdc.org.uk/media/resources/assets-alliance/What%20makes%20us%20healthy.pdf>

The Well London programme is a Big Lottery-funded initiative that is designed to gather high-quality data on the impact of community action projects on health outcomes

<http://www.welllondon.org.uk>

Recommended future local priorities

1. Closer working with relevant partners to look further at how an asset-approach might inform city needs assessment
2. Further develop asset approaches in the city building on learning from the Neighbourhood Governance pilots.

Key links to other sections

- Social connectedness
- Community resilience
- Happiness and wellbeing

Further information

Community Engagement Framework

<http://www.brighton-hove.gov.uk/index.cfm?request=c1218794>

Last updated

June 2013

7.1.1 Antenatal and newborn screening Brighton & Hove JSNA 2013

Why is this issue important?

Around 700,000 women get pregnant in the UK each year and over 95% of these pregnancies result in the birth of a healthy baby. Antenatal and newborn screening identifies diseases or conditions in the mother that may impact on her pregnancy, in the foetus and in the newborn baby.

Table 1: NHS screening programmes in England

Infectious diseases screening is offered to all women in early pregnancy and tests for Hepatitis B, HIV, syphilis and rubella susceptibility.

Fetal anomaly screening (FASP) is offered to all women and includes a test for Down's syndrome and an ultrasound scan to check for physical abnormalities.

Antenatal and newborn sickle cell and thalassaemia¹ programme offers a linked programme of screening for all pregnant women and screening for sickle cell disease for all newborn babies.

Newborn and Infant Physical Examination Programme (NIPE) offers all babies an all over physical check and examination of eyes², heart³, hips⁴ and testes⁵ (boys) at 72 hours after birth and again at 6-8 weeks old.

Newborn bloodspot screening is offered to all parents and screens for phenylketonuria (PKU),⁶ congenital hypothyroidism (CHT),⁷ sickle cell disease (SCD)⁸, cystic fibrosis (CF)⁹ and medium-chain acyl-CoA dehydrogenase deficiency (MCADD).¹⁰

The **newborn hearing screening programme (NHSP)** is offered to all babies aiming to identify

moderate to profound permanent bilateral deafness within 4-5 weeks of birth.¹¹

Key outcomes

- **HIV coverage – The percentage of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result**
- **Syphilis, hepatitis B and susceptibility to rubella uptake: The percentage of women booked for antenatal care, as reported by maternity services, who have a screening test for syphilis, hepatitis B and susceptibility to rubella leading to a conclusive result**
- **The percentage of pregnant women eligible for antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available at the day of report**
- **The percentage of babies registered within the local authority area both at birth and at the time of report who are eligible for newborn blood spot screening and have a conclusive result recorded on the Child Health Information System within an effective timeframe.**
- **The percentage of babies eligible for newborn hearing screening for whom the screening process is complete within 4 weeks corrected age (hospital programmes – well babies, all programmes – NICU babies) or 5 weeks corrected age (community programmes – well babies)**
- **The percentage of babies eligible for the newborn physical examination who were tested within 72 hours of birth**

(All Public Health Outcomes Framework)

Quarterly submission of PCT and Hospital Trust performance against National Key Performance Indicators (KPIs) began in 2011/12. Quality assurance and performance management are an integral part of all national screening programmes.

¹ Estimated one case of alpha thalassaemia major and 234 pregnant carriers of α thalassaemia each year in England and Wales.

² About two hundred children a year are born in the UK with opacity of the lens of one or both eyes - a cataract.

³ Congenital heart anomalies affect about 8 in 1000 (approx. 1%) newborn babies.

⁴ 1 to 2 in 1,000 babies born may have a hip that is dislocated at birth. A slightly larger group have hips which are not safely in the socket or in whom the socket is shallower than it should be

⁵ Around one in 20 male babies is born with Cryptorchidism (undescended testicles) which is most common in premature babies. The incidence at the age of one year is around 1%.

⁶ About 1 in 10,000 babies born in the UK has phenylketonuria (PKU).

⁷ About 1 in 4,000 babies born in the UK has congenital hypothyroidism (CHT).

⁸ About 1 in 1,900 babies born in the UK has a sickle cell disease (SCD).

⁹ About 1 in 2,500 babies born in the UK has cystic fibrosis (CF).

¹⁰ About 1 in 10,000 babies born in the UK has MCADD.

¹¹ 1-2 babies in every 1,000 are born with a hearing loss in one or both ears.

7.1.1 Antenatal and newborn screening Brighton & Hove JSNA 2013

Impact in Brighton & Hove

The most recent data submission for performance against KPIs is for October - December 2012:

Infectious diseases: Brighton & Sussex University Hospital Trust (BSUH) are still unable to provide cohort data for HIV coverage (ID1), although the trust reports that all women are offered HIV screening antenatally and very few opt out. All (100%) of hepatitis B positive women at BSUH were referred and seen by an appropriate specialist within six weeks (Acceptable $\geq 70\%$; Achievable $\geq 90\%$) (ID2).

Foetal anomaly and Down's syndrome screening: 99% of completed lab forms at BSUH were received within the recommended time frame (Acceptable $\geq 97\%$; Achievable 100%) (FA1).

Antenatal sickle cell and thalassaemia: BSUH are still unable to provide cohort data for the proportion of eligible women who are tested and have a conclusive result (Acceptable $\geq 95\%$; Achievable $\geq 90\%$) (ST1). The proportion tested with a conclusive result by 10 weeks gestation was 45.2% (Acceptable $\geq 50\%$; Achievable $\geq 75\%$) (ST2). The proportion of samples submitted to the laboratory with a Family Origin Questionnaire was 98.5% (Acceptable $\geq 90\%$; Achievable $\geq 95\%$) (ST3).

Newborn bloodspot: The proportion of screen eligible Brighton & Hove CCG babies with a conclusive result recorded on the child health system by 17 days is 96.1% (Acceptable $\geq 95\%$; Achievable $\geq 99.9\%$) (NB1). The avoidable repeat rate at BSUH is 5.6% (Acceptable $\leq 2\%$; Achievable $\leq 0.5\%$) (NB2). The proportion of results (screen negative for all conditions) available for communication to parents within six weeks of birth in Brighton & Hove is 98.6% (Acceptable $\geq 95\%$; Achievable $\geq 98\%$) (NB3).

Newborn hearing screening: The proportion of eligible babies in Brighton & Hove PCT area whose screening process is complete by five weeks corrected age is 95.5% (Acceptable $\geq 95\%$; Achievable $\geq 100\%$) (NH1). The percentage of babies referred and receiving their audiological assessment within four weeks is 83.3%, although all babies are offered an appointment within four weeks (Acceptable $\geq 90\%$; Achievable $\geq 100\%$) (NH2).

NIPE: A national pilot was established in 2011 to better understand how care is delivered and to test the Screening Management and Reporting Tools. BSUH was one of the pilot sites and the results of the formal evaluation should soon be available.

Where we are doing well

Most key performance indicators are being met.

Good collaborative working is in place across screening pathways.

Local inequalities

There is no local analysis of screening up-take by deprivation or equalities groups.

Predicted future need

Additional genetic tests may be introduced into the newborn bloodspot following the outcome of the pilot of five additional conditions, which is currently in progress.

The roll out of NIPE 72 hour screening test will be rolled out shortly

Inclusion of the six week check in NIPE will impact on child record systems and GP practices in the future.

What we don't know

There is no local analysis of screening up-take by deprivation or equalities groups.

Additionally, there is no local analysis to identify who does not take up the offer of screening.

Key evidence and policy

All potential screening programmes are the subject of a policy review and assessed against a number of criteria before the UK National Screening Committee decides whether a national screening programme is appropriate.

There are national standards and guidelines for each NHS screening programme:

Infectious diseases

<http://infectiousdiseases.screening.nhs.uk/standards>

Foetal anomaly screening programme

<http://fetalanomaly.screening.nhs.uk/standardsandpolicies>

Newborn bloodspot

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<http://newbornbloodspot.screening.nhs.uk/quality>

Linked antenatal and newborn screening programme (2011)

<http://sct.screening.nhs.uk/standardsandguidelines>

Newborn Infant Physical Examination

<http://newbornphysical.screening.nhs.uk/cms.php?folder=2366>

Newborn hearing screening

<http://hearing.screening.nhs.uk/standardsandprotocols>

Recommended future local priorities

1. NHS England Surrey and Sussex Area Team (AT) to ensure that robust local data is available from Brighton and Sussex University Hospitals Trust (BSUH). Deficiencies in the maternity IT system locally have been an on-going problem.
2. Brighton and Hove CCG to encourage an improvement in the proportion of women booking by 12 weeks of pregnancy as this impacts on the proportion who have antenatal sickle cell and thalassaemia screening by 10 weeks.
3. Brighton and Hove CCG to ensure BSUH introduce bar-coded NHS numbers for labelling of newborn bloodspot cards so as to improve traceability of samples, reduce the risk of samples being missed, eliminate transcribing errors and NHS numbers being missed. This standard was introduced in 2010 but has yet to be achieved locally. Missing NHS numbers initiate a repeat blood spot request from the laboratory thus impacting on the avoidable repeat rate.
4. NHS England Surrey and Sussex Area Team (AT) to monitor the avoidable repeat rate of newborn bloodspot tests due to inadequate spots, since the introduction of new 'Tenderfoot' lancets in BSUH.
5. NHS England Surrey and Sussex Area Team (AT) to work with Sussex Community Trust to ensure that the percentage of babies receiving their audiological assessment within four weeks of referral meets the national target.

Key links to other sections

- Maternal and infant health

Further information

Commissioning frameworks for all programmes:

<http://www.screening.nhs.uk/quality-assurance#fileid9864>

Last updated

June 2013

Why is this issue important?

Ensuring women are as healthy as possible during their pregnancy is important to guarantee the best possible start in life for their child.

A number of factors including deprivation and maternal health have been shown to be associated with an increase in low birth weight and infant mortality. For example, smoking in pregnancy can increase the risk of infant mortality by about 40%. Heavy alcohol consumption in pregnancy or taking drugs can increase the risk of low birth weight and can cause physiological and neurological damage to the baby.¹ Maternal obesity is another factor that can be associated with increased rates of maternal and perinatal² mortality.³

Breastfeeding is one of the most important contributors to infant health. It provides benefits for an infant's growth, immunity and development.¹

Reducing maternal substance misuse and obesity and improving breastfeeding rates are therefore important to improve maternal and infant health.

Key outcomes

- **Infant mortality (Public Health Outcomes Framework and NHS Outcomes Framework)**
- **Low birth weight of babies (Public Health Outcomes Framework and NHS Outcomes Framework)**
- **Breastfeeding (Public Health Outcomes Framework)**
- **Excess weight in adults (Public Health Outcomes Framework)**
- **Smoking status at time of delivery (Public Health Outcomes Framework)**

Impact in Brighton & Hove

In 2012 in Brighton & Hove there were 16 infant deaths. To be able to compare this with other areas this is converted into a rate per 1,000 live births. For the period 2009-2011 the infant mortality rate in the

city was 4.8 per 1,000 live births. This is the same as our comparator group of local authorities and similar to England at 4.4 per 1,000 live births.⁴

Office of National Statistics (ONS) figures from 2011 show that of the 3,291 live births in the city, 7% were considered low birth weight (the babies weighed less than 2500gms). This is the same as the rate in England and similar to the South East (6%). There has been little change in these rates in recent years.⁵

The city has a higher than average overall number of looked after children. As of March 2013 the rate of looked after children is 89 per 10,000 children, above the England average of 59 per 10,000 and statistical neighbour average of 70.5.

After a slight decrease last year, the level of children looked after under the age of one rose to 9% at 31st March 2013 which is higher than the England average of 6% and statistical neighbour average of 7%.

Anecdotal evidence suggests that one of the main contributory factors was substance misuse in parents.

Where we are doing well

Whilst the infant mortality rate in Brighton & Hove varies more year on year, which would be expected given the small number of infant deaths in the city, the trend is in line with the trend for England.

Breastfeeding rates in the city are higher than national rates: 85.8% of mothers initiate breastfeeding when their baby is born and 76% of mothers are still breastfeeding at 6 to 8 weeks which is higher than the England average.⁴ However, there are variations across the city with lower rates in more deprived areas.

National data shows that the percentage of mothers smoking at delivery is almost half the national average. However this is self-reported and evidence shows under-reporting is likely to occur, particularly given that the estimated level of adult smoking in the city is worse than average.

¹ Department of Health: Tackling inequalities in maternal and infant health outcomes. Report of the Infant Mortality National Support Team; 2010. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122844.pdf [Accessed 25/08/2012].

² The period around childbirth.

³ NHS Health Scotland Substance use and misuse in pregnancy. <http://www.maternal-and-early-years.org.uk/topic/pregnancy/substance-use-and-misuse-in-pregnancy#risks> [Accessed on 25/08/2012]

⁴ Chimat. Child Health Profile, Brighton & Hove 2012. March 2013. Available at: <http://www.chimat.org.uk/profiles> [Accessed 17/08/2013]

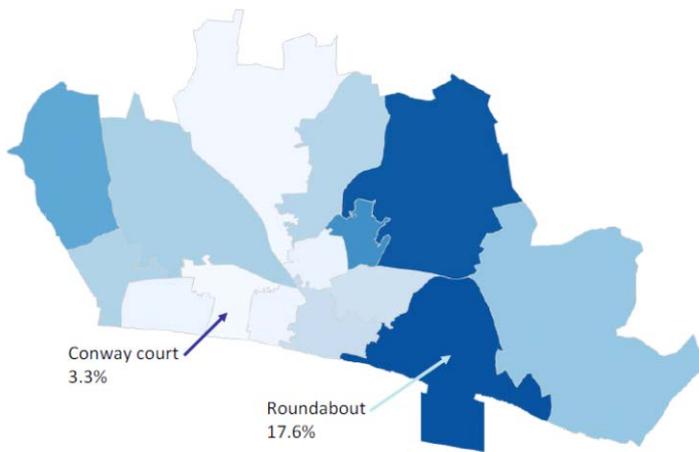
⁵ Office for National Statistics Vital Statistics tables. Brighton and Hove Public Health Directorate 2013.

7.1.2 Maternal and infant health

Local inequalities

Even given the caveats around self-reported maternal smoking, the measure does show clear inequalities across the city when mapped at children’s centre area level (Figure 1). The most deprived areas have significantly higher rates of maternal smoking at delivery: 18% in Roundabout; 17% in Moulsecomb and 13% in Hollingdean. In Conway Court, only 3% of mothers are smoking at the time of delivery.

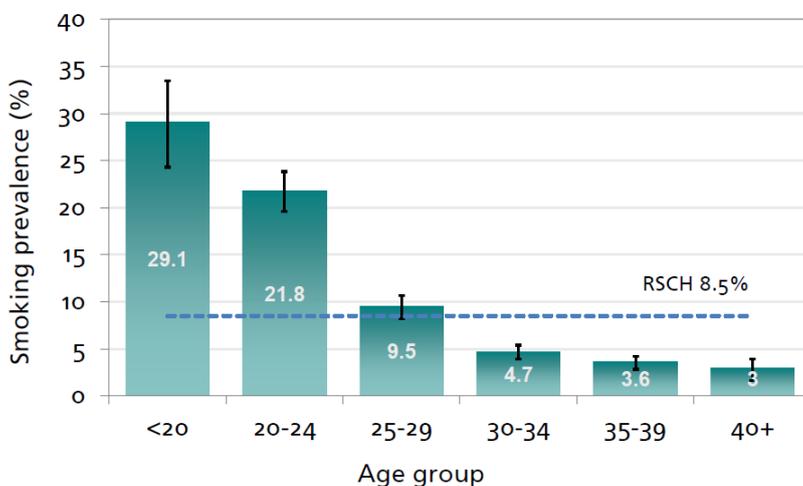
Figure 1: Maternal smoking at the time of delivery by children’s centre area, 2008/09 to 2010/11



Source: Public Health Directorate 2011.

As is the case nationally, there is a gradient effect of age seen locally (Figure 2).

Figure 2: Smoking status around time of delivery (% of known smoking status) by age groups, births at Royal Sussex County Hospital 2008/09 to 2010/11



Source: Public Health Directorate 2011

For mothers under the age of 20 years 29.2% smoke at the time of delivery. For those aged 20-24 years 21.8% smoke. This falls dramatically to just 3.0% of mothers aged 40 years or over. But it is welcome to note that maternal smoking has fallen in every age group since it was first recorded in 2003/04.

Prevalence is significantly higher in White British mothers (10.4%) and significantly lower for Other White (3.8%), Black or Black British (2.2%), Asian or Asian British (0.7%) and Chinese (0%) and Other Groups (2.8%). We could not assess data for mixed ethnicity as numbers were too small.

In contrast to the pattern for maternal smoking, the youngest mothers (<20 years) are least likely to initiate breastfeeding (56.4%). There is a clear age gradient effect (Figure 3), with breastfeeding rates increasing with maternal age up to a rate of 92.4% among mothers aged 40 years or over. There has been little change over time in these rates by age.

Highest prevalence is among White Other mothers (95.3%), with Black or Black British (89.9%) and Asian or Asian British (91.8%) mothers also having significantly higher rates. White British mothers are the least likely to breastfeed at 81.2%. There is a strong link between obesity prevalence and deprivation in the general population⁶. However due to the current lack of

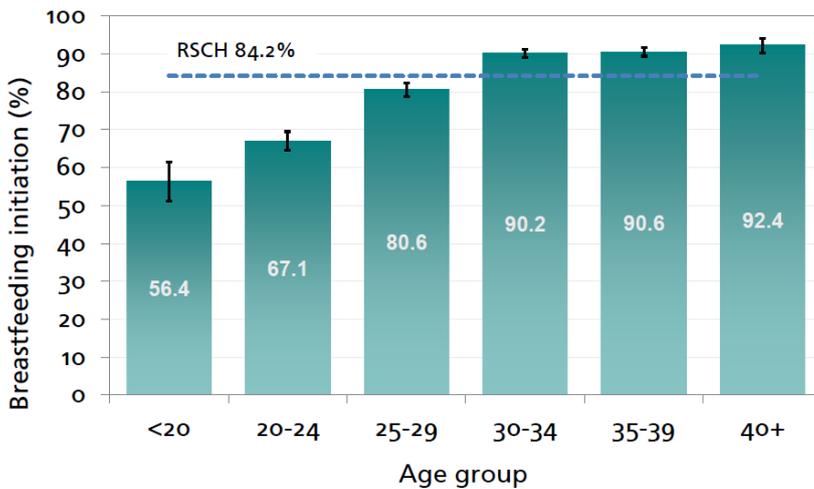
good data on prevalence of obesity in adults and on maternal obesity it is not possible to map this across the city.

There are variations in low birth weight in the city with the lowest rate in Westdene at 2.8% which is significantly below the Brighton rate. The highest rate is in South Portslade at 8.5%.

⁶ National Obesity Observatory. http://www.noo.org.uk/uploads/doc/vid_11474_Slides_adult.ppt#284 Slide 8 [Accessed 25/08/2012].

7.1.2 Maternal and infant health

Figure 3: Breastfeeding initiation (% of known feeding status) by age groups, births at Royal Sussex County Hospital 2008/09 to 2010/11

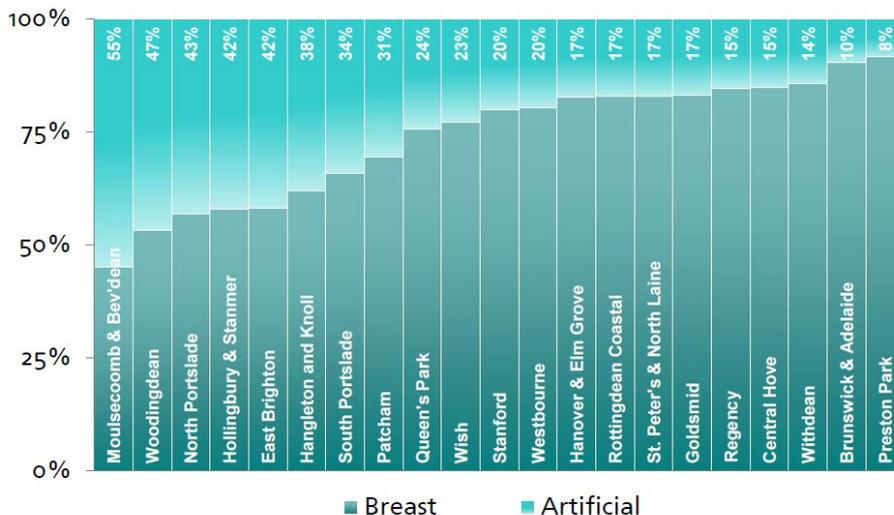


Source: Public Health Directorate 2011.

Similarly to previous years, in 2012/2013 breastfeeding rates remain generally lowest in the East area of the city and highest in the Central area (Figure 4).

The prevalence for 2012/2013 in the 20% most deprived areas is 56% compared to 79% in the rest of the City.

Figure 4: 6-8 week breastfeeding rates by ward, Brighton & Hove 2012/13



Source: Patient Information Management System, Sussex Community NHS Trust.

Infant mortality varies by maternal age. Rates are highest for youngest mothers, fall between the age of 30-34 years after which they again increase but to a lower rate than for the youngest mothers. The risk

of infant death also varies by parental marital status and birth registration status. In 2007 births registered within marriage had the lowest infant mortality rate at 4.2, jointly registered births had a rate of 5.0 and sole registrant births had the highest rate at 6.3 per 1,000 live births.⁷

National evidence shows that infant mortality varies with socio-economic position. The lowest rates are in highest social classes (I and II), and the highest rates are in the lowest social class (V), sole registrants and those in 'other' occupations which could not be classified.⁶

Predicted future need

We would not expect to see significant increases in infant mortality in the city.

The impact of a new service provided for pregnant mothers by Brighton and Sussex University Hospital Trust (BSUH) and within the community should reduce over time the prevalence of maternal smoking and obesity and improve maternal and infant health. The service will support pregnant mothers by offering a referral to a smoking cessation service for those who smoke or a referral to a dietician within BSUH for those with a BMI greater than 30.

If the number of children looked after under the age of one rises again this may result in an increased need for preventative targeted antenatal and postnatal support.

What we don't know

The low number of infant deaths in the city means it is not possible to identify local inequalities.

Whilst we have data for parents in treatment for substance misuse we currently do not have a clear picture of the prevalence of maternal substance misuse. Similarly we do not know the prevalence of maternal obesity in the city but have recently started to collect local data through the new service

⁷ Kurinczuk JJ, Hollowell J, Brocklehurst P, Gray R. Inequalities in Infant Mortality Project Briefing Paper 1: Infant mortality: overview and context. National Perinatal Epidemiology Unit; June 2009.

provided by BSUH to reduce the prevalence of maternal smoking and obesity. This data, together with the forthcoming national maternity data set, will help us get a better understanding of the prevalence of smoking and obesity in pregnancy.

We do not know with certainty why the city has historically and until recently had a significant number of looked after children under the age of one. Evidence from local services would suggest that parental drug misuse is an important factor.

Key evidence and policy

The National Perinatal Epidemiology Unit produced evidence maps providing an overview of the effectiveness of interventions targeting:

- infant mortality and its major medical causes (preterm birth, major congenital anomalies and sudden unexpected infant death).
- major potentially modifiable risk factors for infant mortality (smoking in pregnancy and the postnatal period, maternal obesity and risk factors for sudden unexpected infant death)⁸.

In 2007 the Department of Health published the Implementation Plan for reducing health inequalities in infant mortality: a good practice guide.⁹ It shows how areas can narrow the gap by looking at current examples of good practice.

In 2010 the Department of Health produced a report from the Infant Mortality National Support Team on Tackling Health Inequalities in Infant and Maternal Health Outcomes, with recommendations for commissioners for maternal and infant health improvements and the reduction of infant mortality

Recommended future local priorities

The following actions are taken forward by the maternal health Steering Group which comprises service commissioners and providers.

1. Collect and analyse data on prevalence of drinking, smoking and obesity in pregnancy.
2. Monitor the uptake of smoking cessation and post pregnancy weight management and programmes from women who were referred by the BSUH service. This will be achieved

through closer working between service providers and midwifery.

3. Improve communication between midwives and health visitors, which is particularly relevant in the context of the new proposed health visiting ante-natal at about 34 weeks of pregnancy.
4. All pregnant women should be screened for substance misuse at the midwifery booking appointment and if appropriate given brief advice or referred for extended brief interventions (NICE Guidance)
5. Continue to target breastfeeding support in areas of inequality and to younger mothers.

Key links to other sections

- Healthy weight
- Pregnancy and maternity
- Alcohol
- Substance misuse
- Smoking
- Teenage pregnancy and teenage parents
- Maternity care

Further information

ChiMat Infant mortality profiles

<http://atlas.chimat.org.uk/IAS/dataviews/infantmortalityprofile>

Last updated

June 2013

⁸ <https://www.npeu.ox.ac.uk/infant-mortality> [Accessed 25/08/2012]

⁹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081337 [Accessed 25/08/2012]

7.1.3 Childhood immunisation

Why is this issue important?

Immunisation is an extremely effective public health measure. Nationally it has resulted in a significant reduction in the rate of infectious diseases. Increases in uptake of all vaccines will improve both the health protection of the nation, and morbidity and mortality of individuals.

Diseases for which vaccines are available in the United Kingdom include diphtheria, tetanus, polio, pneumococcal, meningitis C, Haemophilus influenzae, pertussis, measles, mumps, rubella, Hepatitis B and Tuberculosis (with the BCG (bacille Calmette-Guerin) vaccine). Although deaths from vaccine-preventable infections are now rare in the United Kingdom, the recent decreases in uptake of MMR (measles, mumps, rubella) vaccination, for example, have left individuals at risk of potentially fatal infections

Key outcomes

- **Population vaccination coverage (Public Health Outcomes Framework)**

Impact in Brighton & Hove

Brighton & Hove has the second lowest childhood immunisation uptake rates in the South East Coast and is significantly below the national average on all the immunisation indicators in the Public Health Outcomes Framework (2010/11 and 2011/12).

Substantial efforts over the past few years, and the establishment of a specialised focussed immunisation team, has led to an overall increase-although rates remain lower than the national target that 95% of children should receive three primary doses of diphtheria, tetanus, polio and pertussis in the first year of life; that 95% should receive first dose of MMR vaccine by their second birthday.; at least 90% of girls aged 12-13 years old should receive a complete course of HPV vaccine.

The low uptake rate for MMR vaccine resulted in a particularly severe outbreak of measles in the summer of 2012, when the City was described as the measles capital of the UK.

Table 1: Childhood immunisation uptake rates, 2011/12 and July to September 2012

	Brighton & Hove	England	Brighton & Hove	England
	2011/12		July-Sept 2012	
DTaP/IPV/Hib at 1 yr.	92.6%	94.7%	91.6%	94.6%
1st dose MMR by 2nd birthday	89.4%	91.2%	91.2%	92.2%
2nd dose MMR by 5th birthday	82.0%	86.0%	86.0%	87.5%
Preschool booster by 5th birthday (DTaP/IPV)	84.3%	87.4%	86.9%	89.0%
HPV vaccination coverage-girls 12-13	79.8%	86.8%	-	-

Source: NHS Immunisation Statistics 2011/12, NHS Information Centre for Health and Social Care and Immunisation Coverage July-September 2012; Health Protection Agency

A major effort was made to identify and offer immunisation to those school age children who had not been immunised earlier. A number of walk in clinics were established, as well as the children being offered the choice of visiting their GPs for their immunisation. Subsequently, the outbreak subsided with very few cases since October 2012.

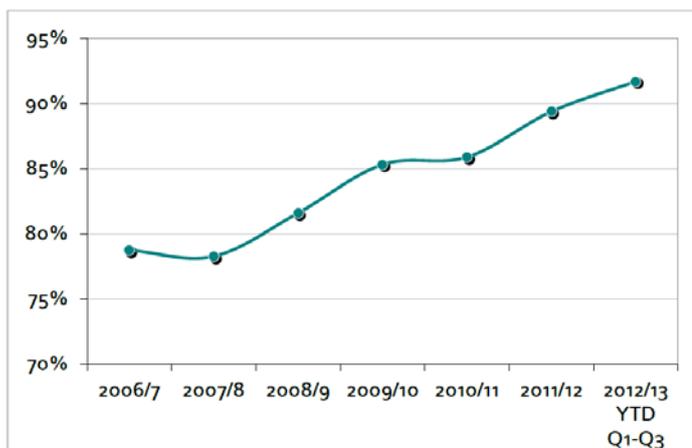
A national programme to ensure that 95% of children aged 10-16 years have received at least one dose of MMR vaccine began in April this year.

Where we are doing well

Immunisation uptake in the under fives has started to improve in the City in recent years (Figure 1).

7.1.3 Childhood immunisation

Figure 1: Increase in MMR vaccination rate by age 2 years



Source: Public health England

Local inequalities

There is currently no local data on immunisation uptake by equality groups, however nationally those who remain incompletely immunised are more likely to live in disadvantaged areas and are less likely to use primary care services. Brighton & Hove has the inverse situation in some wards, where failure to accept vaccination is more a reflection of anti-vaccination views than due to deprivation.¹

Predicted future need

When a sufficient percentage of the population is immune to a disease, through vaccination and/or prior illness, the disease is unable to spread, and those people who are not immune will also be protected. This is known as 'herd immunity' and is particularly important for those who are unable to be vaccinated or who will suffer more severe consequences from catching a disease, for example due to young age or immunosuppression. To achieve herd immunity, immunisation rates need to reach and be maintained at 95%. This figure has not yet been achieved for any childhood vaccination in Brighton & Hove. This means there will be an ongoing need to promote existing vaccination programmes to the local population, as well as introducing any new ones that may be approved nationally in the future.

There is an ongoing need for primary care to ensure that newly registered patients among the

15% migrant population of the city² have an up-to-date immunisation record, and to recommence the immunisation schedule where this is not known.

Additional vaccinations will be added to the current vaccination programme in 2013. Some of these may best be delivered in schools.

What we don't know

There is currently no local data on immunisation uptake by equality groups.

Brighton & Hove has a significant minority who oppose immunisation in principle. It is unclear how we could engage more constructively with this group to encourage vaccination uptake.

Key evidence and policy

NICE Public Health Guidance 21 (2009) <http://guidance.nice.org.uk/PH21/Guidance/pdf/English> provides the evidence base for effective interventions to increase immunisation uptake in the childhood immunisation programme. This includes a benchmark tool against which local action is measured by the Brighton & Hove Immunisation and Vaccination Review Group. Evidence of effectiveness for the seasonal flu programme is provided in the annual CMO seasonal flu letter. The national Joint Committee on Vaccinations and Immunisations (JCVI) reviews the evidence and cost effectiveness of all immunisation programmes.

Recommended future local priorities

1. The responsibility for ensuring delivery of immunisation programmes has moved from the local NHS to a team covering Surrey and Sussex. This shift must not be allowed to compromise improvements made over the past few years.
2. The Specialist Immunisation Team should continue to support GP Practices with data cleansing to ensure accurate uptake records are kept and timely immunisation invitations sent.
3. Primary care needs to gear up to reflect the additional work associated with the new immunisation schedules.

² Office for National Statistics. Migration Indicators Tool. Available from <http://www.ons.gov.uk/ons/rel/migration1/migration-statistics-quarterly-report/may-2013/index.html> -2013/index.html [Accessed 17/07/2013]

¹ Annual Report of the Director of Public Health 2006.

7.1.3 Childhood immunisation

4. Schools need to be engaged to explore the possibility of greater involvement as the settings for some routine immunisations.
5. Further work should be done on opportunistic immunisation and developing outreach services for hard to reach groups.
6. All staff involved with delivering the immunisation programmes should receive up to date training.

Further information

Department of Health: Immunisation against infectious disease:

<http://www.dh.gov.uk/en/Publichealth/Immunisation/Greenbook/index.htm>

Last updated

May 2013

7.2.1 Oral health (Children)

Why is this issue important?

Oral health is central to healthy living and makes an important contribution towards appearance, self-esteem and quality of life. Missing or decayed teeth and ill-fitting dentures can make people feel self-conscious and lead to loss of confidence and social isolation. The most common oral diseases - tooth decay and periodontal disease, can cause pain and infection as well as eventual tooth loss.¹

Although the oral health of children in England has improved over the past few decades, there are still children with unacceptable levels of tooth decay.

Tooth decay in children is largely preventable. The risk factors include a frequent and high sugar diet, which is also common to diabetes and obesity. Topical fluoride such as in toothpastes, varnishes and mouth rinses helps to prevent tooth decay.

Key outcomes

- **Tooth decay in children aged five (Public Health Outcomes Framework)**
- **Ensuring people have a positive experience of care – Patient experience of NHS Dental Services (NHS Outcomes Framework)**
- **Ensuring people have a positive experience of care - Improving access to NHS Dental Services (NHS Outcomes Framework)**

Impact in Brighton & Hove

It is difficult to comment on the state of oral health amongst children aged five and 12 years in Brighton & Hove because the epidemiological survey upon which this data is based has been subject to bias since the national introduction of positive consent for participation in the schools based survey. This has led to lower levels of caries than would be expected.

The most recent data for five year olds from 2011/12 was based on an examination of 89 children, drawn from a sample of 160 (Table 1). Comparisons cannot be made between these two samples of five year olds.

Definitions
Mean dmft – average number of obviously decayed, missing (due to decay) and filled teeth per child
% dmft>0 – percentage of children with decay experience
Care Index % - Proportion of teeth with decay that have been filled

Table 1. NHS Dental Epidemiological Programme for England. 2011/12 and 2007/08 Survey of 5 year old children, Brighton & Hove

	2011/12	2007/08
Sample	160	354
Examined	89 (55.6%)	192 (54.2%)
%dmft>0	7.5%	20.8%
Mean dmft	2.92	0.51
Care Index	Not available	23%

Source: Brighton & Hove Special Care Dental Service, Sussex Community Trust (2011/12) and North West Public Health Observatory.

Table 2. NHS Dental Epidemiological Programme for England for 2008/9 Survey of 12 year old children, Brighton & Hove

	2008/09
Sample	307
Examined	234 (76.2%)
%dmft>0	17.5%
Mean dmft	0.27
Care Index	68%

Source: North West Public Health Observatory

¹ Department of Health . Choosing Better Oral Health. A Health Plan for England; 2005.

7.2.1 Oral health (Children)

In 2011/12 there were 289 children aged 18 or under admitted to BSUH for dental caries.²

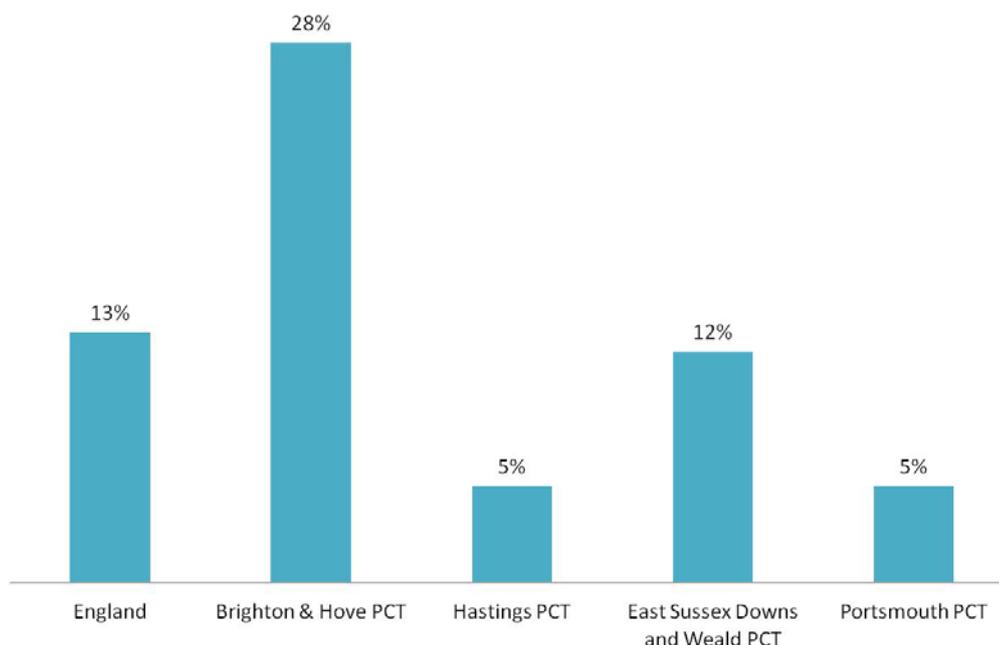
Access to dentists: patients seen within 24 months (for children) have remained constant since June 2011.

Actions to reduce the impact of dental decay in children are being implemented in the city as part of the oral health promotion programme. This targets tooth brushing at children's centres, special schools, and early years; breakfast clubs and child health clinics. It also provides awareness training for the wider workforce and supports the Oral Health Champions Network to encourage oral health promotion in general dental practices.

Where we are doing well

General Dental Practitioners have implemented Delivering Better Oral Health and are following the prescribed patient care pathways, including the application of fluoride varnish. Brighton & Hove has higher levels of fluoride varnish application in its children than England or its comparators (Figure 1).

Figure 1. Percentage of child courses of treatment including fluoride varnish, 2011/12



Source: Health and Social Care Information Centre. Available at: <https://catalogue.ic.nhs.uk/publications/primary-care/dentistry/nhs-dent-stat-eng-2011-2012/nhs-dent-stat-eng-2011-2012-anx2.xls#Table E15!A1> Accessed [10.06.13]

Local inequalities

Nationally, a gap between the oral health status of children in lower socio-economic groups and children in higher socio-economic groups remains. The 2003 National Survey of Child Dental Health highlights inequalities by social background. For example, the probability of having obvious decay experience of the primary teeth was about 50% higher in the lowest social group than in the highest. Among 15 year olds from managerial and professional backgrounds, 47% had obvious decay experience compared with 65% from routine and manual socio-economic backgrounds.¹

In 2009/10 around half of children in Brighton and Hove on the Child Protection Register or looked after (438 children) were treated by the Special Care Dental Service.³

The distribution of tooth decay varies by locality across the City, with proportionately more children in the deprived areas to the east of the city experiencing more decay.⁴

There is a correlation between free school meals (a proxy measure of deprivation among children) and a higher proportion of dmft per child. In 2007, the east locality had the highest proportion of free school meals, so is likely to have the highest level of dmft.⁵

Over a third of children admitted to hospital for dental caries come from the most deprived quintile of the population. Over 40% of the children come from routine and manual socio-economic backgrounds.⁵

³ NHS Brighton and Hove. Special Care Dental Dentistry Needs Assessmentv7. January 2011.

⁴ NHS Brighton & Hove. Oral Health Needs Assessment. September 2008.

² Hospital Episode Statistics; 2011-2012.

7.2.1 Oral health (Children)

Predicted future need

It is estimated there will be a 10% increase in the number of under 15 year olds in the city by 2021 (from 41,799 to 46,116), with a 9% increase in under fives by 2021 (from 15,092 to 16,378).⁵

An unhealthy diet including the consumption of sugary food and drink contribute to both obesity and poor oral health. If obesity continues to increase this is likely to have an impact on the oral health of the population.

What we don't know

We do not have a comprehensive picture of the prevalence of dental caries in 5 and 12 year olds. There is no up-to-date local data describing health inequalities in the oral health of children. There is no direct local data on the correlation between deprivation and dental decay in children, apart from the proxy measure of free school meals.

There is a lack of stakeholder, public and patient consultation data.

Key evidence and policy

Choosing Better Oral Health¹ outlines key interventions for improving oral health in children and adults: fluoride; improving diet and reducing sugar intake; encouraging preventative dental care; reducing smoking; increasing early detection of mouth cancer; and reducing dental injuries.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4123253.pdf

Cochrane systematic review on the evidence for the use of fluoride.⁶

Recommended future local priorities

1. Continue oral health promotion work with children in a range of settings.
2. Support General Dental Practitioners in promoting children's oral health in practices, including the application of topical fluoride.

3. Investigate with Public Health England the potential for delivering topical fluoride application in schools.
4. Continue to monitor the outcomes of national epidemiological surveys, and take appropriate follow-up action.

Key links to other sections

- Oral health (Adults and older people)
- Healthy weight

Further information

NHS Brighton & Hove Oral Health Needs Assessment 2008.

<http://www.brightonandhove.nhs.uk/healthprofessionals/dentistry/documents/OHNAFinalversionDec08.doc>

NHS Brighton & Hove. Special Care Dentistry Needs Assessment. 2011.

Last updated

May 2013

⁵ Office for National Statistics. Interim 2011 based sub national population projections. <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tc%3A77-274527> [Accessed 12/06/2013]

⁶ Marinho VC, Higgins JP, Sheiham A, Logan S. 2003. Fluoride toothpastes for prevent dental caries in children and adolescents. Cochrane Database of Systematic Reviews. Issue 2. Art. no: CD002278 DOI: 10.1002/14651858.

7.2.2 Emotional health and wellbeing (Children and young people)

Brighton & Hove JSNA 2013

Why is this issue important?

The 2011 cross-government national mental health strategy states that *'Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential'*¹

Most mental health problems start in childhood and adolescence and the majority of severe and enduring mental illnesses are diagnosed by the age of 18.¹

One in 10 children between 5 and 16 years of age has a mental health problem, and at any one time, one in six young adults aged 16-24 will have a common mental disorder, such as anxiety and depression, that meets the threshold for a clinical diagnosis.¹

Nearly half (45%) of young people with mental health problems withdraw from full-time education by the age of 15. Young people aged 16-18 with severe and enduring mental health problems are twice as likely as their peers to have no educational qualifications.

The health and wellbeing of children and young people in the UK compares poorly compared with that of children in other industrialised nations. An international comparison of child wellbeing in rich countries found that the UK is the worst place for the wellbeing of children in the developed world.²

Nationally Young Minds have stated that

- Over the last ten years inpatient admissions for young people have increased by 68% due to self harm
- Last year alone hospital admissions for under 25s increased by 10% due to self harm

Amongst females under 25 there has been a 77% increase in the last ten years in inpatient admissions due to self harm³

The 2008 National CAMHS Review⁴ identified the following groups of children and young people who are significantly more likely to experience mental

health difficulties than the general population (Table 1):

Table 1: Children and young people who are significantly more likely to experience mental health difficulties

Looked after children	Nearly 50% of children in local authority care and nearly 70% of children living in residential care have a diagnosable mental disorder ⁵
Learning disability	Over a third of children and young people with an identified learning disability have a diagnosable psychiatric disorder ⁶
Young offenders	Young people involved in the youth justice system have at least three times the prevalence of mental health needs, suggesting a prevalence rate of at least 30% ⁷
Physical disability or serious or chronic illness	Children and young people with physical disabilities or a serious or chronic illness are twice as likely to develop psychological problems, suggesting a prevalence rate of 20% ^{8,9}
Teenage mothers	Teenage mothers are three times more likely than older mothers to suffer postnatal depression and mental health problems in the first three years of their baby's life ¹⁰

Source: Department of Health. Children and young people in mind: the final report of the National CAMHS Review. 2008.

Key outcomes

- **Self-harm (Placeholder)(Public Health Outcomes Framework)**

¹ No health without Mental Health: A Cross-Government Mental Health Outcomes strategy for People of all Ages HM Govt 2011; pg27.

² Children and Young Peoples Mental Health coalition. Improving Children and Young People's Mental Health.

³ Young Minds press release 2.12.11. Available at: www.cisionwire.com/youngminds

⁴ Department of Health. Children and young people in mind: the final report of the National CAMHS Review;2008.

⁵ Meltzer, Gatward, Corbin et al. . The Mental Health of Young People Looked After by Local Authorities in England. London: TSO; 2003.

⁶ Emerson and Hatton. The Mental Health of Children and Adolescents with Learning Disabilities in Great Britain. Lancaster: Institute for Health Research, Lancaster University; 2007.

⁷ Hagnall Ann Dr, The Mental Health Foundation. The Mental Health of Young Offenders; 2002.

⁸ Shooter. Children and adolescents who have chronic physical illness. In Williams and Kerfoot (eds).Child and Adolescent Mental Health; 2005. Services: Strategy, planning, delivery, and evaluation. Oxford: Oxford University Press.

⁹ Parry-Langdon (ed). Three Years On: a survey of the development and emotional well-being of children and young people. Cardiff: ONS; 2008.

¹⁰ Ermisch. Does a 'Teen-Birth' Have Longer-Term Impacts on the Mother? Suggestive evidence from the British Household Panel Survey. Colchester: Institute for Social and Economic Research; 2003.

7.2.2 Emotional health and wellbeing (Children and young people)

Brighton & Hove JSNA 2013

- **Emotional wellbeing of looked after children (Public Health Outcomes Framework)**

Local targets in the service contracts for the delivery of Tier3 mental health services: 100% of first appointments within 4 weeks.

Impact in Brighton & Hove

Taking the Brighton & Hove population of 5-16 year olds to be approximately 38,198¹¹ and using the mental health strategy data of one in 10 children experiencing mental health problems, this would equate to 3,819 children and young people in the city with mental ill-health.

The 2012 Safe and Well in schools survey undertaken in Brighton & Hove indicated that 92.8% of respondents in primary school strongly agreed or agreed that they felt happy with their lives. In secondary school 95% of respondents stated they were often or sometimes happy with their lives. 6% of respondents stated they often feel very sad or depressed.¹²

Fewer primary school respondents (19%) and secondary age pupils (16.5%) reported experiencing bullying in school than in the 2011 survey (21% and 19% respectively).

A newly launched Safe and Well survey was undertaken in three of the city's 6th form colleges. 95% of respondents stated that they were often or sometimes happy with their lives, 7% stated that they often felt very sad or depressed. 5% stated that they reacted to their feelings by harming themselves.¹³

Mental health services for children and young people in Brighton & Hove at Tier 2 (mild to moderate emotional and mental health issues responsive to brief intervention) and Tier 3 (moderate to severe and enduring mental health issues and diagnoses) - community CAMHS and clinical CAMHS received approximately 1,099 referrals in 2012.

Over the last five years, the number of children and young people (0-17) presenting at the Accident and Emergency (A&E) department of the Royal Sussex

County Hospital with serious self harm has increased significantly (local reporting via social work) from 65 in 2009 to 121 in 2012.¹⁴

This is at a higher rate than the England Average; Brighton & Hove 152.2 per 100,000 as compared with 115.5 per 100,000.¹⁵

Where we are doing well

There is strong evidence of engagement with parent carers at Strategic and operational levels. The CAMHS partnership board includes parent carer representation and there is a parent carer user group of CAMHS tier 3 services.

A service user group of young people called 'Mind Me Up' is commissioned as a both a reference group for service developments and a support group for young people.

Brighton & Hove hosts one of four national Right Here projects with a focus on engagement of young people and they have actively participated in self harm research. The project focuses on developing resilience in vulnerable young people via activity and volunteer opportunities.

Brighton & Hove Parent Carer Council (PaCC) have undertaken an evaluation of local health services, including CAMHS and there is a subsequent action plan which is being developed.¹⁶ Key to this is engagement with families in the design of information leaflets and improving communication.

There is a commissioned service for children and young people at the point of transition from children to adults services and to support young people who find accessing services difficult

There is a newly commissioned online counselling service for young people aged 14-25 years.

Tiers 2 and 3 of CAMHS operate a single point of referral and can offer pre-referral consultation if necessary. More joint working, including groups has been established.

Work with GP practices to ensure young people with mental health issues feel they experience contact with their GP positively.

¹¹ Office for National Statistics. Mid year estimates 2010

¹² Brighton & Hove City Council. Safe and Well at School Survey. 2012. Available at: www.bhlis.org/surveys [Accessed 17/08/2013]

¹³ Brighton & Hove City Council. Safe and well survey 6th form colleges. 2012

¹⁴ Brighton & Hove (2013) Local data from social work teams

¹⁵ Child health profile 2012 Chimat Crude rate per 100,000 (age 0-17 years) for hospital admissions for self-harm, 2011/12

¹⁶ Parent carer Talk Health report 2012

7.2.2 Emotional health and wellbeing (Children and young people)

Brighton & Hove JSNA 2013

CAMHS Outcome vs Expenditure tool measures show that for Brighton & Hove, Programme budgeting per head of population is defined as low with CAMHS service effectiveness rated as good.¹⁷

There is a service launching within the Royal Alexandra Children's hospital to support children with long term health conditions and their family alongside a service for children with Chronic Fatigue syndrome. These services acknowledge the need for children and families to be supported at the time of diagnosis and during the lifetime of their illness.

The Family Nurse partnership works with first time mothers under the age of 19 years in an intensive way with the aim of increasing the family resilience and maintaining the child with the birth mother wherever possible.

Local inequalities

Young females are more likely than males to present to A&E with serious self harm. Of the young people under 18 presenting to A&E with serious self harm in 2012, 88% were female.

People with autism or Asperger syndrome are particularly vulnerable to mental health problems such as anxiety and depression, especially in late adolescence and early adult life.¹⁸ This is an area of concern in the city and is a key aspect of the Special Educational Needs strategy

Of the referrals to Tier 3 CAMHS in the period January- September 2012 102 were known to social services.

In the first 11 months of 2012, 58 Looked after children were referred to Tier3 (SPFT) CAMHS. This represents approximately 9% of the total number of referrals in 2012 accepted by Tier3 and demonstrates the higher propensity of looked after children for mental health issues.¹⁹ In December 2012 there were 62 Looked after children on the Tier 3 CAMHS caseload

From April 2008 all local authorities in England have been required to provide information on the

emotional and behavioural health of the children they look after via returned Strengths and difficulties questionnaires (SDQ). The England average score for emotional and behavioural health of looked after children is 13.8 and the Brighton & Hove average is 14.8 (2012) with 0-13 being deemed normal, 14-16 being borderline for concern and 17+ being cause for concern.²⁰

Surveys undertaken by Allsorts, a local support project for LGBT young people, reflect the increased vulnerability of this group to mental health issues: Of the 42 LGBT young people surveyed,²¹ over the last three months:

- 55% had experienced mental health problems (e.g. depression and anxiety) that had left them feeling unable to cope)
- 79% had felt low and had been troubled by fears, obsessive thoughts or habits
- 55% said they had suffered some form of homophobic/biphobic/transphobic incident/discrimination/harassment or bullying
- 50% had done something to injure or harm themselves
- 50% had contemplated suicide and 17% had attempted suicide

An additional survey of a small number of trans young people indicates that this cohort are particularly vulnerable to mental health issues (see section 4.2.5).²²

Analysis from the Compass database (the voluntary register for children and young people with disabilities) shows that as of 1st June 2013 26% of children and young people with an up-to-date record on the register are known to have received support from CAMHS over the past two years.²³

Predicted future need

There is statistical (admissions to hospital for self harm and increases in referral rates to CAMHS) and anecdotal evidence of greater numbers of children

¹⁷ Chimat. Outcome vs expenditure tool updated for 2010/11 data.

¹⁸ Tantam D. Prestwood S. A mind of one's own: a guide to the special difficulties and needs of the more able person with autism or Asperger syndrome. 3rd ed. London: National Autistic Society; 1999.

¹⁹ CAMHS monitoring data.

²⁰ nb national return of SDQ was 70% so data should be treated with caution https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/191971/SFR32_2012_LATables.xls

²¹ Allsorts Youth Project. Allsorts Survey Report, Quarter 4 Jan - March 2013

²² Allsorts Youth Project. Allsorts Trans* Survey Report, Quarter 4 Jan-March 2013

²³ Amaze analysis conducted for the JSNA in June 2013.

7.2.2 Emotional health and wellbeing (Children and young people)

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and young people experiencing mental health issues and distress. This will impact in services specifically related to mental health and also has potential for increased patterns of poor attainment in schools and increased drug and alcohol abuse.

There is increased pressure on in-patient mental health beds.²⁴

There is an expectation that the impact of welfare benefits reforms will impact on young people who will experience increased stress.²⁵

What we don't know

Lack of local data, health data systems are not set up to provide good quality local data. It is therefore difficult to evidence demographic spreads of mental health needs in children and young people.

There is little clarity about the assets available in the City to support children and young people's wellbeing.

It is hard to evidence issues of self-harm where there is not an attendance in A&E.

There is no local evidence available on the mental health needs of some equalities groups in the city, specifically in relation to ethnicity and religion. However, plans are underway to collate information on use of CAMHS services (tier 2) by ethnic group this calendar year (2013).

Nationally there is also recognition through both policy and service delivery that there are gaps in both collection and use of relevant monitoring information on the mental health needs of BME children and young people.^{26,27}

Key evidence and policy

National policy drivers include;

- No Health Without Mental Health

- The Every Child Matters: Change for Children programme
- National Institute of Health and Care Excellence (NICE) guidance

Effectiveness of child and adolescent mental health services (CAMHS) assessed against the following:

- Full range of CAMH services for children and young people with learning disabilities
- Access to services for 16 and 17 year olds who require mental health services
- Arrangements for 24-hour cover for urgent mental health needs
- Delivery of full range of early intervention support for children experiencing mental health problems²⁸

Recommended future local priorities

1. Improved data collection specifically focussed on promoting outcome focussed performance monitoring
2. Implementation of review of services for children and young people who self harm
3. Development of an all age mental health strategy
4. Evaluation of the impact of online counselling pilot
5. Launch of health colleges

Key links to other sections

- Sexual orientation
- Trans
- Parenting
- Substance misuse and alcohol (children and young people)
- Child poverty
- Children and young people with disabilities and complex health needs

Last updated

June 2013

²⁴ Chalkhill bed data as reported monthly to CAMHS funding panel

²⁵ . Youth Access. Under Strain - How the recession is affecting young people and the organisations which provide advice, counselling and support to them. 2010

²⁶ Department of Health. National Service Framework for Children, Young People and Maternity Services: The mental health and psychological wellbeing of children and young people. 2004

²⁷ Street, C., Stapelkamp, C., Taylor, E., Malek, M., and Kurtz, Z (2005) Minority Voices: research into access and acceptability of services for the mental health of young people from Black and minority ethnic groups. London: Young Minds.

²⁸ Department for Education. Statistical release: Effectiveness of CAMHS; April 2011.

7.2.3 Physical activity (children)

Why is this issue important?

Physical activity has significant physical health benefits for children, particularly prevention of overweight and obesity and Type 2 diabetes, and improvements in skeletal health. There are also links to improved psychosocial health in terms of self esteem and tackling depression, all of which provide strong evidence for promoting physical activity amongst children and young people.¹

In England, across Years 1–13 (ages 5–18 years), 55% of pupils participated in at least three hours of high quality PE and out of hours school sport during the 2009/10 academic year. Participation levels are highest at ages 8–11 years and also reasonably high at ages 5–8 years and 11–12 years. They are at their lowest at ages 16–18 years.²

A third more boys than girls aged 2–15 years meet the Department of Health recommendations of at least 60 minutes of moderate intensity physical activity a day.

This level of activity is maintained among boys within this age group, whereas the percentage of girls meeting recommendations of physical activity falls from 31% at aged 5 to 12% at age 14.

Sedentary time generally increases with age for both boys and girls.³

Key outcomes

- **Proportion of children and young people achieving recommended levels of physical activity**⁴
- **A growth in (sport) participation in the 14 – 25 age range**⁵

Impact in Brighton & Hove

71% of primary school children aged 8 - 11 do two hours or less physical activity **in school** in an average week, while just 28% do three hours or more. Of the same age group, 54% do two hours or

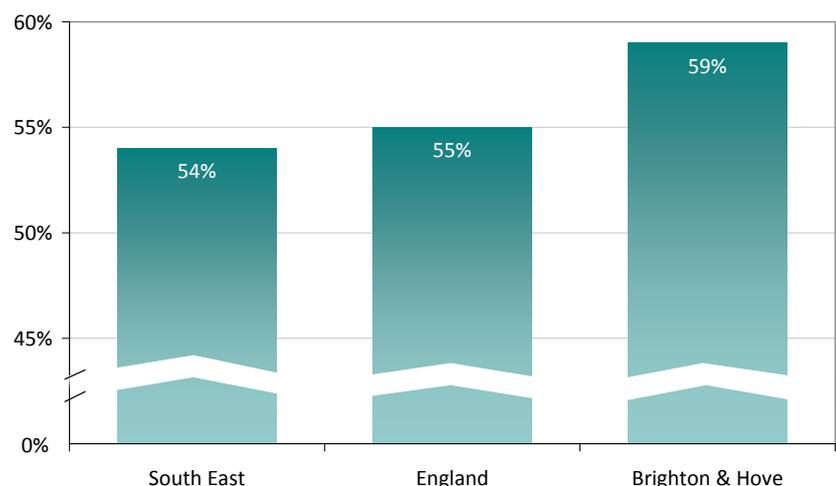
less physical activity **out** of school in an average week, with 20% doing five hours or more.⁶

When asked about which three sporting facilities pupils would like to see more of in the city, the most popular answer was Ice Rinks (46%) followed by Swimming Pools (43%) and Climbing Walls (22%).⁷

Where we are doing well

The last figures available to compare to other areas are from the 2009/10 PE and Sport Survey. According to this survey participation in Brighton & Hove (5-18 year olds participating in at least three hours of PE and out of school sport) was higher than England and the South East (Figure 1).

Figure 1: Pupils aged 5-18 years participating in at least three hours PE and out of school sport 2009/10



Source: The PE and Sport Survey 2009/10

A third of all eligible children in the city have registered for free swimming.

A large number of bespoke programmes are being run aimed at target groups e.g. girls getting active.

Local inequalities

Participation rates in at least three hours of high quality PE and out of hour's school sport during the 2009/10 academic year are higher for boys (61%) than girls (57%).²

¹ National Institute for Health and Care Excellence (NICE) guidance PH 17 www.nice.org.uk [Accessed 25/08/2012]

² Department for Education. PE & Sport Survey. 2009/10.

³ NHS Information Centre 'Statistics on obesity, physical activity and diet: England 2012.

⁴ Department of Health 'Start active stay active'; 2011

⁵ DCMS. Creating a sporting habit for life. 2012

⁶ Brighton & Hove Safe & Well at School Survey 2012. Available at: www.bhlis.org/surveys

⁷ Brighton & Hove Safe and Well at School Survey 2011. Available at: www.bhlis.org/surveys

7.2.3 Physical activity (children)

The percentage of pupils participating in at least three hours decreases steadily from age 14 years onwards and drops off significantly from age 16 years to just 28.5% for boys and 16% for girls.²

Boys aged 8 – 11 years are twice as likely as girls that age to do more than five hours physical activity, in an average week, both in, and out of school.⁶

During school years 7 - 9 (11-14 year olds), 30% of boys and only 14% of girls are doing five or more hours of physical activity out of school a week. By school years 10 - 11 these figures have dropped to 25% and 10% respectively. Girls are more likely to have done less than an hour's physical activity out of school, in an average week, than boys in all year groups.⁶

Less than half of secondary school pupils regularly travel to and from school using physically active modes of travel – 47% walk, 1% cycle, and 1% scooter/skateboard.⁶

As well as older pupils and girls, other groups of pupils in secondary schools more likely to have done less than an hour of physical activity both in and out of school in the last week include LGB and unsure pupils, those who say they are not happy, those who have truanted, been excluded or bullied and those who have tried alcohol, drugs or had sex.⁶

Chinese children (n=54) made up only a very small proportion of the total number surveyed (1%); however, they were significantly more likely to do less than an hour's physical activity both in and out of school, in the last week, than other ethnic groups and this will need monitoring.⁶

Predicted future need

Funding for the national PE and Sports survey ceased in 2011 leaving a considerable gap in monitoring.

Funding for school sports partnerships also ceased in 2011 and there are now no sports co-ordinators operating in schools. New funding for primary school sports was announced in April 2013 and will be available through the additional grant for schools in time for the 2013/14 and 2014/15 academic years. This funding is ring-fenced for improving provision of PE and sport but individual

schools will have the freedom to choose how they do this. This will need careful monitoring by the local authority to ensure that there is equitable provision of PE and sport across Brighton & Hove.

What we don't know

There is no longer national monitoring of PE and sport provision in primary and secondary schools. This means we do not have current information for either Brighton or Hove, or, for comparison, our immediate neighbours.

Information on physical activity levels is not collected for children under seven years of age.

Information is not currently collected relating to disability and physical activity levels in schools⁸ or for carers.

Key evidence and policy

The chief medical officers of the four home countries have produced the following guidance on how much physical activity children and young people should aim to achieve for good health.⁴

Early years (under fives) – for infants who are not yet walking: Physical activity should be encouraged from birth. All under fives should minimise the amount of time spent being sedentary for extended periods.

Early years (under fives) – for children who are capable of walking: Children of pre-school age should be physically active daily for at least 180 minutes, spread throughout the day. All under 5s should minimise the amount of time spent being sedentary for extended periods.

Children and young people (5–18 years): Children and young people should engage in moderate to vigorous intensity PA for at least 60 minutes and up to several hours every day. Children and young people should minimise the amount of time spent being sedentary for extended periods.

NICE guidance PH 17 Promoting physical activity, active play and sport for pre-school and school-age children and young people in family, pre-school, school and community settings.¹

⁸ NHS Brighton and Hove and Brighton & Hove City Council. Children and Young People with Disabilities and/or Complex Health Needs Joint Strategic Needs Assessment. 2010. Available at: www.bhllis.org/needsassessments

7.2.3 Physical activity (children)

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Short, structured programmes of health advice from health professionals have been shown to be beneficial in tackling barriers to activity participation in the UK⁹ as well as diversification of choice of physical activity.¹⁰

Multicomponent interventions and interventions that include school and family and community have the potential to make important differences to levels of physical activity and should be promoted. For children, some evidence of effect was shown for environmental interventions and those targeted at children from low socio-economic backgrounds.¹¹

Recommended future local priorities

Ensure the Safe and Well at School survey continues in its present form and includes both physical activity questions and travel to school question.

Provide sport and physical activity opportunities in and out of school by developing and supporting community groups and facilities.

Develop physical activity participation programmes to reduce inequalities.

Key links to other sections

- Green and open spaces
- Transport and active travel
- Physical activity (adults and older people)
- Healthy weight (adults and older people)
- Healthy weight (children and young people)

Further information

Brighton and Hove Physical Activity and Sport JSNA 2012 <http://www.bhlis.org/needsassessments>

Department of Health 2011 'Start active, stay active: a report on physical activity from the four home countries' Chief Medical Officers' http://www.dh.gov.uk/prod_consum_dh/groups/d

⁹ Rees R et al. Young people and physical activity: a systematic review matching their views to effective interventions. Health Education Research October 13; 2006.

¹⁰ Walker Z et al. Health promotion for adolescents in primary care: randomised controlled trial, British Medical Journal Volume 325; 2002.

¹¹ Van Sluijs EMF et al. Effectiveness of interventions to promote physical activity in children and adolescents: systematic review of controlled trials. BMJ doi:10.1136/bmj.39320.843947.BE; 2007.

[h_digitalassets/documents/digitalasset/dh_128210.pdf](http://digitalassets/documents/digitalasset/dh_128210.pdf)

Department for Culture Media and Sport. Creating a sporting habit for life: A new youth sport strategy 2012.

http://www.culture.gov.uk/images/publications/creating_a_sporting_habit_for_life.pdf

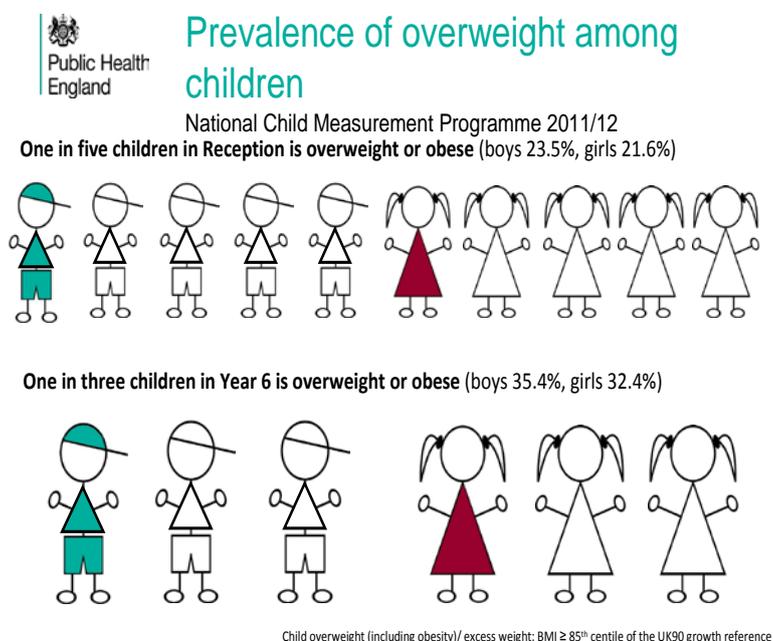
Last updated

May 2013

Why is this issue important?

Childhood obesity is now considered as one of the most serious public health challenges. The proportion of children who are overweight or obese has increased rapidly over the last two decades, reflecting major changes in the way we lead our lives. Calorie intake has increased, activity levels declined, and work patterns, transport, food production and food sales radically altered.¹

In England one in five children aged 4-5 is overweight or obese and one in three children aged 10-11 years is overweight or obese. The chart below from the National Obesity Observatory illustrates the results from the National Child Measurement Programme 2011/2012 for England.



2 Patterns and trends in child obesity

Research suggests that persistent obesity is established before the age of 11; hence it is important to focus efforts on preventing obesity in the early years.²

Obesity is associated with a number of health problems which affect both quality of life and life expectancy and has been estimated to cost the NHS £1 billion a year in direct costs and the UK economy a further £2.3-2.6 billion.³

¹ Government Office for Science. 'Tackling obesity: future choices – project report'. London: Department for Innovation, Universities and Skills; 2007.

² Wardle et al. Cross Government Obesity Unit; 2008.

³ National Audit Office, Healthcare Commission, Audit Commission; 2006.

Key outcomes

- **Excess weight in 4-5 and 10-11 year olds (Public Health Outcomes Framework)**

Impact in Brighton & Hove

Applying estimates from the Health Survey for England to Brighton & Hove, there would be almost 14,000 children and young people aged under 20 years who are overweight or obese in the city.⁴

Reception (4-5 years) and Year 6 (10-11 years) pupils are weighed and measured each year as part of the National Child Measurement Programme (NCMP).⁵ In 2011/12, 15.4% of Year 6 pupils in the city were obese, lower than England (19.2%). The figure has fallen since 2007/08, but the reduction is not statistically significant. The prevalence of overweight (14.2%) is similar to the national average (14.7%) (Table 1).

Of reception children, 7.7% were obese compared to 9.5% nationally. The prevalence of overweight children in reception (11.2%) is also slightly lower than nationally (13%).

The percentage of obese children in Year 6 was double that of Reception children. This is also the picture nationally.

There aren't specific estimates for children but the estimated direct cost to the NHS in Brighton & Hove of diseases related to overweight/ obesity was £78.1 million in 2010 rising to £83.5 million by 2015.⁶

The GP Health Champions project led by Sussex Central YMCA and Portslade Health Centre as part of one of several national pilot projects will gather the views of young people in relation to weight issues and how they would like to access weight management including physical activity services and programmes.

⁴ Health Survey for England, Information Centre for Health and Social Care <http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/health-survey-for-england> [Accessed on 25/08/2012].

⁵ National Child Measurement Programme results, Information Centre for Health and Social Care <http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/obesity> [Accessed on 25/08/2012].

⁶ Aylott J, Brown I, Copeland R, Johnson D. Tackling Obesities: The Foresight Report and Implications for Local Government; 2008. Available at <http://www.idea.gov.uk/idk/aio/8268011> [Accessed on 25/08/2012].

7.2.4 Child healthy weight

Table 1: NCMP results in Brighton & Hove - 2011/12

Classification	Reception (4-5 year olds)	Year 6 (10-11 year olds)
Underweight	0.9%	1.4%
Healthy weight	80.2%	69%
Overweight	11.2%	14.3%
Obese	7.7%	15.4%

Source: National Child Measurement Programme, Information Centre for Health and Social Care

Where we are doing well

Our obesity rates in children are lower than in England, though the number of obese children is still high. Our rates are also low compared with our children’s services statistical neighbours. However, given that the UK has one of the highest rate of obesity in Europe, there’s no room for complacency.

We have few underweight children at 0.9% of reception and 1.4% of year 6 children measured as part of the programme in 2011/12.

The proportion of secondary school aged children reporting having eaten five or more portions of fruit and vegetables the previous day remains stable at around 18%.⁷

In 2006 Brighton & Hove was the first city in the UK to publish a food strategy. In April 2012, the city's refreshed food strategy 'Spade to Spoon: Digging Deeper'⁸ was launched. This includes a range of measures supporting healthy weight and nutrition.

⁷ Brighton & Hove City Council. Safe and Well at School Survey (Secondary) Summary Results 2012. Available at <http://www.bhlis.org/surveys> [Accessed 11/08/2013]

⁸ Brighton and Hove Food Partnership <http://www.bhfood.org.uk/food-strategy> [Accessed on 11/08/2013].

The city’s Healthy Weight Programme Board was established a year ago. It brings together key stakeholders from the public, community and private sector to develop collaborative approaches to preventing overweight and obesity.

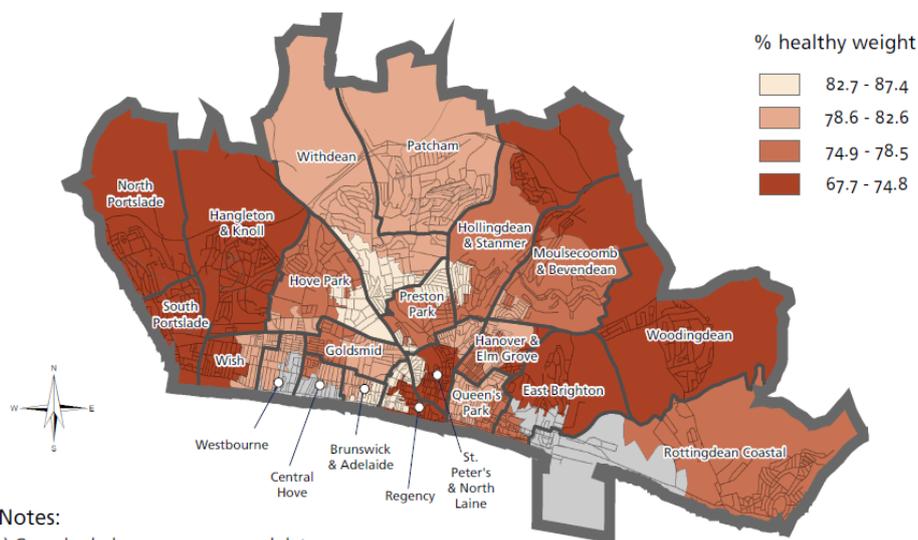
Local inequalities

Locally obesity prevalence is two to three per cent higher for boys than girls in both year groups.

Both locally and nationally, overweight and obesity among children and young people increases with age.

As in previous year, in 2011/2012 there was nationally a strong association between deprivation and rates of children overweight and obesity. This was the case too locally with a correlation between social deprivation (measured by either the Index of Multiple Deprivation or eligibility for free school meals) and childhood obesity.

Children with a healthy weight, reception year (4 to 5 years) 2008/09 to 2010/11



Notes:

- 1) Grey shaded areas = suppressed data.
- 2) Source = National Child Measurement Programme (NCMP) for England, data by Middle Super Output Areas.

Public Health Intelligence, Brighton and Hove
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The proportion of children aged 4-5 years with a healthy weight is significantly lower in East Brighton, Hangleton and North and South Portslade.

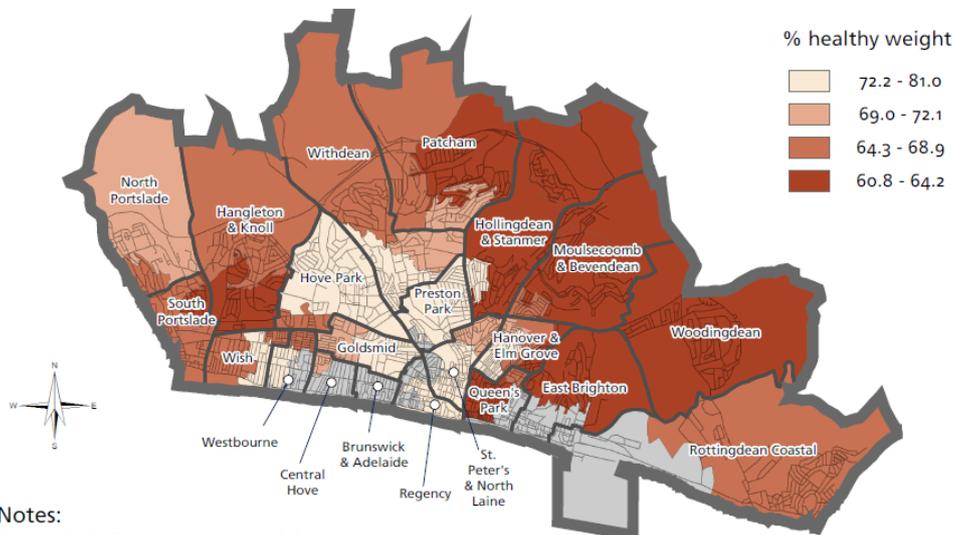
It is a similar picture for children aged 10-11 years with a healthy weight. However, there appears to be a relatively better picture for children with a healthy weight in North and South Portslade

7.2.4 Child healthy weight

compared to the proportion of children 4-5 years with a healthy weight.

There are some gaps in the provision of weight management services and programmes for young people aged 15 years and over which needs to be addressed particularly in light of the predicted increase in prevalence within that age group.

Children with a healthy weight, year 6 (10 to 11 years)
2008/09 to 2010/11



Notes:

- 1) Grey shaded areas = suppressed data.
- 2) Source = National Child Measurement Programme (NCMP) for England, data by Middle Super Output Areas.

Public Health Intelligence, Brighton and Hove
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Across England, results from the NCMP show that obesity prevalence is significantly higher for Asian or Asian British, Any Other Ethnic Group and Black or Black British children and significantly lower for Chinese and White children.

While research is limited, a number of studies show higher rates of overweight and obesity in children with Downs syndrome,⁹ a physical disability,¹⁰ or a learning disability.¹¹

Predicted future need

National projections suggest that by 2020 22% of children aged 2-11 years will be overweight and a further 12% obese. For 12-19 year olds there are gender differences, with 29% of females projected to be overweight and a further 9% obese compared with 18% overweight males and 6% obese males. This suggests that locally there will be around 16,400 overweight or obese children and young people aged less than 20 years by 2020.

⁹ Magge SN, O'Neill KL, Shults J, Stallings VA, Stettler N. Leptin levels among prepubertal children with Down syndrome compared with their siblings. *J Pediatr.* 2008 Mar;152(3):321-6

¹⁰ De S, Small J, Baur LA. Overweight and obesity among children with developmental disabilities. *J Intellect Dev Disabil.* 2008;33:43-47.

¹¹ Emerson E., Baines S. Health Inequalities and People with Learning Disabilities in the UK. Learning disability observatory; 2010.

What we don't know

There is no local data on childhood weight by disability or religion/belief.

The 2010 JSNA on children and young people with disabilities and complex health needs highlighted a gap in local knowledge on childhood obesity.

Locally, data on childhood weight for some ethnic

groups are based on small numbers and so it may not be possible to identify important differences.

There is a lack of knowledge available from young people and their families describing the impact of childhood obesity on their health and wellbeing and how they would like the sensitive issue of weight to be addressed with them.

Key evidence and policy

NICE published comprehensive recommendations on the prevention, identification, assessment and management of overweight and obesity in adults and children for the NHS, local authorities and partners, early-years settings, schools, workplaces, self-help, commercial and community settings in 2006.¹²

Recommended future local priorities

The Healthy Weight Programme Board oversees the strategic delivery of a Healthy Weight Action Plan. Some of the priority actions under each of the domains of the Action Plan include:

1. **Prevention:** Conduct and analyse results from the audit of existing preventative healthy

¹² NICE <http://www.nice.org.uk/CG43> [Accessed on 25/08/2012].

7.2.4 Child healthy weight

weight and physical activity programmes for children and young people across the city to identify any gaps, access issues and inform service commissioning.

- 2. Transforming the environment:** Gain support from Local Authority's councillors to increase the potential use of existing green spaces for active lifestyles for example allowing ball games on green spaces where there are currently restrictions.
- 3. Management and treatment:** a) Re-procure community weight management services to improve provision and access to services for children and young people across the age ranges. b) Work with the Sussex Central YMCA and Portslade Health Centre on the GP Health Champions Pilot project, which seeks to understand the need of young people aged 15-25 in relation to overweight and obesity and their views on the type of service they would like to access. c) Work with primary care to increase the number of children referred to healthy weight services.
- 4. Improving data collection and analysis:** Feedback to schools on the annual results of the National Child Measurement Programme in their areas to help engage them in promoting healthy weight.

Key links to other sections

- Transport and active travel;
- Green and open spaces;
- Good nutrition and food poverty;
- Maternal and infant health;
- Physical activity;
- Healthy weight (adults)

Further information

Brighton & Hove childhood obesity needs assessment (2009)

www.bhlis.org/needsassessment

Brighton & Hove Healthy Weight Strategy

www.bhlis.org

National Child Measurement Programme

www.ic.nhs.uk/ncmp

National Obesity Observatory www.noo.org

NICE guidance www.nice.org.uk/CG43

Last updated

May 2013.

(Children and young people)

Why is the issue important?

In the UK more than 200,005 children aged 11-15 start smoking each year.¹

Young people can become addicted to nicotine soon after their first puff.² The earlier the young person becomes addicted and continues smoking into adulthood the greater the risk of developing heart and lung disease later in life.³

If smoking is seen as the norm children are more likely to become smokers themselves⁴ and about a third of children under the age of 16 live with someone who smokes.⁵ Public support to prevent young people smoking is high.

Packaging plays an important role in encouraging young people to try cigarettes. The government carried out a public consultation which ended in 2012 on the introduction of standardised packaging to prevent young people from starting to smoke. But there has been no decision from the government when they will be introduced.

Young people who smoke are more susceptible to coughs, wheeziness and shortness of breath. This has a direct effect upon school attendance and education due to school absence.⁶

Key outcomes

- **Smoking prevalence in 15 year olds - placeholder (Public Health Outcomes Framework)**

Impact on Brighton & Hove

In Brighton & Hove the latest Safe and Well at School Survey results for 2012 show that:

- 85% of students aged 11-14 years have never tried a cigarette and 10% have tried a cigarette only once or twice
- 50% of students aged 14-16 years have never tried a cigarette and 24% have tried a cigarette only once or twice
- 27% of students stated that someone smokes in their household
- 6% of students aged 14-16 years smoke regularly and would like to give up (half of those who smoke regularly)
- In primary school, only 3% of pupils aged 8-11 said they had ever tried a cigarette⁷

Where we are doing well

Over the last three years, the percentage of pupils aged 11-14 years who have never tried a cigarette has increased (from 80% to 85% - a statistically significant improvement), although the equivalent for 14-16 year olds has remained constant (51% in 2010 and 50% in 2012).

Table 1: Percentage of pupils who have never smoked

	2010	2011	2012
11-14 year olds	80%	83%	85%
14-16 year olds	51%	47%	50%

Source: Safe and Well at School Survey

Local inequalities

The 2012 Safe and Well at School Survey suggests that the following groups of pupils are more likely to smoke:

- Older students - 94% of 11-12 year old students said they have never smoked, falling to 42% for 15-16 year old students

¹ Childhood smokers. Cancer Research UK. 2013. Taken from: Action on smoking and health (ASH). Young People and Smoking Factsheet. July 2013. Available at: http://www.ash.org.uk/files/documents/ASH_108.pdf [Accessed 17/08/2013]

²Gervais A et al. Milestones in the Natural Course of Onset of Cigarette Use Amongst Adolescents in Canada. Medical Association Journal, 175(3), pp. 255-261; 2006.

³BMA Board of Science. Breaking the Cycle of Children's Exposure to Tobacco Smoke. British Medical Association, London, 2007.

⁴Buller D et al, 2003, "Understanding Factors that Influence Smoking Uptake", Tobacco Control 12.

⁵Office of National Statistics. General Life Style Survey 2009, ONS, Newport; 2009.

⁶Smoking and Young People, Royal College of Physicians; 1992.

⁷ Brighton & Hove City Council. Safe and Well at School Survey. 2012. Available at: www.bhlls.org/surveys [Accessed 17/08/2013]

(Children and young people)

- Girls are significantly more likely to smoke, occasionally or regularly, than boys (boys 8%, girls 12%). This difference is not apparent for 11-14 year olds (boys 3%, girls 4%) but is large for 14-16 year old pupils (boys 16%, girls 25%)
- LGB students
- Those who say they are not happy, have truanted or been excluded
- Those who have tried alcohol, drugs or had sex
- There was little difference by ethnic group, though Asian or Asian British pupils (84%) are significantly more likely to have never smoked

National evidence tells us that:

- In families where parents smoke, children in the lower social classes - particularly routine and manual groups – they start smoking at an earlier age than those in high social classes.⁸

A 15 year old living with a parent who smokes is 80% more likely to smoke than one living in a household where no one smokes.⁹

Predicted future need

Prevalence has not changed greatly over recent years so it is not expected that there would be any large increase in the coming years. In younger secondary school pupils it appears to be improving.

What we don't know

We do not know enough about illegal tobacco use in the city. Illegal tobacco is seriously undermining efforts to reduce smoking prevalence as it is sold at around half the price of legal cigarettes. Illegal tobacco sellers target the young, vulnerable and those living in poor and disadvantaged communities making it possible for smokers in these areas to carry on smoking, smoke more and smoke from an earlier age.

⁸West R. The Smoking Pipe: A Model of the Inflow of Smokers in England. 2009.

⁹Loureiro M, Sanz-de-Galdeano A and Vuri D. Smoking Habits: Like Father, Like Son, Like Mother, Like Daughter? Oxford Bulletin of Economics and Statistics, 72(6), pp.717-743; 2010.

Key evidence and policy

NICE has published evidence-based guidance which will assist with the commissioning and delivery of stop smoking interventions. These can be found at www.nice.org.uk

Healthy Lives, Healthy People: A Tobacco Control Plan for England.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917

Recommended future priorities

1. Ensure smoking prevention sessions in schools are part of a Local Tobacco Control Strategy.
2. Ensure interventions delivered in schools are integrated into the curriculum and teachers understand the importance of stopping smoking and consistency in communication.
3. Develop mass media campaigns to prevent the uptake of smoking among young people.
4. Work with partners to deliver youth advocacy programmes in the community and outside school, and encourage peer led education programmes.
5. Enforce age-of-purchase legislation.

Key links to other sections

- Parenting
- Substance misuse and alcohol (Children and young people)

Further information

Healthy Lives, Healthy People: A Tobacco Control Plan for England

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917

Last updated

August 2013

7.2.6 Substance misuse and alcohol (young people)

Brighton & Hove JSNA 2013

Why is this issue important?

The Home Office estimates that 16% of 10-16 year olds are vulnerable to substance misuse issues and 30% of 17-19 year olds are likely to present for substance misuse issues.¹ However, in England there has been an overall decrease in drug use reported by 11-15 year olds since 2001. The prevalence of lifetime drug use fell amongst 11-15 year olds from 29% in 2001 to 18% in 2010.² In parallel there has been a reduction in the proportions of pupils who have ever been offered drugs, from 42% in 2001 to 28% in 2012.³

In 2012 national data³ showed that almost one in six (17%) young people aged 11-15 years in England reported that they have ever taken drugs. Cannabis is the most widely used drug with 7.5% of pupils reporting taking it in the last year, down from 13.4% in 2001. Other drugs included 3.6% who had sniffed glue, gas or other volatile substances and 2.2% had used a Class A drug (from 4% in 2009).³

The national data³ also showed that the majority (57%) of 11-15 year olds had never drunk alcohol, a rise from 38% in 2003. The proportion of pupils who drank alcohol in the last week (of those who had tried alcohol) has fallen from 26% in 2001 to 10% in 2012. The mean amount consumed in the last week was 12.9 units and the median was 8.0 units.³

It is clear from national⁴ and local guidance⁵ that overall it is only a small percentage of under 18s who get into difficulties with drugs or alcohol, but for these the problems can be significant. Young people who misuse drugs and alcohol are more likely to have poor school attendance, not be in education, employment or training (NEET), and more likely to be involved in crime, be homeless, be in care, come from a family who also misuse

drugs and alcohol, have emotional and psychological problems be a teenage parent or pregnant or be involved in commercial sex work.⁶ Young people with disabilities or with Special Education Needs (SEN) within mainstream education are also at an increased risk.⁷

Evidence shows that regular early substance misuse is linked to addiction in adult life and cannabis use at an early stage is associated with mental health issues even after abstaining for at least a year.⁸

Alcohol Concern estimated hospital admissions, A&E attendances and ambulance services call outs due to underage alcohol consumption costs around £19 million per year.⁹ The Department for Education also estimated that the annual cost of crime per young drug and alcohol user to be around £4,000 per person per year in the absence of treatment.¹⁰ The costs of intervention are considerably less.

Key outcomes

- ***To reduce the harm caused to young people where they have used substances (BHCC Children and Young People's Service Outcomes Framework 2011)***
- ***To ensure young people have left treatment in a planned way when their treatment is completed (BHCC Children and Young People's Service Outcomes Framework 2011)***
- ***The resilience of young people, especially those who are vulnerable or at risk of substance misuse, is improved (BHCC Children and Young People's Service Outcomes Framework 2011)***

¹ Brighton & Hove City Council and NHS Brighton and Hove. Young People's Substance misuse (Drugs and Alcohol) Needs Assessment 2011-12.

² Health and Social Care Information Centre. Statistics on Drug Misuse: England, 2011. Available at: <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Good Practice/Statistics on Drug Misuse England 2011v3.pdf>

³ Health and Social Care Information Centre. Smoking drinking and drugs use among young people. 2012. Available at:

<http://www.hscic.gov.uk/catalogue/PUB11334> [Accessed 19/08/2013]

⁴ The National Treatment Agency for Substance Misuse. Substance misuse among young people 2011-12. 2012

⁵ Independent Drugs Commission for Brighton & Hove, 2013. Available at: <http://www.safeinthecity.info/sites/safeinthecity.info/files/sitc/Drugs commission report final.pdf>

⁶ Brighton & Hove City Council. Youth Service Needs Assessment. 2011. Available at: www.bhlis.org/needsassessments

⁷ Brighton & Hove Community Safety, Crime Reduction and Drugs Strategy: 2011-14.

⁸ Van Gastel W, Wigman J, Monshouwer K, Kahn R, van Os J, Boks M, Vollebergh W. Cannabis use and subclinical positive psychotic experiences in early adolescence: findings from a Dutch survey *Addiction* 2012; 107: 381-387; 2012.

⁹ Alcohol Concern. Right time, right place: Alcohol-harm reduction strategies with children and young people. 2010. Available at: <http://www.alcoholconcern.org.uk/assets/files/Publications/Right time right place 23 October 2010.pdf>

¹⁰ Department for Education. Specialist drug and alcohol services for young people – a cost benefit analysis. 2011. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182312/DFE-RR087.pdf

7.2.6 Substance misuse and alcohol (young people)

Impact in Brighton & Hove

In Brighton & Hove, it is estimated that around 3,000 young people aged 10-16 years are vulnerable to substance misuse issues and around 3,500 17-19 year olds will present with problems. Over three quarters (77%) of year 10 and 11 pupils (aged 14-16 years) in the 2012 Safe and Well at School Survey (SAWSS)¹¹ reported never having tried drugs; Of those who had tried drugs, the most frequent was cannabis (80%) and over a third (35%) of these said they take it most days or once a week.

Alcohol remains easily affordable and accessible for many young people and underage consumption of alcohol is a problem. However, 65% of year 7-9 pupils (aged 11-14 years) in the 2012 SAWSS reported having never tried an alcoholic drink (higher than the 59% in 2011). Among those who had drunk, 17% had done so in the last week. Only 21% of older year 10 and 11 pupils had never tried alcohol which was a slight increase compared to 18% in 2011. Furthermore, much higher levels of drinking were reported among older pupils: Of the 79% who had tried alcohol 34% had had an alcoholic drink in the last week and 58% had been drunk in the last month.

Proxy purchasing was a popular way to access alcohol and 36% of year 10 and 11 pupils said they gave someone money to buy alcohol for them; 68% also reported drinking at a friend's house, 36% drank at home with a parent/carer and 32% drank with friends in an open space.

A very small proportion of 14-16 year old pupils reported being given drugs by a parent/carer or family friend (5% of those who have tried drugs) whilst around half (51%) of those from the same age group who drank were given alcohol.

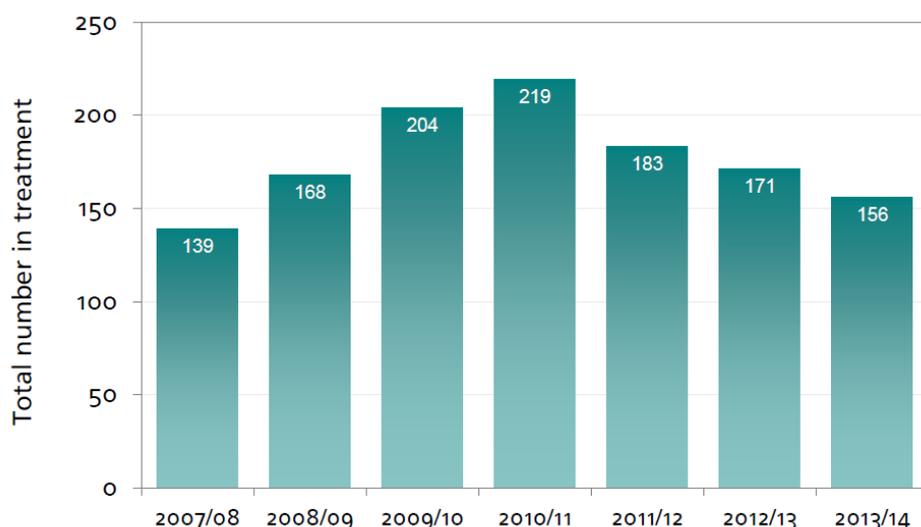
A&E: In 2012/13, there were 176 referrals from A&E to the young people's alcohol worker: 47% were male and 53% were female. Under a half (45%) of young people were supported to address

their issues with alcohol; the rest did not engage with the service. There was a 19% reduction in referrals compared to the previous year when there were 216.

Treatment: During 2012/13, 143 under-18s resident in Brighton & Hove accessed structured treatment and 108 young people started treatment in 2012/13; there is no change compared to 2011/12. Young people in treatment stated as the most frequent primary, secondary or third drugs were cannabis (84%), alcohol (63%), stimulants (36%) and solvents (1%).

Local estimations show a saving of £13,374 for every young person engaging with RU-OK? and completing treatment and reducing their alcohol or drug misuse.¹²

Figure 1: Number of young people entering the specialist substance misuse service, RU-OK?, Brighton & Hove, 2006/07 to 2012/13



Source: National Drug treatment monitoring system

Where we are doing well

There is a strong curriculum programme for drugs and alcohol and the 2012 Safe and Well at School Survey⁷ revealed that 69% of 14-16 year olds said that the drug education they got in school was useful which is in line with the previous year (67%). Three quarters (65%) of 14-16 year olds had heard of the Think Drink Drugs information service, which is an increase from 34% in 2011.

¹¹ Brighton & Hove City Council. Safe and well at school survey. 2012. Available at www.bhlis.org/surveys [Accessed 13/05/2013]

¹² Brighton & Hove City Council. Safer Families Safer Communities Savings Calculation Framework (version 1 26th February 2013)

7.2.6 Substance misuse and alcohol (young people)

Brighton & Hove JSNA 2013

Vulnerable young people are supported in schools and special schools through use of a group work programme (Reflect) which challenges and addresses risk-taking behaviour.

In 2012/13, 84% of young people were successfully discharged from treatment meaning that the young person completed treatment drug free or as an occasional user or treatment completed. This is the same as in the previous year and higher than the national level of 79%.¹³

There is an effective screening programme for the early identification of vulnerable young people at risk of substance misuse who are either engaged with the Youth Offending Service (YOS), living in hostels across the city or who are looked after in care. The programme has been successful in ensuring that young people in need of additional support receive it.

Young people have started to provide feedback on the treatment service, and although this process is in its infancy, current feedback from service users is positive.

Local inequalities

Whilst having tried alcohol is similar for boys (52%) and girls (50%) for 11-16 year olds, girls (42%) aged 14-16 years are more likely than boys (33%) to report 'drinking to get drunk' either often or every time they drink.¹¹

More males access treatment than females: in 2012/13, 61% of young people in treatment were male and 39% were female.¹³ In the SAWSS having tried drugs was similar for boys (22%) and girls (24%). However, young males are more likely than young females to try drugs other than cannabis.¹¹

The young people's population is more ethnically diverse than their older counterparts. During 2012/13 18% of those in treatment were from the Black Minority and Ethnic (BME) community. This compares with the city's BME population (20%).¹⁴

The 2012 SAWSS indicates higher levels of substance misuse in the young lesbian, gay or bisexual (LGB) community and among those unsure

of their sexual orientation compared with the general population of Brighton & Hove.¹¹

Also according to the 2012 Safe and Well at School Survey, young people who drink spirits regularly are twice more likely to be female than male, and females are more likely than males to report drinking to get drunk.¹¹

Predicted future need

Population projections⁶ indicate that the number of young people is expected to increase over the next few years. The increase will impact on the overall need for both prevention and treatment work.

Although the overall number of young people consuming alcohol or taking drugs is decreasing, locally there has been an increase in high volume consumption among a small group of young people.

What we don't know

Research is needed to find out what the needs are for the BME community in terms of substance misuse and alcohol support.

It is not known to what extent young LGBT people or those with disabilities are accessing support or treatment for substance misuse and alcohol issues.

Although substance misuse issues is a local condition for entry into the Safer Families Safer Communities programme, it is not clear yet to what extent this will impact on young people's outcomes.

It is not clear why more young women, compared to men, present for A&E for alcohol issues but the pattern is reversed for engagement in substance misuse treatment.

There is no recent data summarising differences in alcohol or drug use by geographic area.

Key evidence and policy

Smoking, drinking and drug use among young people in England in 2011, NHS Information Centre Young People's Specialist Substance Misuse Treatment – Exploring the Evidence 2009

¹³ National Drug Treatment Monitoring System.

¹⁴ Office for National Statistics. Census 2011.

7.2.6 Substance misuse and alcohol (young people)

Brighton & Hove JSNA 2013

Right Time, Right Place: Alcohol Harm Reduction Strategies with Children and Young People 2010

Positive for Youth: Local Authority guidance on services for young people 2012

Independent Drugs Commission for Brighton & Hove 2013

Recommended future local priorities

1. Strengthen and develop an integrated care pathway which includes all partners and ensures clear thresholds and referral processes.
2. Ensure that early identification screening processes are embedded in schools, youth and Contraception and Sexual Health (CASH) services.
3. Ensure staff have the knowledge, skills and competency to work with young people who use substances.
4. To promote a range of social media and electronic technology for accessing information and advice emphasising on attracting young people from minority groups and those who transition to adult services.
5. To enable young people to undertake activities that are alternatives to the problematic use of alcohol and drugs and reduce their sense of marginalisation.
6. To use real time information about local drug markets and the harms they cause to inform prevention, health and treatment strategies.
7. Reach more parents/carers with key messages about drugs and alcohol awareness.
8. Support primary, secondary and special schools to deliver a quality programme of drug and alcohol education which supports the development of healthy lifestyles.
9. Ensure the voice of young people is heard and they have the opportunity to be involved in the design and development of services; routinely collect feedback from users and use for service development.

Key links to other sections

- Education
- Children in need, safeguarding, child protection and looked after children
- Sexual health (Young people)
- Substance misuse (Adults and older people)
- Alcohol (Adults and older people)

Further information

Substance misuse among young people 2011-12. The National Treatment Agency for Substance Misuse 2012

http://www.nta.nhs.uk/uploads/nta_substance_misuse_among_youth_0910.pdf

Last updated

August 2013

Why is this issue important?

Ensuring young people have the knowledge and skills to make informed decisions about their sexual health is key to enabling them to fulfill their potential and contribute to society. Poor sexual health is linked to social deprivation, health inequality and teenage pregnancy.¹ In comparison to 1990, by 2000: first intercourse was at a younger age; 28% of under 16s reported having sex; a greater proportion of young people had multiple sexual partners; and a greater proportion of men reported having had a same sex partner.²

Sexual health in the UK has deteriorated over the last decade with large increases in many Sexually Transmitted Infections (STIs). Increased diagnoses may be due to greater awareness of STIs and where to get tested, but risky behaviour is still a factor.

Chlamydia is the most common diagnosed bacterial STI and is increasing, especially in young people under 25.³ In 2011/12 there were 1,961,408 chlamydia tests performed in sexual health clinics in England reaching 29% of 15 -24 year olds. The reach was more than twice as high among females (39%) than males (18%). The positive detection rate was 7.3% and the diagnosis rate was 2,089.6 per 100,000. These results indicate an increase in the quantity and quality of screening compared to 2010/11. It has been estimated that this level of screening will have resulted in a fall in prevalence, and that achieving the Public Health Outcomes Framework chlamydia diagnosis rate ($\geq 2,400$) will lead to further falls in prevalence in coming years.

The Department of Health estimated national savings for 2010/11 of £40 million if all Primary Care Trusts ensured 35% of their 15-24 year old population are screened for chlamydia and treated.³

Key outcomes

- **Chlamydia diagnoses (15-24 year olds) (Public Health Outcomes Framework)**

¹National institute for Health and Clinical Excellence. One to one interventions to reduce the transmission of sexually transmitted infections; 2007. <http://publications.nice.org.uk/one-to-one-interventions-to-reduce-the-transmission-of-sexually-transmitted-infections-stis-ph3> [Accessed on 26/08/2012].

² Johnson A, Mercer C, Erens B et al. Sexual behaviour in Britain: partnerships, practices, and HIV risk behaviours. Lancet 2001; 358 (9296):1835-42; 2001.

³Department of Health. Young People's Sexual Health: The National Screening Programme; 2009.

- **The resilience of young people, especially those who are vulnerable or at risk of poor sexual health, is improved (Brighton & Hove City Council Children and Young People's Service Outcomes Framework 2011)**

Impact in Brighton & Hove

The 2012 Safe and Well School Survey (SAWSS) showed that in Brighton & Hove, 80% of year 10 and 11 pupils (aged 14-16 years) had not had sex under the age of 16. The majority (67%) of 14-16 year olds felt that the sex and relationships lessons at school were useful.⁴

The number of young people screened for chlamydia in Brighton & Hove has increased considerably in the last five years (Table 1). The chlamydia positivity rate in Q2 2012/13 was 5.7% and a diagnosis rate of 1,840 per 100,000.

Table 1: Chlamydia screening rates as a percentage of 15-24 year olds – target and actual performance, Brighton & Hove, 2007/08-2012/13 (Q1 and Q2)

Period	15-24 population	Target performance		Actual performance	
		Number	%	Number	%
2007/08	36,600	5,490	15	3,640	10
2008/09	37,414	6,360	17	7,114	19
2009/10	38,400	9,600	25	7,524	20
2010/11	39,360	13,776	35	10,612	27
2011/12	43,174	15,110	35	16,853	39
2012/13 Q1 and Q2	43,685	7,645	17.5	3,536	8.1

Source : National Chlamydia Screening Programme, 2013

Screening data for 2012/13 indicated that chlamydia tests were most frequently carried out by GPs, community Contraception and Sexual Health (CASH) services and in educational settings.⁵

⁴ Brighton & Hove City Council. Safe and well at school survey. 2012. Available at: www.bhlis.org/surveys [Accessed 13/08/2013]

⁵ Public Health England. National Chlamydia Screening Programme Data. 2013. Available at: <http://www.chlamydia-screening.nhs.uk/ps/data.asp> [Accessed 13/08/2013]

In 2012/13 there were 1,197 contacts at school-based health drop-ins most frequently for contraception or a sexual health check. Early identification intervention and targeted support to build resilience in those most at risk has improved across some services.

During January-March 2013, screening levels in young women were around 52% among 13-17 year olds who were looked after and 42% in 16-17 year olds living in hostels.⁶

Where we are doing well

There is improved access to CASH services giving young people access to effective contraception. CASH services have been assessed against 'You're Welcome' criteria for young people's services and developed as appropriate. Feedback from 30 service users was positive and 100% said they were happy with the service, 97% thought the service was very useful with many commenting that it was friendly and helpful.

In the 2012 SAWSS, 45% of 14-16 year olds indicated that they know about chlamydia and where to get tested. Over half (53%) knew where to get condoms free of charge and 87% recognised the C-Card logo for free condoms, with 23% saying they had or would use the service. Overall, since 2011, the awareness of sexual health services has seen a great improvement across the board and confidence in using condoms has continued to rise and is now 88% (compared to 69% in 2010).

There was a 25% increase in the number of pupils using their school-based health drop-in compared to 2011/12 when there were 963 contacts. Around 15% of year 10 and 11 pupils with access to a drop-in used it; 63% said they were aware of the service but had not used it.⁴ Overall awareness was 78% which is a vast improvement compared to the previous year where 55% were aware of their school's drop-in service. Service users (111 in total) have described the service as a place they can get helpful information, free contraception and speak to someone in confidence; 90% stated they would use the service again and 10% were not sure.

There is a locally enhanced service (LES) for young people and their sexual health offered in assigned GP surgeries and pharmacies across the city.

Local inequalities

Among the 15-19 year old population, there were 8,475 chlamydia screens between January and December 2012.⁵ Of these only 30% were for young men.

The 2012 SAWSS results⁴ for 14-16 year-olds indicated that White British young women were more likely to have had sex than Black and Minority Ethnic (BME) young women: 84% of BME young women and 77% of White British young women had not had sex. Young men were also more likely not to be sexually active: 81% of young men compared to 78% young women had not had sex.

Predicted future need

Population projections⁷ suggest that the number of 10-14 year olds will increase slightly in the next few years implying a need for increased sexual health promotion and prevention work with this cohort.

What we don't know

Little is known about the extent to which young people feel CASH services are accessible, particularly those living in deprived areas or from protected groups.

It is not clear how potential changes to youth information, advice and counselling services will affect the accessibility of condoms, chlamydia testing and pregnancy testing across the city.

Key evidence and policy

A framework for Sexual Health Improvement in England (2013)

<https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england>

NICE guidance for preventing sexually transmitted infections and under-18 conceptions (2011).

<http://pathways.nice.org.uk/pathways/preventing-sexually-transmitted-infections-and-under-18-conceptions>

Recommended future local priorities

1. A key priority for 2012/13 is to ensure that early identification screening processes for

⁶ Teenage years are safe and rewarding performance report Q4, 2012/13.

⁷ Brighton & Hove City Council. Youth Service Needs Assessment. 2011. Available at www.bhlis.org/needsassessments

sexual health are embedded in schools and youth services, to a common minimum standard, and are supported by clear care pathways to interventions, CASH services and support.

2. Improve identification of individuals at a high risk of STIs using more opportunities through routine screening with the GP, new patient registrations or during consultations for Emergency Hormonal Contraception.
3. To review how domestic violence, sexual exploitation, coercive behaviour and controlling behaviour is addressed across commissioned CASH services and how needs can be addressed.
4. Ensure the voice of young people is heard and that they have the opportunity to be involved in the design of all services; routinely collect feedback from users and use for service development.
5. Support primary, secondary and special schools (up to the academic age of 18 years) to deliver a quality programme of sex and relationships education which supports the development of healthy and safe relationships.
6. Use effective health promotion as a way of improving young people's knowledge of sexual health and risky behaviour and develop the skills they need to have good sexual health, in particular among male and BME young people.

Key links to other sections

- Teenage pregnancy (children and young people)
- Sexual health (adults and older people)
- Substance misuse and alcohol (young people)

Further information

Brighton & Hove Sexual Health Needs Assessment 2010 www.bhlis.org/needsassessments

Last updated

May 2013

7.2.8 Teenage conceptions and parents Brighton & Hove JSNA 2013

Why is this issue important?

In England, around 29,000 young women aged under 18 become pregnant in 2011 and just under half (49%) of these pregnancies ended in an abortion.¹

The Department for Education (DfE) highlighted that the three risk factors most strongly associated with pregnancy before 18 are: Free School Meal eligibility, persistent absence from school and slower than expected progress between Key Stage 2 and Key Stage 3.² Recent (2013) guidance from the DfE stresses that to make an impact on teenage pregnancy rates, there needs to be a balance between targeted work with high risk groups and universal prevention work. Results from their study indicate that although certain young women are at a much greater risk of conceiving and giving birth as teenagers than others, the majority of young women that conceive do not share these risk factors.

In March 2013, the government extended the definition of domestic violence and abuse to include young people aged 16-17 and included coercive and controlling behaviour.³ The Department of Health also highlighted⁴ that sexual violence, domestic violence, sexual exploitation and abuse can severely affect the mental, sexual and reproductive health of victims. Studies also show an association between domestic violence and pregnancy terminations.

As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS. Teenage pregnancy is estimated to cost around £69 million per year.

The agendas for improving sexual health and reducing teenage pregnancy are closely linked.

Key outcomes

- ***Under 18 conception rate (Public Health Outcomes Framework)***

¹ Office for National Statistics 2013

² Teenage Pregnancy in England. Centre for analysis of Youth Transitions 2013 can be downloaded from:

<http://www.ifs.org.uk/caytpubs/caytreport06.pdf>

³ Brighton & Hove City Council. Responding to 16 and 17 year olds – implications of change in Cross Government definition of Domestic Violence. 30th April 2013

⁴ Department of Health. A framework for sexual health improvement in England, 2013 can be downloaded from:

<https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england>

- ***Sexually active young people are using contraception effectively (BHCC Children and Young People's Service Outcomes Framework 2011)***
- ***Improve children's life chances by improving health outcomes and addressing barriers faced by the most disadvantaged children⁵***

Impact in Brighton & Hove

In 2013, the DfE⁶ reported 127 teenage mothers living locally and there are two or three new under 18 births each month.⁷

The under 18 conception rate is 29.4 per 1,000 women aged 15-17 years meaning around three in 100 young women are conceiving.¹ In 2011 there were 114 conceptions of which 59% lead to an abortion. This is slightly different to the national and regional pictures where the national rate is 30.7 per 1,000 of which 49% end in an abortion and a South East rate of 26.1 per 1,000 of which 52% end in abortion.

In March 2013, 93% of Brighton & Hove's young people in the academic age 16-18 cohort were in education, employment or training (EET) this falls to 30% among teenage mothers.⁶

At the end of April 2013 there were 45 Children in Need (CIN) social care cases where the parent was a teenager: in five of these cases both the parent and the child were CIN; 19% of the total cohort of under ones who were CIN (153 babies) were children of teenage mothers. The need for social care among families of teenage parents and associated costs can be very high: 13 teenage mothers whose children entered the care system in 2010 or 2011 cost the local authority £180,000.

The Family Nurse Partnership (FNP) is a structured and intensive evidence based support programme for teenage parents. It was introduced in October 2012 and to-date has 33 young parents enrolled with 17 more in active recruitment. The programme aims to improve health for the mother and baby, parenting skills, economic stability and life course.

⁵ A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives, Department for Work and Pensions Department for Education, 2011

⁶ Department for Education Local Authority At Risk Tables March 2013

⁷ Brighton and Sussex University Hospitals Data, December 2013

7.2.8 Teenage conceptions and parents Brighton & Hove JSNA 2013

The Joint Commissioning Strategy for Housing and Support for Young People aged 16-25 (2013) recommends improving prevention, creating a young a Housing a support pathway for young people and teenage parent services, and joint commissioning to design the future shape of services to meet needs . This will include looking at the housing and support needs of teenage parents in relation to the services available.⁸

Local estimations show a saving of £1,686 for every young woman at risk of pregnancy who, following an intense intervention, avoids this.⁹

Where we are doing well

Between 1998 and 2011, the under-18 conception rate fell from 48.1 to 29.4 per 1,000 women aged 15-17 (Figure 1). This is a statistically significant 39% reduction which is slightly higher than the 34% seen nationally.

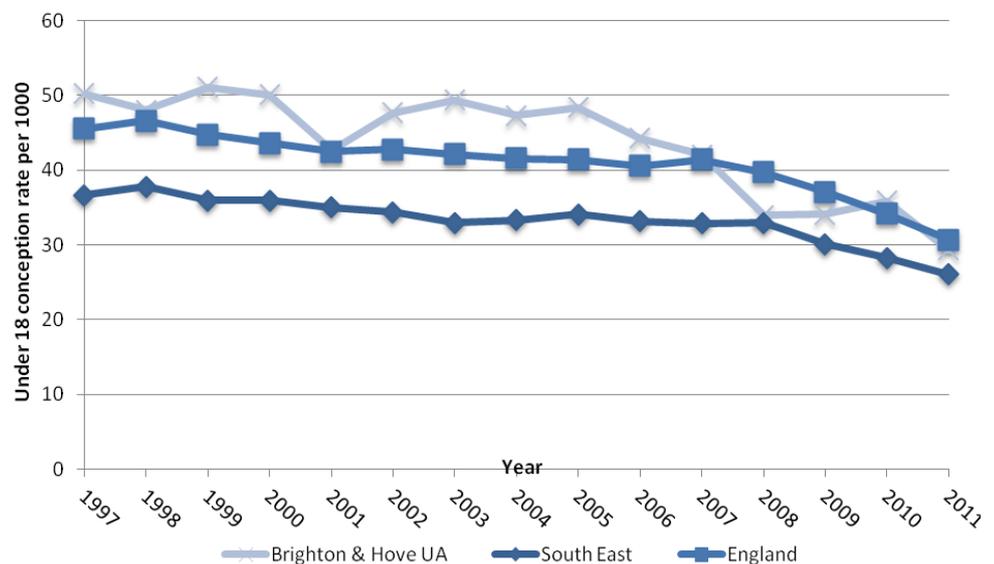
There has been a rapid decline in the under-18 termination rate since the 2007 peak of 27.5 per 1,000 15-17 year old women, to an all-time low of 17.3 in 2011. Second termination rates have also dropped from 12% in 2010 to 2% in 2011.

Thirteen out of twenty one wards have experienced overall rate reductions between 2004/06 and 2008/10 these are Moulsecomb and Bevendean, Westbourne, Brunswick and Adelaide, Woodingdean, Goldsmid, St. Peter's and North Laine, Hollingbury and Stanmer, Wish, Hangleton and Knoll, Patcham, Regency, Queen's Park and South Portslade.

There has been an improvement in young people's resilience through giving them knowledge and skills to experience positive relationships and good sexual health through the delivery of targeted group work in schools or one-to-one support. In 2012, an evaluation¹⁰ of 256 vulnerable young

women who engaged with the Targeted Teenage Pregnancy (TTP) service (between April 2011 and September 2012) showed that nine out of ten (91%) demonstrated improved outcomes. In terms of vulnerabilities, 37% reported mental health problems and 35% reported domestic violence and sexual exploitation. Feedback from 10 young people indicated that the service had increased their knowledge and confidence in accessing services and using contraception, as well as helping them to keep safe and look after their sexual health needs.

Figure 1: Under-18 conception rate, 1998-2011



Source: Office for National Statistics 2013

Access to Contraception and Sexual Health (CASH) services is constantly developing so that young people have the use of effective contraception when they need it. Targeted prevention workers have successfully engaged with the most vulnerable and improved their sexual health outcomes: the 2012 evaluation showed that 15% of clients were using Long Acting Reversible Contraception (LARC) at the initial engagement, this rose to 42% after engagement.¹⁰

In 2012/13, a total of 125 young women were referred for post-termination contraception support. Of the 94% (118 women) who took up the service: 47% were not using any contraception and only 1% were using LARC; after engagement, 68% were fitted with LARC, 30% were using Oral Contraception and the remainder were using condoms.

⁸ Brighton & Hove City Council. Housing and support for young people joint commissioning strategy 2013

⁹ Brighton & Hove City Council. Safer Families Safer Communities Savings Calculation Framework (version 1 26th February 2013)

¹⁰ Targeted Teenage Pregnancy Impact Report 2012

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In total, 138 young women who received support from the post-termination counselling service during 2012/13 demonstrated overall improvements in their sexual health and relationships.

Schools support has improved to develop Healthy Schools outcomes related to risk-taking behaviour and ensuring schools deliver a robust personal, social health and economic (PSHE) curriculum.

There has been success in supporting school-aged mothers to stay in education, complete qualifications and access higher education, employment or training.

Local inequalities

The city's hot spot wards - those with under-18 conception rates over 58.4 per 1,000 young women aged 15-17 years for 2008 to 2010 - are East Brighton (63.0 per 1,000, 43 conceptions), Hanover and Elm Grove (60.0 per 1,000, 34 conceptions), Queen's Park (59.0 per 1,000, 22 conceptions); and Central Hove (90.0 per 1,000, 11 conceptions). The 2008 to 2010 rate for the city was 36.5 per 1,000 females aged 15-17 years: a total of 443 conceptions across the three years.

Those who more likely to engage in sexual activity at an earlier age tend to be more vulnerable due to their circumstances e.g. being bullied, identifying as lesbian, gay or bisexual or using drugs and alcohol.¹¹

Predicted future need

Whilst there has been a fall in the under 18 conception rate in recent years, it appears that those women who do conceive are increasingly likely to have an abortion which indicates that more work might be needed to support these young women. This highlights a need to make more of opportunities for early identification and striking a balance between delivering targeted prevention work and a strong sex and relationships curriculum.

What we don't know

Little is known about under-18 conception rates among different vulnerable groups such as those from the lesbian, gay, bisexual and transgender communities or those who have disabilities.

Although, Black and Minority Ethnic data is available, it is not used to its full potential.

It is not yet clear to what extent the Safer Families Safer Communities programme will impact on young people's outcomes and whether the model of delivery could be mirrored for working with families with multiple needs where teenage pregnancy or teenage parenthood is a contributing factor.

Key evidence and policy

A framework for sexual health improvement in England 2013

<https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england>

NICE guidance for preventing sexually transmitted infections and under-18 conceptions.

<http://pathways.nice.org.uk/pathways/preventing-sexually-transmitted-infections-and-under-18-conceptions>

Recommended future local priorities

1. Continue to develop effective early identification and ongoing support thorough a lead professional. This should be underpinned by a multiagency care plan which works in a team around the family.
2. Build capacity of the Community and Voluntary Sector to support early identification and intervention for sexual health.
3. To ensure that there is equity of service for young people from protected and vulnerable groups.
4. To review how domestic violence, sexual exploitation, coercive behaviour and controlling behaviour is addressed across commissioned CASH services and how needs can be addressed.
5. Continue to explore family interventions which promote strengths, build resilience, reduce family breakdown and promote positive parenting.
6. To review the extent to which engagement in development programmes such as the FNP constitutes as EET activities and how they can be accredited.

¹¹ Brighton & Hove City Council. Safe and well at school survey. 2012

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7. Ensure teenage parents know their housing options to prevent homelessness and reduce the number of young families needing support from social care or housing support.
8. Ensure the voice of young people is heard and that they have the opportunity to be involved in the design and development of services.

Key links to other sections

- Sexual health (young people)
- Substance misuse and alcohol (young people)
- Education
- Not in education, employment or training

Further information

Brighton & Hove Sexual Health Needs Assessment 2010 www.bhlis.org/needsassessments

Services for Young People: Joint Commissioning Strategy 2012 [http://www.brighton-hove.gov.uk/downloads/bhcc/children/young_peoples_services_downloads/Services for Young People Joint Commissioning Strategy 2012 to 2015.doc](http://www.brighton-hove.gov.uk/downloads/bhcc/children/young_peoples_services_downloads/Services_for_Young_People_Joint_Commissioning_Strategy_2012_to_2015.doc)

Last updated

May 2013

7.2.9 Children and young people with disabilities and complex health needs

Why is this issue important?

The 2010 Equality Act defines disability as “a physical or mental impairment that has a ‘substantial’ (completing a task takes much longer than it usually would) and ‘long-term’ (12 months or more) negative effect on ability to do normal daily activities”.¹ Children with complex health needs are defined as either children with severe and multiple impairments or children who require support from a complex network of agencies.²

National estimates suggest that around 6% of those aged 0-19 have a disability.³ This equates to 762,600 0-19 year olds in England or 167,400 in the South East.⁴ Currently 19.8% of school aged children are identified as having Special Educational Needs (SEN).⁵ National research suggests approximately 1 in 100 children have autism spectrum condition (ASC)⁶ and an estimated 410,000 children have a learning disability.⁷

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.⁸

Compared with their peers, children and young people who are disabled or who have a Statement of SEN (2.8% of the pupil population⁹) are considerably less likely to achieve well at school and are four times less likely to participate in

higher education. Pupils with SEN are more than twice as likely to be eligible for free school meals as their peers (30% compared to 14%)⁵ and pupils at School Action Plus are 20 times more likely to receive a permanent exclusion than pupils with no identified SEN. Looked after children are three-and-a-half times more likely to have SEN compared with all children.¹⁰

Nationally, the number of children whose statement lists autism as a primary need has increased by 5% since 2011, and for School Action Plus² autism as a primary need has increased by 12%.⁷

National estimates suggest that over 50% of children who have a disability live on or near the margins of poverty.¹¹

National estimates suggest that 35-40% of children and young people with a learning disability are likely to have a mental health issue.¹²

Among those needing specially adapted housing, disabled children are least likely to be living in suitable housing compared to all other age groups of disabled people, with less than half of disabled children (47%) living in suitable accommodation.¹³

National research identifies transport as a key issue, particularly in relation to extended services through the school system (getting to and from school and accessing clubs and leisure activities) with research showing 10% disabled young people believe transport is the greatest barrier to participation in sports events.¹⁴ This is particularly pertinent due to the increase in the proportion of children who are overweight or obese, and the decrease of children participating in physical activity over the last two decades.

¹ Great Britain. Equality Act 2010. Chapter 15. London: stationary office.

² Centre for Excellence and Outcomes in Children and Young People's Services (2009) Disability: Progress map summary. June 2009. Improving the wellbeing of disabled children and young people through improving access to positive and inclusive activities. Department for Education

³ Department of Work and Pensions, Office for Disability Issues: An overview of official UK disability statistics from the Office for Disability Issues based on data from Family Resources Survey 2010/11.

<http://odi.dwp.gov.uk/disability-statistics-and-research/disability-facts-and-figures.php#3> [accessed on 22/05/2013]

⁴ Based on ONS national and sub-national Mid Year population estimates 2011 of 12,710,562 0-19 year olds in England and 2,079,025 0-19 year olds in the South East

⁵ Department for Education (17th October 2012) Statistics Children with special educational needs: an analysis - 2012

⁶ Baird G, Simonoff E, Pickles A, Chandler S, Loucas T, Meldrum D, et al. Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP). *Lancet* 2006; 368: 210-5

⁷ Emerson and Robertson (2011) The Estimated Prevalence of Visual Impairment among People with Learning Disabilities in the UK. Supported by the Department of Health

⁸ Marmot, M. (2010). Fair society, healthy lives. The Marmot review Executive Summary. London: The Marmot Review.

⁹ Department for Education (2011) Special Educational Needs in England.

¹⁰ Department for Education. Support and aspiration: A new approach to special educational needs and disability (SEN Green Paper); 2011.

<https://www.education.gov.uk/publications/standard/publicationDetail/Page1/CM%208027> [Accessed on 26/08/2012].

¹¹ Preston, G. with Robertson, M. (2006), Out of Reach: benefits for disabled children, London: Contact a Family/Child Poverty Action Group

¹² Emerson, E. (2003) Prevalence of psychiatric disorders in children and adolescents with and without intellectual disability. *Journal of Intellectual Disability Research*, 47, 51 -58.

¹³ Department of Communities and Local Government (2007) Housing in England 2005/06: a report principally from the Survey of English Housing 2005/06. London: DCLG.

¹⁴ Department for Children, Schools and Families (2007) A transition guide for all services: key information for professionals about the transition process for disabled young people.

7.2.9 Children and young people with disabilities and complex health needs

In addition to the needs of children and young people with disabilities there are wider implications for those caring for these children. The unpaid carer population saves the UK an estimated £87 billion a year.¹⁵

Key outcomes

The Brighton & Hove Child Development and Disability Strategy 2011 published a series of high level outcomes with the following commitments:

- ***Parent carers will have easy access to the full range of opportunities and choices to maintain a good quality of life, having a life of their own, having a caring system on their side and being recognised as expert care partners.***
- ***Children and young people with disabilities will receive services that meet their needs and aspirations***

Impact in Brighton & Hove

Application of national estimates of the prevalence of child disability to Brighton & Hove suggests a prevalence of between 3% (1,767) and 5.4% (3,181) of children and young people with disabilities in the city.¹⁶ However, literature suggests approximations are underestimates as not all children with disabilities and complex health needs are registered for Disability Living Allowance (DLA) or SEN. DLA provides a contribution towards the extra disability-related costs of severely disabled people under the age of 65 years.

Each local authority has a statutory responsibility to hold a register of disabled children. In Brighton & Hove this is The Compass database administered by Amaze, a local parent support CVS organisation. Registration on the Compass is voluntary and there has been a steady increase in the number of registered children with up-to-date records¹⁷ from 1,266 in 2008/09 to 1,526 in 2012/13. The associated incentive leisure/sporting card means

the voluntary register has a much higher sign-up than most local authority registers.

Families self-report the needs of their child and the five highest reported groups of children on the Compass are identified as having moderate mobility problems (29.3%) moderate learning difficulties (26.9%), severe challenging behaviour (24.4%), moderate challenging behaviour (22.9%) and severe learning difficulties (19.5%). Children can have more than one of the needs above.¹⁸

The most prevalent formal diagnoses on the Compass are: speech and language difficulties (462), Autism Spectrum Condition (421), moderate learning difficulties (410) and emotional and behavioural difficulties (348).¹⁶

In Brighton & Hove 1,420 under-16s were claiming DLA in November 2012 (10% of DLA claimants).¹⁹ Amaze data indicates that of the families registered on the Compass that were supported by the charity's DLA service in 2011/12 47% live entirely on benefits.²⁰ Of those parents and carers using the Amaze DLA service in 2012/13:

- 27% have more than one disabled child;
- 44% are lone parent families¹⁸ with local research indicating that 70% of all lone parent households in the city are out of work.²¹
- 18% have one or more parents with mental health problems.¹⁸
- A quarter (24%) of parents caring for disabled children reported their housing is inadequate to meet their disabled child's needs²⁰

The number of school age pupils with statements of special educational need have reduced slightly over the last few years, from 1,065 in 2009 (3.5% of the school population) to 975 in 2012 (3.3%). Whilst this remains higher than the England average (2.8% of the school population) it needs to be noted that Brighton & Hove includes a proportionately high number of pupils in Brighton & Hove schools, in particular special schools, who have Statements from neighbouring authorities.²²

¹⁵ Buckner, L., and Yeandle, S. (2007) Valuing Carers – calculating the value of unpaid care, Carers UK. University of Leeds

¹⁶ Thomas Coram Research Unit and Institute of Education, University of London. Disabled Children: Numbers, Characteristics and Local Service Provision. Report to DCSF, 2008. Based on Mid Year population estimates 2011 of 58,900 0-19 year olds in Brighton & Hove

¹⁷ Total numbers on the database were 1,480 in 2008/09 and 1,908 in 2012/13 (figures in the main text are those children and young people with records updated in the last two years).

¹⁸ Amaze, Compass Database accessed 29th May 2013.

¹⁹ Department for Work and Pensions.

²⁰ Amaze, Compass Database accessed 29th May 2013.

²¹ Amaze survey 2011.

²² Brighton & Hove Council (2012) Special Educational Needs Annual Report 2011/12 March 2013

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Of those with statements, the most prevalent identified needs in 2012 were: Autistic Spectrum Condition (21%), Speech, language and

Table 1: Percentage of pupils with statements of SEN or at School Action Plus by type of need

	%
Speech, Language & Communications Needs	25.6
Behaviour, Emotional & Social Difficulties	20.8
Specific Learning Difficulty	21.2
Moderate Learning Difficulty	9.2
Autistic Spectrum Disorder	6.8
Other Difficulty/Disability	3.9
Severe Learning Difficulty	3.9
Physical Disability	3.3
Hearing Impairment	2.8
Visual Impairment	1.3
Profound & Multiple Learning Difficulty	1.1
Multi-Sensory Impairment	0
Total	100

communication difficulties (17%) and Behaviour, Emotional and Social Difficulties (14%).²³

Mascot are a parent-led voluntary group with over 130 members supporting families affected by Autistic Spectrum Condition (ASC) in Brighton & Hove. A 2012 Mascot survey of 77 local parents of young people with ASC looked at services and identified difficulties in: obtaining a statement (44%); the communication approach and strategy in mainstream schools (49%) and bullying of the young person (50%). There was also a recognised difficulty with obtaining an initial diagnosis (44%). However, parents reported a good/very good quality of teaching (72%) and teaching staff (75%) in schools. Just over half of this cohort reported that their family had a good/very good quality of life.²⁴

Analysis by the Department for Education on January 2013 school census data shows that there were 3,674 pupils with an identified need (a Statement or in the School Action Plus scheme).²⁵

²³ Brighton & Hove City Council (June 2013) SEN resource manager

²⁴ Mascot (2013) Mascot Survey of services for children with an Autistic Spectrum Condition in Brighton & Hove Oct-Dec 2012. 19th March 2013

²⁵ Brighton & Hove School data Service (2013) School Census Trend Report Summary Spring (January) 2013

This amounts to 24.8% of the school population, compared to the national figure of 19.8%.²⁶ Table 1 shows the percentage of pupils in this cohort by type of need identified. According to the Census, the percentage of children with an identified need of specific learning difficulty in the city (21.2%) is twice the national level (10.8%).

Source: 2013 Schools Census, Brighton & Hove

In 2012 34.3% of pupils with SEN were also eligible for Free School Meals (FSM)²⁷

The 2009 Mapping of youth activity for young people with disabilities in the city found the need for greater flexibility with transport to and from school clubs to be one of the main challenges for service provision for children with disabilities.²⁸ In 2010, 23% of children on the Compass received transport services to school.²⁹ Transport accessibility, availability and expense are common themes in local feedback from children and young people and their carers.³⁰

Where we are doing well

The Child Development and Disability Service offers an integrated care pathway involving health, education and social care professionals in the assessment and management of children with disabilities.

The City Council residential care settings consistently achieve Outstanding Ofsted inspection ratings.

Community and Voluntary sector providers of short break services are of consistent high quality and are fully engaged in service developments.

A parent carer partnership charter has been developed by parents and service managers and is being used to 'star rate' the effectiveness of services at engaging with families.

Parent carers and other stakeholders are represented on all strategic groups and play an active part in the development of services both

²⁶ <http://www.education.gov.uk/rsgateway/DB/STR/d001092/index.shtml>

²⁷ Brighton & Hove Council (2012) Special Educational Needs Annual Report 2011/12 March 2013

²⁸ YMCA Sussex Central (2009) Mapping Research of Youth Activity for Young People with Disabilities in Brighton & Hove May 2009, commissioned by Brighton & Hove Children and Young People's Trust

²⁹ Amaze (2010) Compass database received and desired services

³⁰ Brighton & Hove City Council and NHS Brighton and Hove (2010) JSNA Children and Young people with disabilities and complex health needs

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strategically and operationally. For example, the Disabled Children’s and SEN Strategic Partnership Boards bring together all key stakeholders and parent carer representatives to review strategic developments across education, health and social care.

In line with national guidance, there is an Individual budget pilot underway.

Amaze drafted 309 new or appeal DLA claims in 2012/13 as part of their Disability Living Allowance project, an increase of 9.6% on the previous year. They calculate the annual income generated from this project to be in excess of £2.3million, with a further £1million through passported benefits such as Carers Allowance.³¹

Figure 1: Children and young people aged 0-20 years registered on the Compass Database (rate per 1,000)

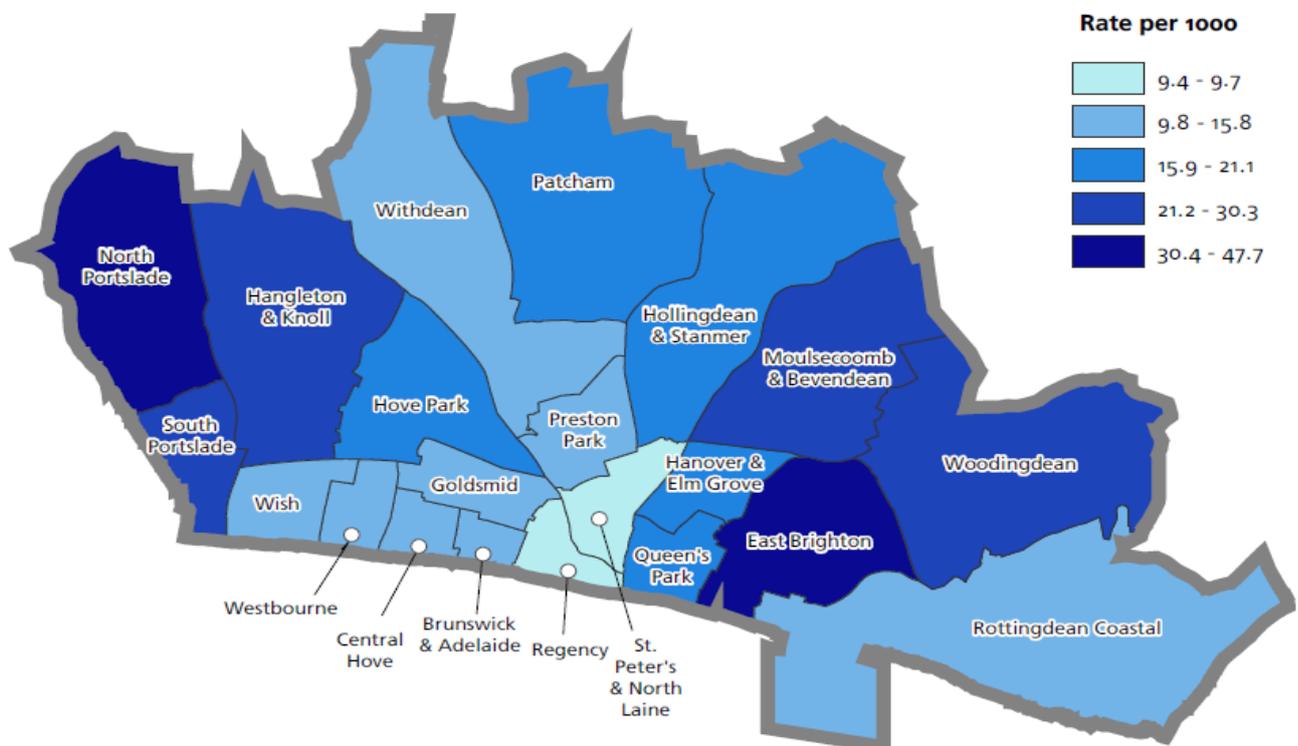
Local inequalities

Of the 1,526 people registered on the Compass in 2012/13, the largest proportion (46%) are aged 11-16. However, over the last five years the largest increase in registration has been in the under fives (11.5% in 2008/09 to 12.7% in 2012/13).³²

Extrapolation of national prevalence rates to Brighton & Hove suggest that children aged zero to four years display lower prevalence of mild disability than children in the higher age groups, yet display a higher estimated prevalence of severe disability.³³

Over two thirds of children and young people with disabilities are male (68%), and 15% are from a Black or Minority Ethnic group.³⁴

In support of national findings, the greatest rates of those on the Compass are in more deprived areas of the city (Figure 1).



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³¹ Amaze. Annual Report 2011. 2011. Available at <http://www.amazebrighton.org.uk/resources/publications/reports/> [Accessed on 26/08/2012]

³² Amaze. Compass statistics. 2012/13

³³ ONS (2004) The health of children and young people Prevalence rates extrapolated locally using ONS 2011 population estimates. Chimat Service Snapshot - Disability Selection: Brighton & Hove Geographies: Top level local authority. [Accessed 28/05/13]

³⁴ Amaze. Compass statistics. 2012/13

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Predicted future need

The Institute for Public Care Projecting Adult Needs and Service Information System (PANSI) is designed to look at how demography and certain conditions can impact on populations aged 18-64 years. Whilst there is no system for those under the age of 18, examination of PANSI projections for 18-24 year olds in the city help indicate the level of need of this cohort when they are in Children's Services. The evidence suggests that prevalence of many types of disability for those aged 18-24 will remain on or around current levels between 2012 and 2020. However predictions are not yet available beyond 2020 due to ongoing incorporation of 2011 Census population updates, so indication of projected impact on children's services is limited.

What we don't know

The Compass is the primary data source for children with disabilities but as it is a voluntary database it does not contain full information regarding local equalities groups. There is no single reporting mechanism for disabled children. New national legislation governing disabled children – the Children and Families Bill – will require local authorities to plan services for disabled children from the age of 0-25. The Compass only records young people to the age of 19 and the Council is considering how this register can be extended.

Local health data systems do not capture disability data in a way that helps predict future patterns of referral.

Key evidence and policy

The local 2011 Child Development and Disability Strategy, took account of, amongst others:

- The Disability Discrimination Act (DDA) 2005
- The Children Act 2004
- SEN Code of Practice revised 2013
- Equalities Act 2010
- The Children and Young Persons Act 2008 : the new short breaks duty
- SEN green paper; Support and aspiration: A new approach to special educational needs and disability.

Recommended future local priorities

1. Implementation of the Individual budgets pilot for social care short breaks and maintaining high quality services for those families not able or choosing an individual budget
2. Development of the single Education, Health and Care plan (EHCP) as per the SEN green paper ensuring plans are outcomes focused and child-centred and that services are jointly planned and commissioned.
3. Enhancement of early intervention services to prevent families reaching crisis point.
4. Development of parent information and support services to increase their resilience and wellbeing.

Key links to other sections

- Child poverty
- Emotional health and wellbeing (children and young people)
- Carers

Further information

Brighton & Hove Children and Young People with disabilities and/or complex health needs JSNA 2010
www.bhlis.org/needsassessments

www.bhlis.org/children_and_young_people/

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Why is this issue important?

Obesity rates in England have tripled in the past three decades, and England now has the highest levels of obesity in Europe and the 9th highest in the world.¹ Lifestyle changes resulting in higher calorie diets and lower levels of physical activity are key contributors to the expanding population.

The most common method of measuring obesity is the Body Mass Index (BMI). BMI is calculated by dividing body weight (kilograms) by height (metres) squared. An adult BMI of between 25 and 29.9 is classified as overweight and a BMI of 30 or over is classified as obese. In 2010, 42% of adults living in the UK were classified as overweight (BMI \geq 25) and a further 24% obese (BMI \geq 30).² Approximately 3% of adults were morbidly obese (BMI \geq 40).³

Fewer people each year are classed as having a healthy weight, although levels of overweight have not increased substantially since 1993.⁴ This suggests that as many people are moving from a healthy weight to overweight as are moving from overweight to obesity, and that everyone is getting bigger—not just those at the top of the spectrum.⁵

Figure 1 illustrates recent data from the Health Survey for England which show that the average waist circumference of both men and women increased significantly between 1993 and 2009, as did the proportion of individuals whose waist circumference was above healthy levels.

Obesity is linked to many health issues, such as Type II diabetes and heart disease, which reduce life expectancy and significantly burden the health care system and the economy. It is estimated that

poor diet-related ill-health cost the NHS in the UK £5.8 billion per annum.⁶

Figure 1: Adult (16+) mean and Raised Waist Circumference (RWC)* 1993 to 2009



*RWC = >102cm in men and >88cm in women
Source: Health Survey for England

Key outcomes

- **Excess weight in adults - proportion of adults classified as overweight or obese (Public Health Outcomes Framework)**

Impact in Brighton & Hove

National data suggest that in Brighton & Hove, 20% of adults are obese, and an estimated 3% are either morbidly or very morbidly obese (Table 1).⁷

The annual direct cost of obesity to NHS Brighton & Hove is estimated to be £78.1 million.⁸

In the local Health Counts survey 2012, 14% of respondents were classified as obese; this is considerably lower than the national estimates for the city.⁹ There was a significant increase in obesity prevalence from 2003 (10%) to 2012, but no significant change in the prevalence of overweight (33% vs. 30%), healthy weight (54% vs. 53%) or underweight (3% in both surveys).

There was no a significant difference, between the two surveys, in those whose self perception was

¹National Obesity Observatory 2010. Epidemiology of Adult Obesity. Available from: <http://www.noo.org.uk> [Accessed on 26/08/2012].

² Government Office for Science 2007. Tackling obesity: future choices – project report. London: Department for Innovation, Universities and Skills.

³ National Obesity Observatory 2010. *About Morbid Obesity*. Available from: <http://www.noo.org.uk> [Accessed on 26/08/2012].

⁴ National Obesity Observatory 2010. Epidemiology of Adult Obesity. Available from: <http://www.noo.org.uk> [Accessed on 26/08/2012].

⁵ Rutter, H 2012. Setting the context: Obesity in the UK. Transcript from Westminster Food and Nutrition Forum on Obesity. London, 7th February 2012.

⁶ Scarborough P, Bhatnagar P, Wickramasinghe KK, Allender S, Foster C, Rayner M. 2011. The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006-07 NHS costs. *Journal of Public Health Dec*;33(4):527-35.

⁷ Health Profiles 2008. Health Summary for Brighton and Hove. Available from: www.healthprofiles.info [Accessed on 26/08/2012].

⁸ Foresight 2007. Tackling Obesities: Future Choices (2nd edition). Government Office for Science. London.

⁹ NHS Brighton & Hove. Health Counts. 2012. Available at <http://www.bhlls.org/surveys>

7.3.2 Healthy weight (adults)

that they are a little or very overweight. However, 48% of people still think they are overweight to some degree, according to the 2012 results.

A series of four focus groups was held in February 2013 as part of a qualitative evaluation of the Brighton & Hove Food Partnership's (FP) adult weight management group and 1:1 programmes. These groups highlighted the high and varying level of support needs of attendees with weight management issues, both during and after, attending a group or 1:1 programme. This level of need was much higher than was previously appreciated.

Table 1: Estimated number and percentage of local population by BMI category and risk of obesity-related co morbidities¹⁰

BMI (Weight Category)	Risk of related co morbidity	% of local population	Estimated number
BMI (25-29) Overweight	Increased	30-40%	64,200-85,600
BMI(≥30) Obese	Moderate	20%	42,800
BMI (≥40) Morbidly obese	Severe	3%	6,420
BMI (≥50) Very morbidly obese	Very Severe	<1%	220

Source: Health Policy Support Unit

Where we are doing well

Rates of obesity in Brighton & Hove (20%) are lower compared with the England average (24%) and the South East Coast average (25%).¹¹

Healthy weight and good nutrition has been identified as one of the five priorities in the cities

¹⁰ South East Coast Primary Care Trusts. Policy Review and Recommendation Process: Bariatric surgery for obesity and related co-morbidities (Final Report). Health Policy Support Unit; 2011.

¹¹ Department of Health. Health Survey for England (Chapter 10): Adult anthropometric measures, overweight and obesity; 2010. Available from www.dh.gov.uk/publications

draft Health and Wellbeing Strategy and an Obesity Programme Board has been set up to oversee the implementation of the Obesity Programme Action Plan.

Brighton & Hove City Council uses evidence-based commissioning and nationally endorsed evaluation mechanisms to inform local programmes in a range of settings which include clinical guidance, 1:1 support, exercise subsidies, community outreach, group programmes, and/or self-management aids.

In 2006 Brighton & Hove was the first city in the UK to publish a food strategy. In April 2012, the city's refreshed food strategy was launched. This includes a range of measures supporting healthy weight and nutrition.¹²

Local inequalities

Locally men are significantly less likely to be a healthy weight than women, and, since local underweight prevalence is 3% for males and females, this therefore means men are more likely to be overweight or obese.⁹ Nationally, women are more likely to be morbidly obese, although the rate of increase of morbid obesity is higher for men.¹³

The percentage of males and females of a healthy weight falls with age up until 65-74 years but then rises in those aged 75 years or over. Men are less likely to be a healthy weight in all age groups.⁹

Local data found that the prevalence of healthy weight amongst White British and BME populations was 52% and 59% respectively, this difference was not statistically significant.⁹ National findings suggest that compared to the general population, obesity prevalence is lower among Black African, Indian, or Pakistani men, and lowest in Bangladeshi and Chinese communities. Among women, obesity prevalence appears to be higher for Black African, Black Caribbean and Pakistani women than for women in the general population and lower for women from the Chinese ethnic group.¹⁴

Although there is an association between obesity and socioeconomic status, with higher levels of obesity among more deprived groups, the

¹² Brighton and Hove Food Partnership. Spade to Spoon: Digging Deeper. 2012. Available at: <http://www.bhfood.org.uk/food-strategy>

¹³ NOO. About Morbid Obesity. 2010 www.noo.org.uk/NOO_about_obesity/morbid_obesity.

¹⁴ NOO: Obesity and ethnicity 2011. http://www.noo.org.uk/uploads/doc/vid_9851_Obesity_ethnicity.pdf

7.3.2 Healthy weight (adults)

prevalence of obesity in England has increased across all classes between 1997 and 2009.¹⁵ In Brighton and Hove individuals in the most deprived areas are 1.7 times more likely to be obese than those in the most affluent.⁹

Predicted future need

Projections suggest that if significant impact is not made soon, 60% of men and 50% of women will be obese by 2050.⁸ The implications of such high rates of obesity for both the health system and the economy are alarming. Similarly, if current trends continue, the cost of obesity to the NHS in Brighton & Hove is expected to rise to £83.5 million by 2015.

What we don't know

BMI thresholds were designed for White populations so may not be appropriate for BME groups, and the relationship between ethnicity and obesity may not be wholly understood.

There is a lack of qualitative data to understand the impact of obesity on individuals living in Brighton & Hove. Future research should use qualitative and community-based research methods to understand the voice of local individuals regarding obesity.

Key evidence and policy

- Health Survey for England 2011: England 2011 Statistics on Obesity, Physical Activity and Diet
- NICE 2006. CG43: Clinical Guidance on Obesity. <http://www.nice.org.uk/CG43>
- NICE PH42 2012: Obesity- Working with Local Communities <http://guidance.nice.org.uk/PH42/Guidance/pdf/English>
- NICE (expected 2014): Overweight and obese adults - lifestyle weight management
- NICE (expected 2014): Overweight and obese children – lifestyle weight management
- Department of Health 2011. Healthy Lives, Healthy People: A Call to Action on Obesity in England. <http://www.dh.gov.uk>

Recommended future local priorities

The Healthy Weight Programme Board oversees the strategic delivery of a Healthy Weight Action Plan. Priority actions include:

1. Re-procure community weight management services to improve provision and access to services for adults and older people.
2. Focus on prevention through a life-course approach, and which recognises specific risk periods (e.g maternity and smoking cessation).
3. Develop a comprehensive adult weight management care pathway from Primary Care settings into appropriate weight management services, with clear referral procedures and mechanisms for evaluation, and increase point-of-care obesity interventions.
4. Transform local environments to be more conducive to health, and to enable individuals to make healthier choices more often.
5. Improve the collection, analysis, and dissemination of local level data by assisting all service providers to implement the National Obesity Observatory Evaluation Framework and to manage obesity databases.

Key links to other sections

- Healthy weight (Children and young people)
- Physical activity (Children and young people)
- Physical activity (Adults and older people)
- Transport and active travel
- Green and open spaces
- Good nutrition and food poverty
- Maternal and infant health

Further information

Brighton & Hove Healthy Weight Strategy www.bhlis.org

National Obesity Observatory www.noo.org

Last updated

May 2013

¹⁵ NOO: Adult obesity and socioeconomic status. 2012 http://www.noo.org.uk/uploads/doc/vid_16966_AdultSocioeconSep2012.pdf

7.3.3 Physical activity (Adults)

Why is this issue important?

Emerging evidence shows an association between sedentary behaviour and overweight and obesity, with some research also suggesting that sedentary behaviour is independently associated with all-cause mortality, type 2 diabetes, some types of cancer and metabolic dysfunction. While increasing the activity levels of all adults is important, targeting those adults who are significantly inactive (i.e. engaging in less than 30 minutes of activity per week) will produce the greatest reduction in chronic disease.¹

In England, only 21% of adults are doing enough regular physical activity to benefit their health; 30% do no 30 minute sessions of activity in an average month. Men generally do more physical activity than women but for both men and women levels of physical activity decrease with age.²

The estimated annual cost of physical inactivity to the NHS alone is estimated to be £0.9 billion. This would be much higher if taking into account indirect costs to the health service.³

Key outcomes

- **Proportion of physically active and inactive adults (Public Health Outcomes Framework)**
- **Utilisation of outdoor space for exercise/health reasons (Public Health Outcomes Framework)**

Impact in Brighton & Hove

Participation rates in physical activity for adults in Brighton & Hove (sport, recreational cycling and walking, cycling and walking for active travel purposes, dance and gardening) are as follows:

- 23% did no 30 minute sessions in the previous 28 days
- 62% did four or more 30 minute sessions in the previous 28 days (once a week)²
- An estimated 46 deaths per year, from all cause mortality, are preventable if we could get 50% of the 40 – 79 years of age Brighton & Hove

population physically active at recommended levels.⁴

- 16% of adults in Brighton & Hove participate in at least three 30 minute sessions of sport per week and 34% participate in at least one session per week.²
- A local survey in 2011 showed that lack of time, work commitments and cost are the greatest local barriers to participation.⁵

Local results from the Sport England Active People Survey show that the majority (64%) of adults in Brighton & Hove want to do more sport. Whilst only 44% of adults in the city indicate they are satisfied with local sport provision, this is lower than the average for the South East (49%) and England (46%).²

Where we are doing well

28% of adults in Brighton and Hove achieve recommended levels (of physical activity). This is 6% higher than both South East and England participation rates.²

A quarter of respondents to the 2012 Health Counts self-report survey were doing the recommended level of physical activity, this was a statistically significant increase from 15% in the 2003 survey.⁶

Women's activity levels have increased significantly since 2003; in most cases almost doubling, and, in the 18–24 year age group, increasing threefold.⁶

In Brighton & Hove, 18% of adults use outdoor space for exercise/health reasons; this is higher than the England average of 14%.⁷

In Brighton & Hove the financial cost of physical inactivity across five diseases linked to physical inactivity (ischaemic heart disease, ischaemic stroke, breast cancer, colon/rectum cancer and diabetes mellitus) is £1.4 million per 100,000 population; this is lower than in either West or East

¹ Department of Health 'Start active stay active'; 2011

² Sport England Active people Survey 5

http://www.sportengland.org/research/active_people_survey.aspx

³ Scarborough et al. The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs Journal of Public Health; 2011.

⁴ Health Impact of Physical Inactivity (HIPI) – a tool for Joint Strategic Needs Assessment

<http://www.apho.org.uk/resource/view.aspx?RID=123459>

⁵ Brighton and Hove Physical Activity and Sport JSNA 2012.

⁶ Health Counts 2012 <http://www.bhlis.org/>

⁷ Public Health Outcomes Framework <http://www.phoutcomes.info/>

7.3.3 Physical activity (Adults)

Sussex; £1.9 and £2.4 million per 100,000 population respectively.⁸

We are developing and delivering regular, inclusive programmes and initiatives to improve health and reduce inequalities e.g. the Active for Life Programme and Health walks.

We are working in partnership to pool resources and meet joint outcomes e.g. TakePart.

We are providing support to community clubs to assist with long term development and sustainability.

There is a city-wide exercise on referral scheme available through GP practices and many secondary care providers.

Local inequalities

In Brighton & Hove, male respondents to the Health Counts Survey are more likely than female to meet the recommendations for physical activity (27% for males and 22% for females), although neither group are significantly different to all respondents. Males were more likely to meet the recommended physical activity level in all age groups with the exception of 55-64 year olds.⁶

Only 19% of women participate in at least three times 30 minute sessions of sport and active recreation per week compared with 26% of men.²

Participation in at least three times 30 minute sessions of sport and active recreation per week peaks at 37% of 26 – 34 year olds, and is lowest at 22% of adults aged 55+.²

There is a ward level difference in the proportion of adults active at recommended levels; the lowest is 18% in Queens Park and the highest is 34% in Regency.⁶

The proportion of disabled residents who play no sport at all is 62.5% which is 14% higher than for non disabled. Non disabled residents are also twice as likely as disabled to have taken part in organised sports competition in the previous 12 months.⁹

⁸

http://www.sportengland.org/support_advice/local_government/local_sport_profile_tool/costs_of_physical_inactivity.aspx

⁹ Sport England Active people 6

http://www.sportengland.org/research/active_people_survey.aspx [

National participation data confirms relatively low levels of participation in sport among BME communities. Nationally, gender disparity is greater among BME communities in terms of sports participation.¹⁰

Participation levels in moderate intensity sport and active recreation are highest in the highest socio-economic (SEC) groups and lower in the lowest SEC groups. People in the lowest SEC groups display significantly higher levels of sedentary behaviour than those in the highest SEC groups. This is consistent with national and regional trends.²

Physical activity is significantly associated with general health, happiness, not being depressed or sad in the last two years; healthy weight (self reported heights and weights) and eating five portions of fruit and vegetables per day.⁶

Predicted future need

Both nationally and locally the overall percentage of adults achieving the physical activity recommendations for health is increasing. This may indicate a longer term trend of increasing physical activity levels. However due to the overall low prevalence of adults being active at levels that would benefit their health, and the continuing gap between men's and women's activity levels, there continues to be a need to develop new and innovative opportunities to enable people to be active.

What we don't know

The gaps in local data identified in the 2012 JSNA have been filled by the health counts survey.⁶ However as this survey only occurs every 10 years, gaps are likely to emerge again in future.

Key evidence and policy

The National Institute for Health and Clinical Excellence (NICE) have produced two specific pieces of guidance to increase physical activity:

PH2: Four commonly used methods to increase physical activity. 2006.

<http://publications.nice.org.uk/four-commonly-used-methods-to-increase-physical-activity-ph2>

¹⁰ Long et al. A Systematic Review of the Literature on Black and Minority Ethnic Communities in Sport and Physical Recreation. Carnegie research institute; 2009.

7.3.3 Physical activity (Adults)

PH8: Physical activity and the environment. 2008

<http://publications.nice.org.uk/physical-activity-and-the-environment-ph8>

NICE have also included recommendations in several other guidance (PH 13, 16, and 25):

PH13: Promoting physical activity in the workplace. 2008

<http://publications.nice.org.uk/promoting-physical-activity-in-the-workplace-ph13>

PH16: Mental wellbeing and older people. 2008.

<http://publications.nice.org.uk/mental-wellbeing-and-older-people-ph16>

PH25: Prevention of cardiovascular disease. 2010.

<http://publications.nice.org.uk/prevention-of-cardiovascular-disease-ph25>

PH 35: Preventing type 2 diabetes: population and community interventions. 2011.

<http://publications.nice.org.uk/preventing-type-2-diabetes-population-and-community-level-interventions-ph35>

PH 38: Preventing type 2 diabetes: risk identification and interventions for individuals at high risk. 2012.

<http://publications.nice.org.uk/preventing-type-2-diabetes-risk-identification-and-interventions-for-individuals-at-high-risk-ph38>

Recent reviews have found that interventions for increasing physical activity in adults are a cost-effective approach, and can provide value for money when compared with other preventative interventions. In terms of return on investment, NICE established that a brief intervention for physical activity in primary care costs between £20 and £440 per quality-adjusted life year (QALY) (when compared with no intervention) with net costs saved per QALY gained of between £750 and £3,150.¹¹

Recommended future local priorities

1. NICE public health guidance: NICE produce guidance, specific recommendations and aids to implementation. Effective implementation of NICE recommendations could lead to major positive changes in the way physical activity

services are planned, implemented and managed.

2. Implement a life course approach to service commissioning and delivery; including: prevention of sedentary behaviour/physical inactivity and promotion of physical activity using the Chief Medical Officer's guidelines for all ages.¹
3. Develop programmes and initiatives to encourage regular participation in sport and physical activity to address inequality and improve health.⁵
4. Support and develop local voluntary clubs and groups to provide sustainable sport and physical activity provision.⁵
5. Implementation of the Sports Facilities Plan 2012-2022 to improve quality and quantity of sports facilities in the city.
6. Re-procurement of city-wide exercise referral scheme.

Key links to other sections

- Physical activity (Children and young people)
- Green and open space
- Transport and active travel
- Healthy weight (Children and young people)
- Healthy weight (Adults and older people)

Further information

Department of Health 2011 'Start active, stay active'

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128210.pdf

Brighton and Hove Physical Activity and Sport JSNA 2012 <http://www.bhlis.org/needsassessments>

Last updated

May 2013

¹¹ Department of Health. 'Let's Get Moving. A new physical activity care pathway for the NHS, Commissioning Guidance'; 2009.

7.3.4 Sexual health (adults)

Why is this issue important?

England continues to experience worrying levels of poor sexual health: rates of sexually transmitted infections (STIs) and unintended pregnancies remain high.

Following a decade of steady annual increases in the number of infections, there was a slight decrease (1%) in the number of diagnosed STIs between 2009 and 2010.¹ Unfortunately 2011 saw an overall increase of 2% in the number of infections diagnosed.

There are variations in the trends of specific infections and higher rates of infections in some population groups: younger people and men who have sex with men (MSM) are disproportionately affected by poor sexual health.

Chlamydia is the most common bacterial STI and is increasing, especially in those under 25. As Chlamydia often has no symptoms and can have serious health consequences (pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility) a national opportunistic screening programme has been established.

Key outcomes

- **Chlamydia diagnoses - 15-24 year olds (Public Health Outcomes Framework)**

Impact in Brighton and Hove

In 2011, Brighton and Hove had the 3rd highest rate of common sexually transmitted infections (chlamydia, gonorrhoea, syphilis, herpes and warts) outside of London at 1,345 per 100,000 people compared with 792 across England (Figure 1).² Local rates also exceed those of London overall and rates of most of the individual infections far exceed those of the South East Coast (SEC) Strategic Health Authority and those of England (Table 1).

Attendances at the main genitourinary medicine (GUM) clinic in Brighton and Hove remain very high, at approximately 24,000 in 2012/13, and are increasing year on year. The trend in new cases of the commonest infections is shown in Figure 2. 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 has been maintained to date.

Figure 1: Top ten local authorities outside London for highest acute rates of sexually transmitted infections (2011)



Source: Health Protection Agency annual data tables

Table 1: Rates of selected Sexually transmitted infection (STI) and acute STI diagnoses per 100,000 population (all ages): 2011

	Brighton and Hove	South East Coast SHA	England
Chlamydia (age 15 – 24)	2,110.6	1,695.2	2,124.6
Chlamydia (age 25+)	221.6	74.2	102.8
Gonorrhoea	112.5	22.1	39.1
Syphilis	18.5	3.7	5.4
Herpes	98.2	52.2	58.1
Warts	223.4	135.8	141.8
Acute STIs	1,344.9	632.5	792.1

Source: Health Protection Agency

The Brighton and Hove Health Counts survey in 2012 asked people about their sexual health and if they had ever been diagnosed with an STI. Almost

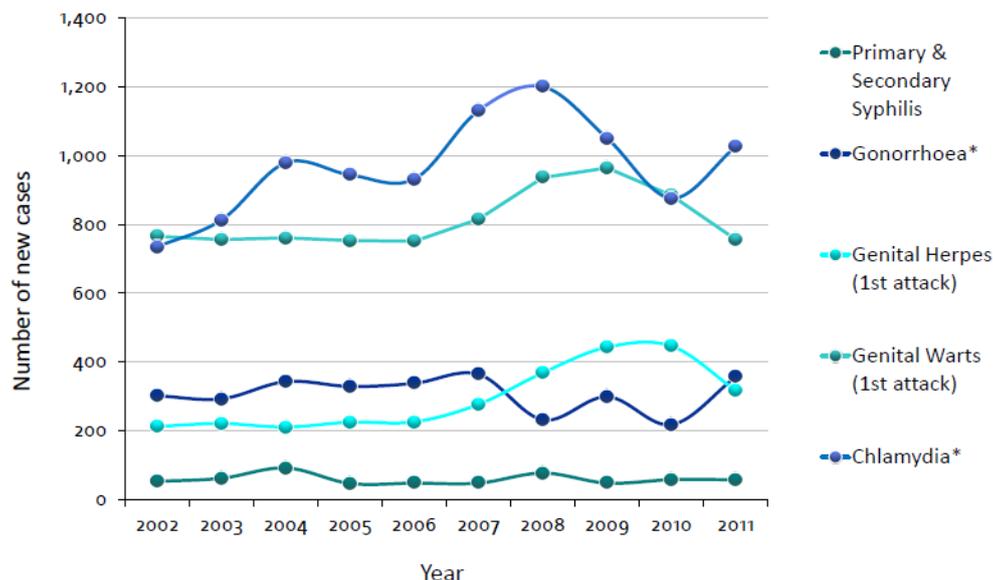
¹ Health Protection Agency, Health Protection Report, weekly Report, 5: 24. June 2011. <http://www.hpa.org.uk/hpr/archives/2011/hpr2411.pdf> [Accessed on 26/08/2012].

² Health Protection Agency, Sexual Health Profiles, 2011. Available at <http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/SexualHealthProfilesAndIndex/> [Accessed on 26/08/2012].

7.3.4 Sexual health (adults)

without exception around double the proportion of Health Counts respondents report being diagnosed with any of the STIs listed³ than respondents to the national 2010 Health Survey for England.⁴

Figure 2: Number of new cases of the top five sexually transmitted infections seen at the GUM clinic in Brighton and Hove, 2002 to 2011



Source: GUMCAD

*In 2010/11 GUM clinic return KC60 was replaced by GUMCAD. The 2000 to 2009 data only includes non complicated Gonorrhoea and Chlamydia. Data for 2010 and 2011 includes both complicated and non-complicated.

Brighton and Hove had a higher rate of terminations of pregnancy (18.5 per 1,000 women aged 15 - 44 years) in 2011 than England (17.6) and these rates remain unchanged from 2010.⁵

The proportion of terminations carried out early (at less than 10 weeks gestation) in 2010 was 85% in Brighton and Hove compared with 76.5% for England. The local and national rates both show a slight improvement on 2009.

An increase in the provision of long acting reversible contraception (LARC) is a proxy measure for wider access to the range of contraceptive methods and should also lead to a reduction in rates of unintended pregnancy. The rate of GP-prescribed LARC has been increasing locally and

nationally since 2008. In 2010 there was a similar rate of GP-prescribed LARC in Brighton and Hove (52.2 per 1,000 GP-registered female population aged 15-44) compared with England (51.6). As a proportion of all GP-prescribed LARC in 2010, provision of the most effective methods was higher in Brighton and Hove than nationally (33% for contraceptive implant compared with 26% in England and 43% for IUD/IUS (coil type contraceptives) compared with 32% in England) and lower for the less effective contraceptive injection (24% in Brighton and Hove compared with 42% in England).⁶

Where we are doing well

We have increased access to testing and treatment services in the city – everyone seeking an appointment to be seen at the GUM clinic will be

offered an appointment to be seen within 48 hours. The clinic also offers walk-in appointments, as does the Brighton Station Health Centre, seven days per week. Reducing the time between infection and diagnosis and treatment will continue to reduce the overall incidence and prevalence of infections. Brighton and Hove exceeded the chlamydia screening target for 2011/12 achieving 39% coverage (16,583 people screened) of the under-25 population with a positivity rate of 5.6%. This placed us in the top 20 performing Primary Care Trusts for 2011/12.

Local inequalities

The burden of sexual ill-health is not shared equally; younger people (under 25 years old) and men who have sex with men (MSM) are disproportionately affected. Rates of STIs in these groups far exceed those of the general population locally and nationally.

Of all respondents reporting having sex in the last year, MSM reported four times as many sexual

³ Genital warts, Chlamydia, Non specific urethritis (NSU) / Non gonococcal urethritis (NGU), Herpes, Gonorrhoea, Syphilis

⁴ The Health and Social Care Information Centre. Health Survey for England 2010. 2011. [Accessed 26/04/2013] Available at: www.ic.nhs.uk/pubs/hse10report

⁵ Health Protection Agency, Sexual Health Balanced Scorecard, Data tables, 2011. http://www.apho.org.uk/default.aspx?QN=SBS_PAGE02 [Accessed on 26/08/2012].

⁶ Health Protection Agency, Sexual Health Balanced Scorecard, Data tables, 2011. <http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/Page/1237277176628> [Accessed on 26/08/2012].

7.3.4 Sexual health (adults)

partners as the general population. Forty per cent of MSM reported ever having been diagnosed with one of the STIs listed compared with 17% of the general population.

Lesbian, Gay, Bisexual, Unsure or other respondents were significantly more likely to have one of the listed STIs (35%). There was little difference by marital status, with the exception of widowed respondents who had a significantly lower rate of STIs (6%) though age may be a factor here. Those with no religion were significantly more likely, and those of Christian religion significantly less likely to have had a listed STI, though again the relative younger age of those with no religion could explain part of this difference.

However, the survey did not show a significant difference for carers, for those with a limiting long-term illness, disability or health problem nor between for White British or Black and Minority Ethnic (BME) groups. Though national data suggest that in addition to younger heterosexuals and MSM, BME communities are at increased risk of acquiring gonorrhoea.⁷

What we don't know

There is no voice evidence available identified for this summary.

Predicted future need

Current high rates of infection and the trend for increased demand year on year for all sexual health services suggest that the need for services is likely to continue to increase over the next five years.

Increased access to LARC at the community contraception clinic and at termination of pregnancy will reduce unintended pregnancies and repeat terminations.

Key evidence and policy

A Framework for Sexual Health Improvement in England (2013)

<https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england>

⁷ Health Protection Agency. Gonorrhoea figures 2011.

http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317136485598

The National Strategy for Sexual Health and HIV (2001)

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4058945.pdf

Progress and priorities – working together for high quality sexual health. Review of the National Strategy for Sexual Health and HIV (2008)

http://www.medfash.org.uk/publications/documents/Progress_and_priorities_working_together_for_high%20quality_sexual_health_FULL_REPORT.pdf

Recommended Standards for sexual health services (MedFASH 2005)

http://www.medfash.org.uk/publications/documents/Recommended_standards_for_sexual_health_services.pdf

NICE Guidelines on Long acting reversible contraception (2005, reviewed 2011)

<http://www.nice.org.uk/CG030>

Recommended future local priorities

1. Review of Brighton Hove HIV and sexual health strategy to ensure that targeted, evidence based health promotion and prevention interventions underpin all service provision.
2. Ensure that risk taking behaviours associated with drugs and alcohol are addressed by sexual health services.
3. Increase opportunities for STI testing in community settings accessed by at risk groups
4. Improve integration between GUM and contraception services.

Key links to other sections

- Sexual health (children and young people)
- Teenage conceptions and teenage parents
- HIV and AIDS

Further information

Brighton and Hove Sexual Health Needs Assessment 2010

www.bhlis.org/needsassessments

Last updated

September 2013

7.3.5 Smoking (Adults and older people) Brighton & Hove JSNA 2013

Why is the issue important?

Tobacco remains one of the most significant public health challenges today. Every year, over 100,000 smokers in the UK die from smoking related diseases and half of all regular cigarette smokers will eventually be killed by their addiction (Ash smoking statistics 2012).

People who smoke between 1 and 14 cigarettes a day have eight times the risk of dying from lung cancer compared to non-smokers (ASH smoking statistics 2012)

Smoking cessation is the single most cost effective life-saving intervention. The government spent £88.2m on services to help people stop smoking and a further £66.4m on stop smoking medication. (ASH Smoking Statistics 2012) Smoking costs the NHS approximately £2.7 billion a year for treating diseases caused by smoking. (ASH Smoking statistics)

Table 1 below shows the number of years gained against the age they stopped smoking.¹

Table 1: Years of life gained by stopping smoking, by age	
Age stopped smoking	Years of life gained
30	10
40	9
50	6
60	3

Source: Doll R et al. Mortality in Relation to Smoking: 50 Years Observations on Male British Doctors. BMJ 2004.

Key outcomes

- **Smoking prevalence in Adults over 18 years (Public Health Outcomes Framework)**

Impact on Brighton & Hove

Local tobacco profiles provide a snapshot of the extent of tobacco use, tobacco-related harm and the measures being taken to reduce this harm in

Brighton & Hove.² Deaths due to smoking and the smoking prevalence in Brighton & Hove in the adult population are both significantly worse than the England average:

- Between 2008 and 2010 there were on average 381 deaths per year related to smoking in the city. This is an age-standardised rate of 226 deaths per 100,000 people compared with the England average of 211 deaths per 100,000 people.
- The smoking prevalence from the integrated Household Survey shows that in Brighton & Hove for 2011/12 is estimated to be 23% compared with an England average of 20%.
- In 2011/12 the city had a significantly higher rate of successful quitters in NHS Stop Smoking Services than the England average.

Since the introduction of the NHS Stop Smoking Service over 10 years ago, over 30,000 people have accessed the service in Brighton & Hove.

Figure 1 highlights the estimated cost due to smoking in lost productivity, smoking-related illnesses, domestic fires and clean-up operations in Brighton & Hove – adding up to a total cost of £82.9 million.³

In 2012 Health Counts Survey⁴ gave a smoking prevalence figure of 23.1% in Brighton & Hove. According to the Integrated Household Survey of all areas in England the smoking prevalence in Brighton & Hove is 22.9% for 2011/12 so the Health Counts results are the same as this national survey. Both give a local prevalence which is higher than England (20.0%).

Where we are doing well

Local data shows that in 1992, 27% of people in Brighton & Hove were daily smokers and that in 2012 this had statistically significantly decreased to 14%. The percentage of respondents smoking occasionally rose from 6% to 9% over the last twenty years but overall the smoking prevalence

² London Health Observatory. Local Tobacco Control Profiles for England.

³ <http://www.ash.org.uk/localtoolkit/> [Accessed 26/08/2012].

⁴ NHS Brighton and Hove and Brighton & Hove City Council. Health Counts Survey. 2012. Available at: www.bhlls.org/surveys [Accessed 17/08/2013]

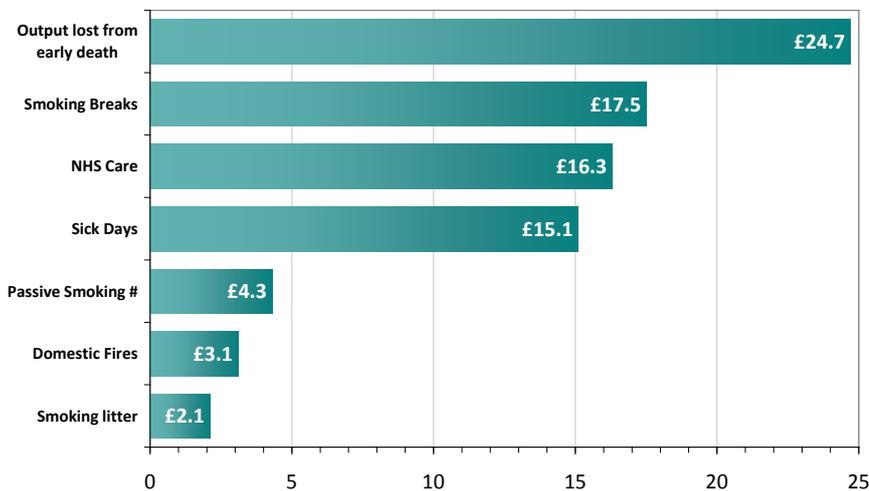
¹ Doll R et al. Mortality in Relation to Smoking: 50 Years Observations on Male British Doctors. BMJ 2004. 328pp. 1519-27.

7.3.5 Smoking (Adults and older people) Brighton & Hove JSNA 2013

rate (daily and occasional smokers) fell from 33% to 23% - a statistically significant fall.⁴

There had been a slight reduction in inequalities in smoking in the city from 2003 to 2012.⁴

Figure 1: Estimated cost of smoking (£m) in Brighton & Hove



Passive smoking: lost productivity from early death (not including NHS cost & absenteeism)

Source: Ash local toolkit

<http://www.ash.org.uk/localtoolkit/>

Local inequalities

The 2012 Health Counts Survey⁴ showed that:

- There is no significant difference in smoking prevalence between males and females (males 25%, females 22%).
- There is however, a clear relationship with age, with smoking prevalence falling with age but with a few exceptions – for example in men smoking prevalence increases between the ages of 18-24 years and 25-34 years where it reaches 35% in Brighton & Hove. By the age of 75 years or over, for males and females, smoking prevalence reaches its lowest point (5% for males and 10% for females).
- Smoking prevalence is strongly associated with deprivation, and those living in the most deprived 20% of areas in the City are twice as likely to smoker as those living in the 20% least deprived areas.
- LGB and unsure respondents (30%) are more likely to say that they smoke than

heterosexuals (22%) – though neither group was significantly different to all respondents.

- The highest smoking prevalence is seen amongst bisexuals (40%) – significantly higher than for all respondents.
- Those who are single are significantly more likely to smoke (33%) than all respondents and those who are married, in a civil partnership or living as a couple significantly less likely (18%).
- There was no difference in smoking prevalence between BME respondents and White British respondents (23%). Smoking prevalence is highest in Mixed ethnic groups (32%), though this difference is not significant.
- There is no significant difference in smoking prevalence by religion, though it is higher in those with no religion (27%).
- There is no significant difference in smoking prevalence between carers (24%) and all respondents.
- Respondents who own their own homes (14%) are significantly less likely to smoke, but those who rent from a private landlord (31%), or rent from a housing association or local authority (42%) or were significantly more likely to smoke daily or occasionally.
- Respondents who are unemployed and looking for work, unable to work due or caring for home and family are significantly more likely to smoke (41%). Retired respondents are significantly less likely (13%) to smoke.
- Respondents with degree level, or higher, qualifications are statistically significantly less likely to smoke (15%).

Supporting people to permanently quit smoking will significantly improve health and reduce health inequalities in Brighton & Hove. Brighton & Hove stop smoking services work with all smokers who want to quit with a special focus on

7.3.5 Smoking (Adults and older people) Brighton & Hove JSNA 2013

routine and manual workers, hospital inpatients, BME Communities, young people, lesbian, gay, bisexual and transgender residents, and individuals with HIV.

In England, routine and manual workers are most likely to be heavily addicted compared with managerial and professional groups.⁵ Figure 2 shows that the clients referred to the local Stop Smoking Service from the most deprived areas had a relatively low quit rate compared with the least deprived areas. However, the service is effectively targeted, getting more people from deprived areas into the service.

Predicted future need

Estimates of adult smoking prevalence in the city have been relatively stable.

What we don't know

We do not have local smoking prevalence data for most equalities groups. The 2012 Health Counts survey should provide some local data.

We currently do not have local voice information.

In order to plan effective methods of reducing health inequalities through tobacco control, we must have a comprehensive understanding of our population and factors that influence tobacco use amongst priority groups in order to target them more effectively and improve resource utilisation.

Key evidence and policy

Research has shown that smokers are four times more likely to stop smoking when accessing a dedicated stop smoking service.

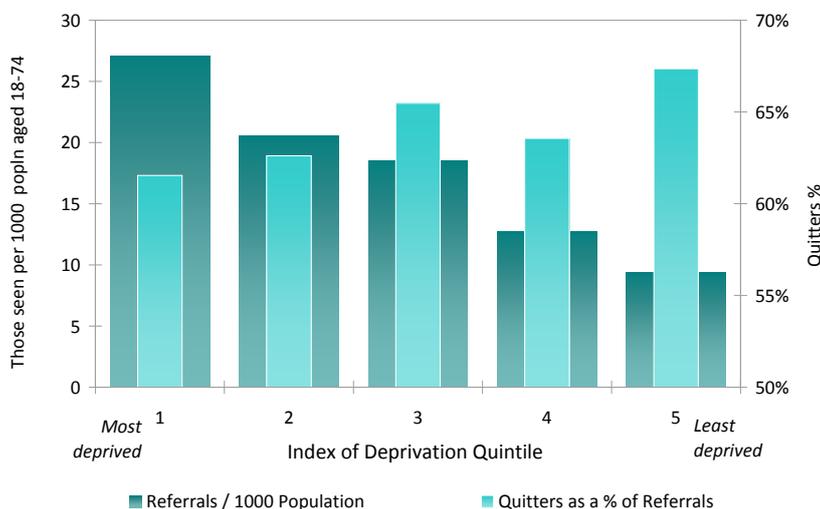
NICE evidence-based guidance which will assist with the commissioning and delivery of stop smoking interventions. www.nice.org.uk

The Coalition Government published a new Tobacco Control Strategy in 2011 – Healthy Lives, Healthy People: A Tobacco Control Plan for England, which will support efforts to reduce tobacco use in the next five years.

⁵Department of Health. A smokefree future. A comprehensive tobacco control strategy for England; 2010.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917

Figure 2: Referrals and quitters for the Brighton & Hove Stop Smoking Service by quintile of deprivation, 2009/10



Source: NHS Brighton and Hove

Recommended future priorities

There is a need to help the most deprived groups more effectively to stop smoking and reduce the associated health inequalities. The Tobacco Control Plan for England sets out three national ambitions to focus tobacco control work by 2015. These are:

- Reduce smoking prevalence among adults in England to 18.5% or less
- Reduce smoking prevalence among young people to 12%
- Reduce smoking in pregnancy to 11%

Local recommendations include:

1. The NHS Brighton & Hove Stop Smoking Service will continue to provide a specifically tailored service to the community, targeting people in high prevalence groups, such as routine and manual workers.
2. The Brighton & Hove Tobacco Control Alliance, working together as partners, to succeed in reducing smoking prevalence and health inequalities in the city.

7.3.5 Smoking (Adults and older people) Brighton & Hove JSNA 2013

3. Improve data collection from primary care so that up-to-date analysis can be used to target resources more effectively.
4. Raise awareness of the NHS Brighton & Hove Stop Smoking Service in the city.

Key links to other sections

- Maternal and infant health
- Smoking (Children and young people)
- Cancer
- Coronary heart disease
- Respiratory disease

Further information

Department of Health. Healthy Lives, Healthy People: A Tobacco Control Plan for England
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917

Local tobacco control profiles
http://www.lho.org.uk/LHO_Topics/Analytic_Tools/TobaccoControlProfiles/

Last updated

August 2013

7.3.6 Alcohol (Adults and older people) Brighton & Hove JSNA 2013

Why is this issue important?

As indicated in the recently published National Alcohol Strategy,¹ fifty years ago the United Kingdom had one of the lowest drinking levels in Europe. However, it is now one of the few European countries whose alcohol consumption has increased. In 2010/11 there were almost one million alcohol-related violent crimes and 1.2 million alcohol related hospital admissions. The cost of alcohol related harm is estimated to cost society £21 billion annually.¹

Key outcomes

- ***People entering prison with substance dependence issues who are previously not known to community treatment (Public Health Outcomes Framework)***
- ***Successful completion of drug treatment (Public Health Outcomes Framework)²***
- ***Under 75 mortality rate from liver (Public Health Outcomes Framework and NHS Outcomes Framework)***
- ***Alcohol related admissions to hospital (Placeholder) (Public Health Outcomes Framework)***

Local outcomes

- **Number of alcohol-related hospital admissions per 1,000 population³**
- **Percentage of patients leaving alcohol treatment who completed successfully (no longer requiring structured alcohol treatment)³**
- **Number of service users moving on to or maintaining independence (from housing input)**
- **Reduction in the number of problematic street drinkers (from housing input)**

Impact in Brighton & Hove

Within Brighton & Hove, the impact of alcohol is considerable. Rates of alcohol-related A&E attendance and hospital admissions continue to increase year on year, and in the recent Big Alcohol

Debate, 36% of respondents were worried about the effect alcohol has on people in the city.

However, the sale of alcohol through pubs, clubs and restaurants is very important to the economy of the city, and this fine balance must be considered when implementing policies locally.

Each week in the city there is an average of:⁴

- 66 ambulance call-outs due to alcohol
- 46 attendances at Brighton A&E department related to alcohol
- 11 people under the age of 25 years seen by Safe Space
- 97 alcohol-related inpatient hospital admissions for adult residents of Brighton & Hove
- Two deaths associated with the impact of alcohol (almost one death a week wholly related to alcohol)

The costs to Brighton & Hove of alcohol misuse are estimated at £107 million per year⁵: £10.7 million due to the health impact, £24.5 million due to economic effects and £71.8 million as a result of crime. Alcohol is also an important contributor to health inequalities.

Alcohol-related A&E attendances have generally increased in the over-18s in Brighton & Hove (Figure 1).⁵

Alcohol plays a part in tenancy breakdown and evictions within hostel accommodation leading to a cohort of revolving door clients with complex needs who are not moving on to greater independence. 60% of those evicted from hostel accommodation in 2011/12 had alcohol misuse issues and 52% of those evicted were evicted for an incident or incidents which took place when they were under the influence of alcohol.

The Integrated Support Pathway (housing support) includes provision of high level supported hostel accommodation through to low level floating support. In 2011/12 74% of rough sleepers and 46% of Band 2 hostel residents reported needs around alcohol misuse.

¹ HM Government. The Government's Alcohol Strategy. March 2012.

² National Treatment Agency Quarterly Alcohol Summary Report.

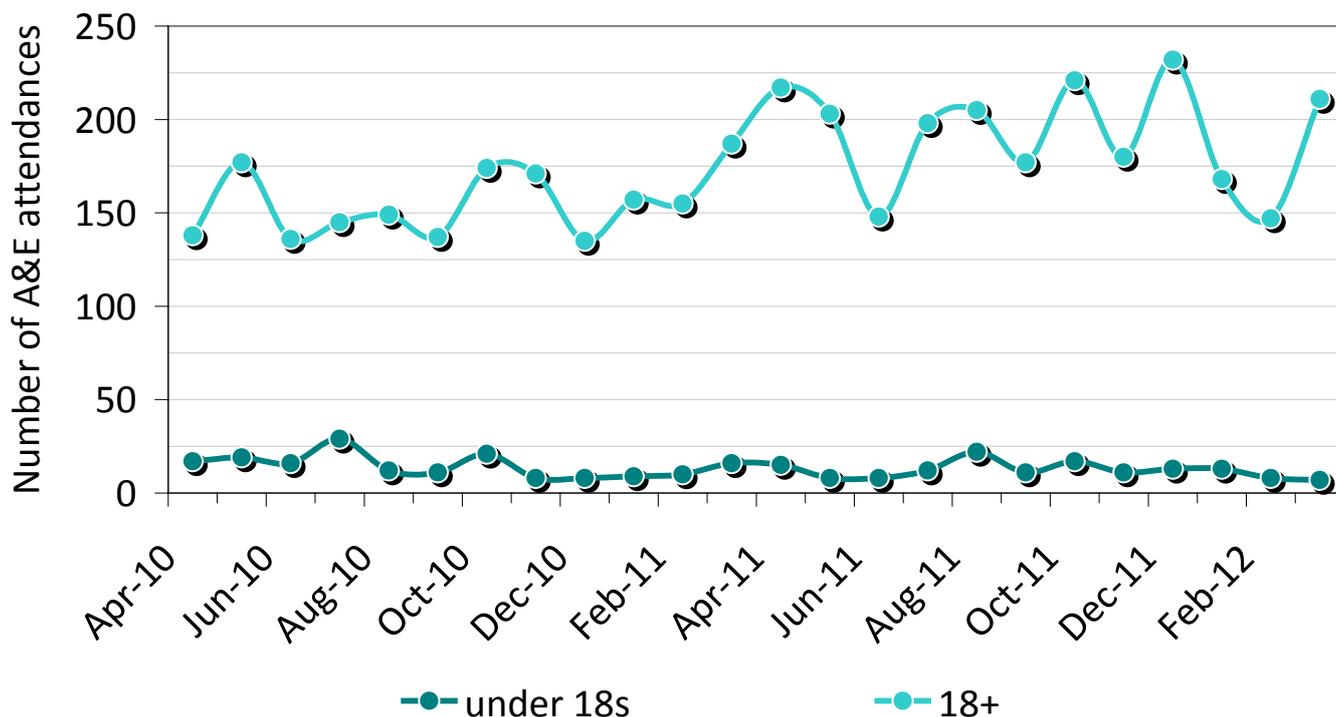
³ Brighton & Hove Safe in the City Quarterly Performance and Activity report.

⁴ Paper for Brighton and Hove City Council Cabinet - Big Alcohol Debate. Interim Findings and Alcohol Commissioning Plan, January 2012.

⁵ Brighton & Hove Safe in the City Partnership. Strategic Assessment 2011 Alcohol Misuse and Alcohol related crime and disorder. 2012.

7.3.6 Alcohol (Adults and older people) Brighton & Hove JSNA 2013

Figure 1: Monthly A&E attendances related to alcohol since April 2010, by age



Source: Secondary Users Service (Hospital activity data)

profile of alcohol brief interventions as a way of helping people to seek the support they need

Where we are doing well

There is a strong partnership between commissioners and providers of treatment services in Brighton & Hove. The care pathway for entry into alcohol treatment services has recently been amended to allow people to 'drop-in' to assessment services, rather than having to pre-book appointments. As a result, it is now easier for clients to access treatment services.

A number of initiatives have had a positive impact on alcohol related hospital attendances:

- Specialist alcohol nurses are based in A&E and see any person attending hospital with an alcohol related attendance. The nurses are able to provide brief interventions and signposting to support services.
- A 'frequent attender' worker engages more assertively with individuals frequently attending A&E with an alcohol related issue. This group will have alcohol dependence issues and will be consistently failing to complete the assessment and treatment process.
- Recently an A&E Consultant has agreed to take on the role of 'Clinical Alcohol Champion' for the hospital. This role will help to raise the

Local inequalities

It is a recognised paradox that households in more deprived areas are less likely to drink at increasing risk levels but are more likely to experience alcohol related mortality.⁶

The nature of alcohol excess and addiction means that it is often the most vulnerable who are the victims.⁵

Alcohol-related attendances at A&E are 50% higher in city residents from the most deprived quintile compared with those in the most affluent quintile of the population.⁵ Brighton & Hove ranked in the top quartile of PCTs for alcohol specific mortality with death from chronic liver disease being higher than the national average.⁷

The alcohol needs analysis⁸ indicates that:

- Lesbian, gay, bisexual and transgender people living in St. James Street and Kemp Town were

⁶ Bellis MA, Jones L, Morleo M. Understanding The Alcohol Harm Paradox to focus the development of interventions. Centre for Public Health Liverpool John Moores University

⁷ North West Public Health Observatory Local Alcohol Profile England 2012 (Brighton and Hove PCT Area)

⁸ Brighton & Hove Community Safety Partnership. Alcohol Needs Assessment. 2010. Available at: www.bhlis.org/needsassessments

7.3.6 Alcohol (Adults and older people) Brighton & Hove JSNA 2013

more likely to drink alcohol than those in other areas; those who lived in rented and privately owned property were more likely to drink than those in social housing; and those who were frequently concerned about their use of alcohol or amount they drank had experienced problems in getting accommodation.

- Longer-term alcohol-related health problems are seen in increasing numbers of 35-54 year old males being admitted to hospital for alcohol specific conditions i.e. for alcohol intoxication, dependence and harmful use.
- Young men aged 19-29 years old were the most frequent group attending A&E for alcohol or assault reasons.
- Ethnicity was not shown to be a significant factor in assaults recorded by either A&E or the police, or in all alcohol-related attendances to A&E.
- People with severe and enduring mental illness are three times more likely to be alcohol dependent than the general population. Up to 10% of problem drinkers have severe mental illness, 50% have a personality disorder and up to 80% have neurotic disorders.

Local data⁹ suggests that people of White Irish ethnicity are more likely to be at increasing/high risk of alcohol related harm (25% compared to 18% across all ethnic groups in the city). Other Ethnic, Asian or Asian British and Black or Black British groups are more likely not to drink alcohol. These findings correspond to national research.¹⁰

Predicted future need

The month-on-month alcohol-related hospital admission rate is starting to flatten¹¹ after showing an upward trend since the beginning of 2010.¹² A similar picture is shown in respect of hospital admissions for Alcohol Attributable Conditions which fell from 2,572 per 100,00 to 1,986 per

100,00 between 2009/10 and 2010/11.¹³ These changes may in part be a reflection of the overall fall in hospital activity across all conditions.

However, though subject to seasonal variation, the long term trend is an increase in alcohol-related A&E attendance. More detail on trend information is being sought to assist in predicting future need.

As the number of rough sleepers is rising, there may be a corresponding rise in those who are street drinking which would cause a rise in anti-social behaviour and fear of crime amongst the community.

What we don't know

Alcohol treatment providers report relatively low levels of uptake from people from BME communities. There may be some issues with capturing this information when people do present to treatment services, but anecdotally it is felt that people from Black and Minority Ethnic (BME) communities are less likely to present to treatment.

Service user consultation is an integral part of service provision, but there is much we could still learn, in order to continue to improve services and make them as 'user-friendly' as possible. This should encourage more people into treatment.

There is a paucity of local information on alcohol use for some equality groups including: carers; disability and religion.

Key evidence and policy

NICE clinical guidance identifies the need for the use of screening and brief interventions, alongside structured brief advice and extended brief interventions.¹⁴

The alcohol needs assessment highlights the need to have information on cost of services and associated outcomes in order to assess value for money and return on investment. It also identifies the need to consider capacity of services to deliver treatment in the context of addressing health inequalities, with the potential need to tailor services to different population groups.

⁹ NHS Brighton and Hove and Brighton & Hove City Council. Health Counts Survey. 2012. Available at: www.bhlis.org/surveys

¹⁰ Hurcombe, R., Bayley, M., and Goodman, A (July 2010) Ethnicity and Alcohol: A review of the UK literature. Joseph Rowntree Foundation.

¹¹ . Secondary User Service. Cumulative Rate of hospital admissions per 100,000 population. April 2012-February 2013

¹² Brighton & Hove Safe in the City. Quarterly performance and activity report.

¹³ North West Public Health Observatory Local Alcohol Profile England 2012 (Brighton and Hove PCT Area)

¹⁴ Alcohol-use disorder – Preventing the development of hazardous and harmful drinking. NICE PH Guidance, PH24 – Issues. June 2012.

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In 2010 the Government published a new drug strategy. The strategy puts the emphasis on supporting people to recover fully from their substance misuse problem (including alcohol), and reintegrate in the community. This continues to focus on the right treatment services being available, but also prioritises things such as appropriate housing, training/education opportunities and structured daily activities such as volunteering or paid employment. This strategy applies to both drug and alcohol treatment.¹⁵

Recommended future local priorities

Alcohol misuse remains a concern for Brighton & Hove. As with substance misuse services, there will be a procurement exercise across all drug and alcohol treatment services, with the aim of having new contracts in place for 2015/16. The new service model will have recovery and reintegration at its heart.

Whilst the service development work is undertaken the following developments will continue:

- Initiatives to be developed with a focus on education and training for frontline workers, providing advice, information and brief/extended interventions and reducing A&E attendance and hospital admissions.
- Work with the hospital clinical alcohol champion to promote the integration of alcohol services throughout the hospital in order to improve patient health, to reduce re-attendances/re-admissions and to reduce length of stay in hospital
- Service user consultation to broaden, including working with BME and LGBT communities.
- Work with the Alcohol Programme Board to implement a programme of alcohol-free events, which in turn help to challenge the 'drinking culture' reputation of Brighton and Hove.

Key links to other sections

- Rough sleeping and single homeless
- Substance misuse and alcohol (Children and young people)

- Substance misuse (Adults and older people)
- Dual diagnosis
- Urgent care

Further information

Safe in the City Alcohol Needs Analysis 2010
www.bhlis.org/resource/view?resourceId=1051

The Government's Alcohol Strategy 2012
<http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy>

NICE guidance – preventing the development of hazardous and harmful drinking (PH24)
<http://www.nice.org.uk/guidance/PH24>

Last updated

July 2013

¹⁵ HM Government: Drug Strategy 2010. Reducing demand, restricting supply, building recovery. Supporting people to live a drug free life.

7.3.7 Substance misuse (Adults)

Why is this issue important?

Reducing the supply and availability of drugs and promoting recovery from drug related harms are a national and local priority. The misuse of drugs causes physical, psychological and social harm to the individuals concerned, as well as giving rise to significant disruption and cost to families and communities.¹

It is estimated that in 2009-10 there were approximately 306,000 heroin and/or crack cocaine users in England and that offenders who use these drugs commit between a third and a half of all acquisitive crime. In 2012 the National Treatment Agency published a report on the emerging use of novel psychoactive substances and 'club drugs'. The evidence for the health effects of these newer psychoactive substances is not clear however, there have been several isolated reports of death and heavy use can develop into a dependency.²

In 2010 the Government published a new national drug strategy.³ The 2010 strategy highlights the need to focus on building recovery in communities by creating a system that gets people into treatment, but also getting people into full 'recovery', and completely free from dependence on drugs or alcohol.

Key outcomes

National outcomes

- **Successful completion of drug treatment (Public Health Outcomes Framework)**
- **People entering prison with substance dependence issues who are previously not known to community treatment (Public Health Outcomes Framework)**

Local outcomes

- **Number of drug users over 18 years in effective treatment**
- **Percentage of people aged 18 and over leaving treatment who do so as a planned exit**

- **Percentage of people over 18 leaving treatment who do so in a planned way and do not re-present within 6 months**
- **Successful completions as a proportion of all in treatment – opiate**
- **Successful completions as a proportion of all in treatment – non-opiate**
- **Percentage of people who have been in treatment for over four years**
- **Number of drug related deaths**
- **People successfully maintaining independent living (from housing input)**

Impact in Brighton & Hove

The impact of drug misuse on the city of Brighton & Hove is well documented. The Brighton & Hove Drug Treatment Needs Assessment 2013-14⁴ indicates that there are 1,582 clients in drug treatment during 2012. A third of this client group have been in treatment for over four years. Table 1 shows the main problem drugs of those in treatment during 2012 for Brighton & Hove.

Primary Drug	In Treatment During 2012
Heroin	65%
Cannabis	11%
Cocaine	4%
Crack	3%
Other	17%

Source: Brighton & Hove Drug and Alcohol Action Team

The drug using population are considerably more at risk from blood born viruses. Data for 2011 indicates a local prevalence of hepatitis C of 66% for this population, compared with 43% for England, Wales and N.Ireland.⁴

¹ Brighton & Hove Safe in the City Partnership. Community Safety, Crime Reduction and Drugs Strategy 2011-14.

² National Treatment Agency. Club drugs: Emerging Trends and Risks. 2012

³ HM Government. Drug strategy 2010. Reducing demand, restricting supply, building recovery: supporting people to live a drug free life.

⁴ Brighton & Hove Drug and Alcohol Action Team. Substance Misuse (drugs) Needs Assessment 2013-14 draft.

The average age of those in treatment is 38 years and eight months for males and 36 years and 8 months for females. The proportion of women in treatment continues to grow making up 29% of the treatment population in 2012. The National Treatment Agency Cluster classification places Brighton & Hove in group E for opiate users, and group D for non-opiate users (with group A being the least complex and group E the most complex). For opiate users, this indicates a population of opiate users locally who present with the greatest complexity. Between February 2012 – January 2013, 8.6% of opiate users (n= 103) left treatment successfully. This places Brighton and Hove 7th out of 28 (up from 25th place) of local authorities in the Cluster E group (highest complexity) for opiate users.⁴

During 2012 there was an average of 12.5 attendances at the Royal Sussex County Hospital A&E department each month related to “drug addiction”.⁴ It is likely that this represents an under reporting of activity. The cost of A&E attendance and hospital admissions is high.

Drug misuse can have a major impact on young people’s education, health, families and long-term life chances.¹ In Brighton & Hove, 48% of clients are parents, but only 15% are actually living with a child.

The impact on the community is also documented.⁵ There is often an impact on housing, and significant numbers of people within the integrated support pathway have substance misuse issues. Across the band two (24 hour hostel accommodation) and band three (supported accommodation) supported housing, high self reporting of a need to manage a substance misuse problem is seen in residents, with 87% reporting need in Glenwood Lodge Hostel, 85% in West Pier Project Hostel and 57% reporting need in band three (all supported housing provision for single homeless clients).⁵

Using National Programme on Substance Abuse Deaths (np-SAD) data, in 2011 Brighton & Hove had the 7th highest rate of drug-related deaths in the country⁴. There were 20 np-SAD drug-related deaths in residents aged 16 years and over, or 8.77 per 100,000 population, falling from a peak of 32.6

per 100,000 in the year 2000. This equates to a drop from 67 deaths to 20. The highest rate in 2011 was City of Manchester with 14.86 per 100,000 people. Local data (from the police and substance misuse data set which uses a much broader definition) indicate that during 2012 there were 31 deaths. The data sets do use different methodology, and this must be considered when comparing the year on year statistics. Programmes of work are underway to reduce the number of drug related deaths e.g. naloxone mini jet provision and training and first aid/overdose prevention training.

A service user involvement worker undertakes consultation with clients currently in the treatment system. The key priorities identified in 2012 were:

- Access to appropriate housing to support recovery and reintegration into the community
- A focus on those with a ‘dual diagnosis’ (usually substance misuse and mental health needs)
- Improved quality of care and support in hostels
- Improved access to counselling services and ongoing support
- Greater access to employment and training opportunities for service users

Local inequalities

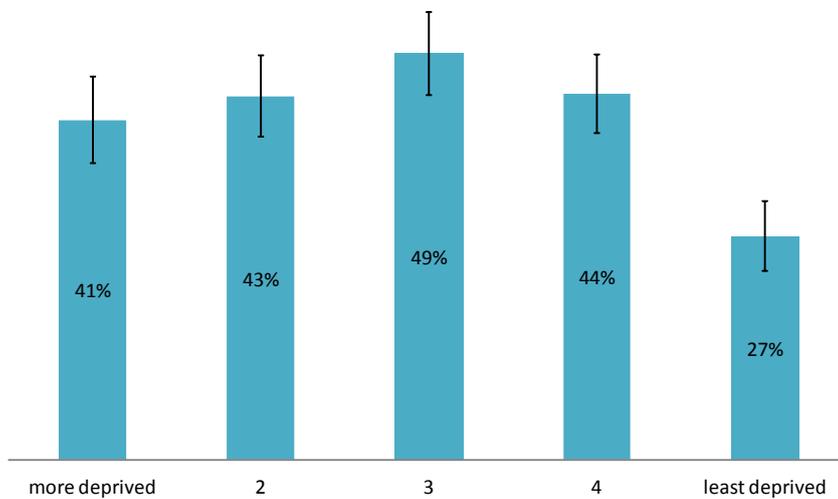
A question on drugs was included for the first time in the 2012 Health Counts Survey. Most respondents, 60% had never taken drugs not prescribed to them or available at a chemist, 10% had taken in the last four weeks and an additional 7% in the last year (but longer ago than four weeks).

Having ever taken drugs is not associated with deprivation within the city. Whilst it is lowest in the least deprived areas it is highest in the middle three quintiles (Figure 1).

⁵ Brighton & Hove City Council. Housing Commissioning Team Contract Monitoring.

7.3.7 Substance misuse (Adults)

Figure 1: Percentage of respondents ever having taken drugs by quintile of deprivation within Brighton & Hove, 2012



Source: Health Counts Survey 2012

The Health Counts 2012 Survey also showed that:

- Having ever taken drugs is higher for males than females (45% for males and 36% for females) and this is the case in all age groups. Having ever taken drugs is highest in those aged 25-34 years and falls in each age band after this age to just 5% of males and 0% of females aged 75 years or over.
- LGB and unsure respondents (63%) are statistically significantly more likely to have ever taken drugs than all respondents. The highest percentages were for lesbian/gay women (76%), bisexuals (74%), and those who are unsure of their sexual orientation (86%), however, it should be noticed that the sample sizes in those groups are very small.
- Drugs use is lower in BME respondents (34%) than White British respondents (42%), though the difference is not significantly significant.
- Those who are single are significantly more likely to have ever tried drugs (48%) and those who are widowed (9%) or separated or divorced (26%) significantly less likely.
- Carers (33%) were significantly less likely than all respondents to have ever tried drugs.
- Respondents with no religion (60%) were significantly more likely to have ever tried drugs than all respondents (though this could be related to age), Christians were significant less

likely (21%) and 36% of those with another religion had ever tried drugs.

- Respondents who rent from a private landlord were significantly more likely to have ever tried drugs (54%).
- Employed respondents are significantly more likely to have ever taken drugs (49%). The figure was also higher for students (46%), though not significantly so. Retired respondents were significantly less likely (4%) to have ever taken drugs, though this is likely to be strongly age related.
- Respondents with degree level qualifications or higher were statistically significantly less likely to have ever tried drugs (22%).

There is an under-representation of the lesbian, gay, bisexual and transgender (LGBT) community within the treatment population (8%) in treatment compared with an estimate of 13% within the City).⁴ Use of substances within this community may not be problematic, however given evidence of higher levels of use and under-representation within treatment it is possible that a gap in provision exists. The LGBT community are over represented in respect of use of "Club Drugs" 40% (n=19) of the 48 people in treatment who were being supported for use of these substances come from this community.

There is also under representation from the Black and Minority Ethnic (BME) groups. Anecdotally, feedback indicates that this may be due to cultural issues, and the preference to deal with these types of issues within communities, rather than approaching treatment services.

Substance-free accommodation can be very important for a person in the treatment system. However, there is a lack of this in the integrated support pathway for those who exit treatment into band 3 supported accommodation.⁶

Where we are doing well

There is a well established substance misuse treatment service in Brighton & Hove. With support from the National Treatment Agency (now

⁶Housing Commissioning Team.

known as Public Health England), commissioners and providers work in partnership to improve outcomes for service users. Services have been reconfigured and are now more accessible to all clients. Assessment and entry to treatment services is on a 'drop-in' basis. By quarter 4 of 2012/13, performance rates for opiate users in treatment had improved considerably compared to the previous year. More opiate users are successfully completing treatment and not re-presenting to services within 6 months. Harm reduction rates (acceptance of HBV vaccinations and HCV testing) are considerably higher than national figures, and reflect the hard work of treatment providers to engage with clients⁷.

There fall in drug-related deaths from 67 in 2000 to 20 in 2011 can, in part, be attributed to the extensive roll out of take home naloxone, and the provision of overdose and first aid training which has been instrumental in increasing service user and staff knowledge on how to support someone who may be overdosing.

Within the substance misuse field there has been a renewed emphasis on implementing the recovery model, and the Recovery 'Golden Thread' Implementation Group will ensure recovery runs through every aspect of service delivery.

Predicted future need

The National Treatment Agency indicates that a greater focus is needed on non-opiate clients, as performance for this client group is dropping off⁷.

The services to support young people transitioning to adult services seem to be in place. However, it is likely that there is a group of people between the age of 18 and 25 not presenting to treatment service, particularly for alcohol and cannabis abuse. It is likely that this will be an area of future focus.

It is possible that there are a number of different cohorts of people using novel psychoactive substances who could benefit from support. Evidence to date suggests these could include men sleeping with men, club drug users and people in employment who are unlikely to engage with 'traditional' treatment services. It is also possible that there are a cohort of individuals addicted to

pain medication following a period of ill health. Supporting these individuals to successfully detox from the medication will be vital.

There will need to be a continued focus on the development of recovery-orientated services, ensuring that aftercare/post successful completion services are available to support people to stay in recovery. This will include a focus on health and wellbeing services, alongside employment, training and housing support.

What we don't know

The inequalities identified in the LGBT and BME groups indicate that there may be a number of individuals who could benefit from treatment services, but do not present to treatment. We do not know the reason for this. It may be cultural, with more people from these community groups not considering themselves to have a problem with substances, or it could be because the communities are reluctant to present to treatment. It could be that these individuals do not actually have an issue with substance misuse. In the future, more detailed consultation work will be undertaken with these groups to identify barriers.

Key evidence and policy

The 2010 National Drug Strategy
<http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010>

The National Treatment Agency produces a number of key evidence and support documents.
<http://www.nta.nhs.uk/>

Recommended future local priorities

As the last procurement exercise took place in 2007, and given the recent national strategy developments, it is timely to review drug and alcohol services available locally, and undertake a re-tendering exercise to shape the future delivery of services. This would be with a view to having new contracts awarded and services operational from 1st April 2015.

Whilst this development work takes, the ongoing service improvement work streams will continue. These are:

1. Ongoing review of existing services to ensure they focus on recovery and reintegration

⁷ National Drug Treatment Monitoring System. *Diagnostic Outcomes Monitoring Executive Summary*. National Treatment Agency. Q4 2012/13

7.3.7 Substance misuse (Adults)

2. Establishment of an evening clinic session for novel psychoactive substance users away from 'traditional' treatment services
3. Work with colleagues from the Pain Clinic to identify individuals who could benefit from support to detox from pain killers
4. Development of a Brighton and Hove Recovery Communication strategy with a view to changing the community perspective regarding people in recovery.
5. Work with Work Programme Providers to support more people into employment

Key links to other sections

- Alcohol and substance misuse (Children and young people)
- Alcohol (Adults and older people)
- Dual diagnosis

Further information

Brighton & Hove Drug and Alcohol Action Team (DAAT) Substance Misuse Needs Assessment 2012/13 <http://www.bhlis.org/needsassessments>

Last updated

July 2013

7.3.8 Domestic & sexual violence/abuse Brighton & Hove JSNA 2013

Why is this issue important?

Domestic violence and abuse is an incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 years or over who are or have been intimate partners or family members, regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial and emotional. This also includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Sexual violence and abuse is any behaviour perceived to be of a sexual nature which is unwanted and takes place without consent or understanding. This includes: rape and sexual assault; sexual violence and abuse (by partners, family members and by strangers); sexual harassment; trafficking and commercial sexual exploitation and child sexual abuse.

Domestic and sexual violence and abuse, and a range of other associated crime types,¹ affect both women and men. However, there are gender differences in the scale, incidence and effects of these crime-types,² and women and girls experience them disproportionately and cumulatively during their lifetime. They are a significant cause and consequence of gender inequality, and impact on women's ability to fully participate in employment, education and in local communities. Nationally, research shows:

- Around 31% of women and 18% of men report experiencing any domestic abuse since the age of 16. These figures were equivalent to an estimated 5 million female victims of domestic abuse and 2.9 million male victims between the ages of 16 and 59.
- In 2011/12, 88 women were killed by a current or former partner: 51% of female homicide victims were killed by a partner or ex-partner, with an additional 18% killed by other family

members; the respective numbers for men are 5% and 11%.³

- 20% of women and 3% of men report experiencing a sexual assault since the age of 16, with young women at the greatest risk.³

In addition:

- Up to 6,500 girls are at risk of female genital mutilation (FGM) in the UK each year.⁴
- In 2012 the Forced Marriage Unit gave advice or support in 1,485 cases of possible forced marriage (FM).⁵ While FM can happen to both men and women, most cases involve young women and girls aged between 13 and 30. It is also frequently under-reported.⁶
- 2,077 potential victims of human trafficking were identified in the UK in 2011 and just over half were women.⁷ It is likely that the number of victims is higher than this given the nature of human trafficking, which makes gathering statistics on the scale of the problem difficult.⁸

There is also an increasing amount of evidence available about the direct impact on children and young people. For example, national research on teenage partner violence found that 25% of girls and 18% of boys in intimate relationships experienced physical abuse, 75% of girls and 14% of boys experienced emotional abuse and 33% of girls and 16% of boys experienced sexual abuse. Girls reported greater incidence rates, experienced more severe abuse more frequently and suffered more negative impacts, compared with boys.⁹

Domestic and sexual violence and abuse, and associated crime types, can have a range of acute impacts which will result in the use of health services. These can include physical injury, as well as the impact on mental and emotional wellbeing, employment and education, social capital, health

³ Office for National Statistics. The Crime Survey for England and Wales: Focus on: Violent Crime and Sexual Offences, 2011/12. 2013

⁴ FORWARD <http://www.forwarduk.org.uk/key-issues/fgm>

⁵ Forced marriage unit. Statistics January to December. 2012. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/141823/Stats_2012.pdf

⁶ HM Government. Multi-Agency Practice Guidance: Handling Cases of Forced Marriage. 2009

⁷ Serious Organised Crime Agency (SOCA). UKHTC: A Baseline Assessment on the Nature and Scale of Human Trafficking in 2011. 2012

⁸ STOP THE TRAFFIK (<http://www.stopthetraffik.org/the-scale-of-human-trafficking/>).

⁹ National Society for the Prevention of Cruelty to Children (NSPCC). 2009

¹ Including: rape and sexual violence; stalking; female genital mutilation (FGM); forced marriage; crimes committed in the name of 'honour'; trafficking; sexual exploitation, including commercially through prostitution and the sex industry; and sexual harassment in the workplace and public sphere.

² Equality and human rights commission (EHRC). Walby, Armstrong and Strid. Physical and legal security and the criminal justice system: a review of inequalities. 2010

7.3.8 Domestic & sexual violence/abuse Brighton & Hove JSNA 2013

behaviours and homelessness. There can also be longer term impacts such as poor school achievement, reduced economic prospects, behavioural problems, substance abuse, poor mental, sexual or physical health, and the risk of further violence.¹⁰

The direct physical health consequences of domestic and sexual violence can include physical injury, sexually transmitted infections and unwanted pregnancy. Long-term consequences include post-traumatic stress disorder, anxiety and panic attacks, depression, social phobia, substance abuse, obesity, eating disorders, self-harm and suicide.^{11,12} Similar issues can arise for those affected by FM.¹² Violence in the home can also normalise violence in future relationships for both girls and boys, whereby girls think it is normal to accept it and boys think it is normal to be violent.¹³

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 is not only cost-effective but contributes to the health and wellbeing of the population. For example, more women suffer rape or attempted rape than have a stroke each year, and the level of domestic abuse in the population exceeds that of diabetes many times.¹⁴

Key outcomes

- **Domestic abuse (Public Health Outcomes Framework)**
- **Violent crime (including sexual violence) (Public Health Outcomes Framework)**

The citywide outcome, which will be reviewed and extended in 2013/14 to include all associated crime types as part of the VAWG strategy, are for local residents and communities to be free from domestic and sexual violence and abuse by:

- Increasing survivor safety;
- holding perpetrators to account;

- Decreasing social tolerance and acceptance;
- Increasing people's ability to have safe, equal, violence-free relationships.¹⁵

Impact in Brighton & Hove

In 2012/13, 3,404 domestic violence incidents and crimes were reported to the police in Brighton & Hove, an increase of 0.9% on 2011/12. In the same period, there were 339 finalised domestic violence prosecutions, of which 232 were successful. In 2012/13 there were 373 police recorded sexual offences, an increase of 12% compared with the previous year. However, police recorded data is an underestimate of the number of crimes committed since substantial numbers of people do not report such violence to the police.

Based on the 2010 Home Office Ready Reckoner tool,¹⁶ developed to estimate the prevalence and cost of violence against women and girls, and 2011 census population data for Brighton & Hove, it is estimated that in the last year between 5,816 women aged between 16 and 59 experienced domestic violence; 2,953 experienced sexual assault; and 7,212 were victims of stalking. The individual, economic and social cost of domestic and sexual violence and abuse alone to the city is estimated to be £143 million per annum.

Results from Brighton & Hove's Citizen Panel in 2010 showed that fear of sexual assault disproportionately affects women: 13% of women reported that they were very or fairly worried about being the victim of a sexual assault compared with 2% of men.¹⁷

In 2012/13 221 homeless applications were made due to domestic violence, of which 48 were accepted. In the same year, the local independent specialist domestic violence service (RISE) supported 1,629 survivors in Brighton & Hove. In 2012/13, 335 clients were supported by the RISE Independent Domestic Violence Advisor Service

¹⁰ Department of Health. Protecting people Promoting health. 2012

¹¹ Home Office and Department of Health. Itzen C. Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Abuse. 2006

¹² Forced Marriage Unit. Report on the Implementation of the Multi-Agency Statutory Guidance for Dealing with Forced Marriage (2008). 2012

¹³ Women's Health and Equality Consortium. Better Health for Women. 2013

¹⁴ Department of Health. Taskforce on the Health Aspects of Violence Against Women and Children. 2010.

¹⁵ For a description of the outcomes and associated sub outcomes please refer to the Brighton & Hove Preventing Violence against Women and Girls: An Integrated Strategy and Action Plan 2012-2017. Available at: www.safeinthecity.info/vawg

¹⁶ Home Office. Violence Against Women and Girls Ready Reckoner Tool. 2010. Available at:

<http://webarchive.nationalarchives.gov.uk/20100104215220/http://crimerecord.uction.homeoffice.gov.uk/domesticviolence/domesticviolence072.htm> [Accessed 15/08/2013]

¹⁷ Brighton & Hove Citizens' Panel. Community Safety Survey. 2010.

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(IDVA) for clients at high risk of harm; of these, 51% identified as having some form of mental health issue, 18% identified as misusing alcohol, and 11% identified as misusing drugs.

In 2012/13, the Saturn Centre - the local Sussex Sexual Assault Referral Centre (SARC) - supported 68 Brighton & Hove clients. These clients were then referred to Survivor's Network's, the local independent specialist sexual violence service.

Of the 180 women receiving counselling from the Brighton Women's Centre in 2011/12, 38% had experienced sexual abuse, 42% domestic abuse and 29% childhood abuse. The Brighton Women's Centre also runs inspire, a partnership project working with women offenders in the city. Of the 169 women accessing Inspire in 2011/12, 66% reported having been raped, abused or experienced domestic violence.¹⁸

Previous research identified that between 2001 and 2004 there were 112 maternities to women with FGM in Brighton & Hove.¹⁹

A 2007 study into the sexual exploitation of young people across Sussex 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.²⁰

Consultation with survivors locally found that whilst they welcome and highly value the support offered by independent specialist domestic and sexual violence services in the city, they have little confidence in many public services, which they said failed to identify and respond to their needs; made them feel excluded, isolated, judged and blamed for the violence; and hampered their ability to seek help.

Local inequalities

Domestic and sexual violence and abuse occur in every socio-economic group, across all communities. However, while these and associated crime types affect women and men, they are not

gender neutral when considering prevalence, frequency or impact.

Reflecting the gendered nature of these crime types, the City's approach sits within a broader strategy to prevent Violence against Women and Girls (VAWG). This strategy reflects the United Nations (UN) Declaration (1993) on the elimination of violence against women, which identifies violence against women as *"any act of gender-based violence that is directed at a woman because she is a woman, or acts of violence which are suffered disproportionately by women, that results in, or is likely to result in, physical, sexual or psychological harm or suffering to a woman or girl, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life."*

Although domestic and sexual violence and abuse and associated crime types are predominately experienced by women and girls, they can affect men. While there is limited evidence available, the existent research highlight the complexity of working with this group, in particular heterosexual men, who may perpetrate or experience abuse.²¹ Consequently, in addition to working with men and boys who use violence and abuse, it is important to ensure that there is support available, proportionate to need, for men and boys who are victims of violence and abuse. Men are also included in the City's strategy in order that they might participate in campaigns to end violence and abuse, such as the White Ribbon campaign.

It is also important to recognise the impact of additional vulnerabilities. National evidence shows that some women face significant disadvantage and marginalisation, including those in prison, prostitution or sex work, as well as women who are asylum seekers, migrants, Black and Minority Ethnic and Refugee (BAMER), disabled, lesbian or bisexual.¹³ Other groups with identified needs in terms of risk or access to services include trans people²² and gay and bisexual men.²³

Brighton & Hove has large lesbian, gay, bisexual and trans (LGBT) communities, estimated to make up 14% of the population. Count Me In Too

¹⁸ Brighton Women's Centre. Inspire and Women's Counselling Service data and feedback. June 2013.

¹⁹ FORWARD. A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales. 2007

²⁰ Banardos, Tipping the Iceberg - A pan Sussex study of Young People at Risk of Sexual Exploitation and Trafficking. 2007

²¹ Robinson A. Rowlands J. The Dyn Project: Supporting Men Who Experiencing Domestic Abuse. 2006

²² Brighton & Hove City Council. Trans Equality Scrutiny Panel report. 2013

²³ Stonewall. Domestic Abuse: Stonewall Health Briefing. 2012

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(2007)²⁴ suggested that locally 8,750 lesbians, gay men, bisexual and trans experience abuse at some point in their lives as an adult or child, and between 2001 and 2006, 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, in March 2013, 150 children (54% of children with child protection plans), had domestic violence as an underlying cause for having a Child Protection Plan in place.²⁵ Young people may also be experiencing domestic and sexual violence in their relationships, although limited data is available on this locally. A local study into the profile of local young teenage mothers highlighted that around one in three were subject to domestic violence.²⁶

There is a lack of data locally about prevalence in Black and Minority Ethnic (BME) communities, disabled communities and amongst older people. In 2012/13, of 380 victims of domestic violence assessed as high-risk of harm locally and referred to the Multi-Agency Risk Assessment Conference (MARAC), 13% were from BME communities and 8% were identified as disabled. Brighton & Hove's Scrutiny Panel on Older People (2009) heard evidence that signs of domestic violence amongst older people were not being well recognised amongst professionals locally, which is why data on domestic violence in older age groups is limited.

Predicted future need

Domestic and sexual violence prevention continues to be central to agendas on public health promotion: reducing crime; safeguarding children and adults with support needs; supporting families facing multiple disadvantages; promoting equality, and improving education, learning and skills development.

Between 2004/04 and 2008/2009 the number of recorded violence incidents fell, although this does not take account of the continued high levels of

under-reporting²⁷ or the increasing number of referrals to specialist services noted above. Other emerging trends include the increase in reporting of historic sexual offences.²⁸

Nationally, reforms to immigration legislation, eligibility for legal aid, welfare and housing reforms are likely to have a significant impact on victim and survivors' access to protection and support. At the same time, the effect of public expenditure reductions will have an impact on the provision of violence against women services. For example, 230 women (9% of those seeking refuge) were turned away by Women's Aid on a typical day in 2011 due to lack of space. This is likely to lead to a greater pressure on local services,²⁹ with service users presenting with more complex needs.

What we don't know

Locally (as with most public services) we have no data available from health services about victim/survivors' and perpetrators' use of NHS service. We also lack information about the compliance of local safeguarding services with national statutory guidance on forced marriage and multi-agency guidelines on female genital mutilation.

There is a paucity of data on the impact of these crime types on local equality groups such as carers or with reference to religion.

Many of these crime types share common features, including under-reporting and the risk of repeat victimisation. For example, only a third of those reporting domestic abuse tell someone in an official position, while only one in ten victims of serious sexual assault report the incident to the police.³⁰

Key evidence and policy

Local policy drivers in Brighton and Hove include:

- Domestic Violence Needs Assessment 2010/11

²⁴ Browne K, Lim J. Count me in too, General Health Additional Findings Report University of Brighton and Spectrum; 2008.

www.realadmin.co.uk/microdir/3700/File/CMIT_DV_Report_final_Dec07.pdf [Accessed 26/08/2012].

²⁵ Please note that more than one underlying cause can be recorded for Child Protection Plans.

²⁶ Brighton & Hove Children's and Young People's Trust. Health Visitor Caseload report. 2009

²⁷ Walby S. The cost of domestic violence: up-date 2009. 2009

²⁸ Safe in the City, Brighton & Hove Community Safety Partnership. Strategic Assessment of Crime and Disorder. 2012

²⁹ Walby S. Measuring the impact of cuts in public expenditure on the provision of services to prevent violence against women and girls. 2012

³⁰ Smith K, Osbourne S, Lau I et al. Homicide, firearm offences and intimate violence 2010/11: supplementary volume 2 to Crime in England and Wales 2010/11. 2012

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- Domestic Violence Commissioning Strategy 2012-15
- Community Safety, Crime Reduction and Drugs Strategy 2011-14
- Preventing Violence Against Women and Girls: An Integrated Strategy and Action Plan 2012-17
- The UK Government's 'Call to End Violence against Women and Girls' and updated action plan 2013 is a key national policy driver.

Recommended future local priorities

More work is needed to co-ordinate responses to domestic and sexual violence and abuse. Priorities for these crime types should be built around the key themes from the VAWG strategy (*prevention, provision, protection and partnership*). These include delivering or commissioning:

Prevention initiatives, including:

- Earlier identification and improved response to domestic violence and abuse by implementing IRIS³¹ in general practices.
- Developing work with children and young people, with a focus on prevention, early intervention and increased resilience, as well as safeguarding and services for families facing multiple disadvantages.
- Including domestic and sexual violence and abuse, and associated crime types, within induction, continuing training and development.

Provision initiatives, including:

- Identifying operational leads within each health setting to advise on appropriate services, care pathways and referrals, e.g. Lead health professional to facilitate referral to, and engagement with, the Multi-Agency Risk Assessment Conference (MARAC).
- Continued delivery of the Specialist Domestic Violence Court (SDVC), the Multi-Agency Risk Management Conference (MARAC), and the Sexual Assault Referral Centre (SARC).

- Implementing the statutory guidance on FM and multi-agency guidance on FGM.

Protection initiatives, including:

- Sustaining the provision of a Health Independent Domestic Violence Advocate (HIDVA).

Partnership initiatives, including:

- Delivering publicity campaigns within a health setting to raise awareness and knowledge.
- Identifying strategic leads within each health setting to advise on appropriate services, care pathways and referrals.
- Developing the data available to assess the effectiveness of local services in meeting citywide outcomes.
- Explore opportunities for reinvestment and resource pooling
- Joint commissioning to sustain and develop provision, in particular from the independent specialist sector, to deliver services to support the above programmes, as well as to promote recovery and resilience for victims and survivors and to hold perpetrators to account.
- Supporting the new VAWG Programme Board and a review of priorities so that the response to domestic violence and abuse, and associated crime types, is a citywide priority.

Key links to other sections

- Parenting
- Maternal and infant health
- Emotional health and wellbeing
- Crime and safety

Further information

<http://www.bhlis.org/needsassessments>

Last updated

June 2013

³¹ IRIS (Identification and Referral to Improve Safety) is a general practice-based domestic violence and abuse (DVA) training support and referral programme that has been evaluated in a randomised controlled trial (<http://www.irisdomesticviolence.org.uk/>)

Why is this issue important?

Older people (those aged 65 and over¹) are the fastest growing population group in England and Western Europe. Growing old is not the same as growing infirm. The rate of decline in health and wellbeing is largely determined by factors related to lifestyle as well as external social, environmental and economic factors and people can take some control over their ageing. There is solid evidence that promoting physical and mental health in older people prevents or delays the onset of disability as do public policy measures, such as promoting an age-friendly living environment.^{2,3,4,5}

Material conditions, social factors and the interaction between them influence how well individuals age. The life satisfaction and general wellbeing of older people is reduced when they are isolated, poor, in ill-health, living alone or in unfit housing and rundown neighbourhoods, when they require or are a carer or live in a care home. Bereavement presents an additional threat to quality of life.⁶ Transport is another important factor in determining older people's ability to access vital amenities and allows older people to remain independent and active in later life and helps people stay connected.

There has been a national policy shift towards an adult social care and health service that has prevention, early intervention and enablement at its core, as well as choice and control over services through personalisation. This approach has the potential to enhance wellbeing and also save money.

¹ In the absence of any guidance as to definition of 'older', this summary is using 65 or over as the starting point .

² Banks J, Breeze E, Lessof C, Nazroo, J. Retirement, health and relationships of the older population in England: The 2004 English Longitudinal Study of Ageing (Wave 2). 2006.

³ Bassey EJ. Physical capabilities, exercise and ageing. Reviews in Clinical Gerontology 1997; 7(4): 289–297.

⁴ Center for Lifespan Psychology. Annual report 2003–2004. Available at: www.mpib-berlin.mpg.de/sites/default/files/media/pdf/25/lip_report_11.pdf . [Accessed April 2011]

⁵ World Health Organization. Global age-friendly cities: a guide. 2007. Available at:

http://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf [Accessed 16/05/2013]

⁶ Brighton & Hove Annual Report of the Director of Public Health 2010: Resilience. Available at:

<http://www.bhlis.org/needsassessments/publichealthreports> [Accessed 26/05/2013]

Key outcomes

- ***Older people's perception of community safety (Placeholder) (Public Health Outcomes Framework)***
- ***Falls and injuries in the over 65s (Public Health Outcomes Framework)***
- ***Health related quality of life for older people (Public Health Outcomes Framework)***
- ***Hip fractures in the over 65s (Public Health Outcomes Framework)***
- ***Excess winter deaths (Public Health Outcomes Framework)***
- ***Dementia and its impacts (Public Health Outcomes Framework)***
- ***Enhancing the quality of life for people with dementia (NHS Outcomes Framework)***
- ***Helping older people to recover their independence after illness or injury (NHS Outcomes Framework)***
- ***Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation service (Adult Social Care Outcomes Framework)***

Impact in Brighton & Hove

Currently there are 35,800 people aged 65 or over in the City; 20,100 females and 15,800 males⁷, with the ratio of women to men increasing with age.⁸

The largest percentage of residents aged 65 years and over are in five wards, with over half the City's older people living in the 40% most deprived areas for older people in England, and some in the 4% most deprived. The West locality has the highest number of older people and prevalence of stroke, diabetes and dementia. In seven wards, fewer than one in ten people is aged 65 years or over.⁹

Brighton & Hove has a relatively large proportion of older people living alone and potentially isolated who are more dependent upon public services.

⁷ Figures do not sum due to rounding

⁸ Office for National Statistics. Population Estimates for England and Wales, Mid-2011 (2011 Census-based). Released: 25 September 2012. Available at <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-262039> [Accessed 17/07/2013]

⁹ Census 2011. ONS

7.3.9 Ageing well

Single pensioner households are higher than average and the majority of people aged 75 or over live alone; of those living alone, 34% are male, 61% female.^{6, 10}

Across all sectors older people are presenting with more complex needs.

The City has almost twice the national suicide and undetermined injury death rate in older people. Up to 16% of people aged 65 and over have depression, 2–4% have severe depression.⁶

Older people feel less safe in their neighbourhoods after dark, particularly those on low income or in more deprived areas – 45% of those aged 75 and over compared to 23% of all residents.¹¹

The majority (62%) of people with a limiting disability (more likely to be older people) do no 30 minute sessions of moderate intensity sport and active recreation a week compared to 38% of people without a limiting disability. Only 7% of adults aged 55 years and over participate in at least three 30 minute sessions of sport per week.¹²

Some older people require assistance and support to be able to make use of free travel.⁶

Many older people in the City may not claim the benefits to which they are entitled and which would increase their resilience.⁶

In some areas of the City, 12% of men over 50 have an average weekly alcohol consumption of over 35 units, well above recommended limits.¹³

There are many carers, including 11,500 aged over 50, with increasing numbers of older parent carers of adults with LD/autism. Significant numbers of carers report feeling out of control of their daily life, lonely and detached from society and want support for their own issues.¹⁴

Older people with increasing levels of need are being discharged early from hospital to be

supported at home by informal/formal carers, this potentially increases their isolation.

Personalisation and personal budgets should have significantly changed the way services are delivered to improve the older person's experience, however outcomes are mixed and take-up of direct payments by older people locally has declined.

The local NHS and Brighton & Hove City Council (BHCC) both fund 'gateway' organisations to ensure older user voices inform decision making, including BME elders. There are many older people user-led organisations/groups including MindOut (peer support for LGBT elders with mental health issues); Hangleton and Knoll 50+ Group which coordinates health activities; The Neighbourhood Care Scheme is directed by users and is a good neighbour scheme to primarily isolated older people; Lifelines volunteers (all 50+) design and deliver individual and group activities in partnership with an extra care housing scheme.

The voice of older people is evidenced in the Place Survey and Brighton & Hove Age UK/Brighton University Wellbeing research published in 2012, "Well-being in old age: findings from participatory research". This research evidences that older people want a person centred approach to daily living.¹⁵ Findings have also been developed into learning resources and are feeding into local policy and practice.

Further, the analysis revealed the very different experiences that constitute old age and the varied factors that affect wellbeing at this stage of life. Relationships of different types are important and the resources and capacities that people have to adapt to personal and social changes can make a big difference to people's sense of being well in old age. In addition, security, feeling like you 'belong', and being confident that help is there if you need it are all important.¹⁵

The report suggests that there is a danger that definitions that emphasise physical health, people's capacity to plan and set goals, and to be active within their communities, may exclude people for whom old age is accompanied by illness,

¹⁰ Institute for Public Care. Projecting Older People Population Information System (POPPI). Available at: <http://www.poppi.org.uk/> (registration required). [Accessed 30.05.2013]

¹¹ Brighton and Hove Safe in the City Partnership. Older people and Community safety – extract from the Strategic Assessment of Crime and Disorder: 2010.

¹² Brighton & Hove physical activity and sport needs assessment. 2012 <http://www.bhlis.org/needsassessments>

¹³ University of Kent. Health Counts: Analysis of a survey of people aged over 50 in Hangleton and Knoll and Queen's Park. 2005/6.

¹⁴ Department of Health. Government Information for Carers. www.carers.gov.uk

¹⁵ Ward L. Barnes M. Gahagan B. Well-being in old age: findings from participatory research. University of Brighton & Age UK Brighton & Hove. 2012. <http://www.brighton.ac.uk/sass/older-people-wellbeing-and-participation/Full-report.pdf>

a reduction in physical horizons because of mobility problems and who, because of advanced old age, are focused on being well in the present rather than planning for the future. The authors suggest it is useful to explore what wellbeing means to older people within the context of their relationships with other people, the place that they live and the giving and receiving of care, rather than setting a standard against which to measure older people's wellbeing.¹⁵

Where we are doing well

Brighton & Hove has recently been affiliated by the WHO into its Age Friendly City network. This will encourage active ageing by optimizing opportunities for health, wellbeing and participation. This strategic approach which has cross-party support will raise the profile of older people, prevention and wellbeing services.

Brighton & Hove has nearly double the national average of independent active older people and a smaller proportion with high care needs. Healthy life expectancy and disability-free life expectancy at age 65 years are higher for females in Brighton & Hove than in England.⁶

The new Ageing Better partnership has identified best practice engagement, including outreach, home visits, a range of information dissemination and proactive engagement to enable access by older people, in neighbourhoods or across communities of identity/interest.

Day activities were reviewed by older people and their carers, resulting in a radical new way of commissioning services.

Free bus travel has helped reduce social isolation among older people.

Older people appear to be more satisfied with their local area than those in younger age groups, with those aged between 65-74 years most satisfied. Older people in the City are more likely than younger people to be satisfied with public services and feel they work to make areas cleaner and greener.¹⁶

Although older people are less willing to give up smoking, once they have decided to quit they seem to be more successful than younger age groups.⁶ By

the age of 75 years or over, for males and females, smoking prevalence reaches its lowest point (5% for males and 10% for females).¹⁷

The 2012 Health Counts Survey showed that residents aged 65-74 years were most happy: 78% for men and 77% for women compared with 72% for all adult respondents. In addition, whilst just 58% of survey respondents felt very or fairly strongly that they belonged to their immediate neighbourhood, this feeling increases with age for both men and women: 78% of those aged over 75 years feel very or fairly strongly that they belong compared to just 46% of those aged 18-24 years.¹⁸

Older people in Brighton & Hove appear to have a better diet than the average younger person.¹⁹

A relatively high proportion of older people have higher level qualifications and the proportion with no qualifications is lower than England. Brighton & Hove has a large number of organisations providing adult learning at affordable cost.⁶

A higher proportion of older people participate in groups making decisions affecting their local area and a significant proportion contribute through volunteering, in line with the national picture.¹⁵ Sense of belonging increases with age for both males and females, with 78% of those aged over 75 years feeling very/fairly strongly that they belong compared to 46% of those aged 18-24 years.¹⁶

Older people are less likely than younger people to be victims of crime or a repeat victim of crime.¹⁵

The City has a strong and broad range of voluntary and statutory sector services which support vulnerable older people and enable them to participate in community activities, including older people/user led organisations/groups. Public sector funding for Voluntary and Community organisations (VCOs) is dependent on evidence of user involvement in design and delivery of services which continue to evolve in response to feedback.

Arts organisations have engaged older residents to help redesign programming, exhibitions and staff

¹⁷ Brighton & Hove City Council. Health Counts in Brighton & Hove 1992-2012

¹⁸ Brighton & Hove City Council and NHS Brighton & Hove. Annual Report of the Director of Public Health. Happiness: the eternal pursuit. 2012/13. Available at: http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/Director%20of%20Public%20Health%20Annual%20Report%202013_web_0.pdf [Accessed 15/08/2013]

¹⁹ University of Kent. Health Counts: Analysis of a survey of people aged over 50 in Hangleton and Knoll and Queen's Park. 2005/6.

¹⁶ Brighton & Hove City Council. Brighton and Hove Place Survey. 2008.

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training to increase the older audience, now up by 6% on 2003.

The City's Active for Life team designs and delivers activities with older people in targeted neighbourhoods, which helps raise awareness of what is on offer, significantly improving uptake.

Independence is important to older people; older people's home care services are increasing in line with a decrease in care home placements.

Assistive technology is being actively promoted demonstrating positive outcomes.

Local inequalities

Relative to East Brighton and other deprived parts of the City, the deprivation scores of the wards where higher numbers of older people live are quite low.

Brighton & Hove has a relatively high proportion of 'non-decent homes', and the highest rates are where the head of household is aged 85 years or over.²⁰

Some LGBT groups experience significant marginalisation and are less likely to feel that their local area is inclusive. Older LGBT groups experience discrimination, especially in communal accommodation.

There are isolated BME elders, including travellers. Service providers find it difficult to reach out to them - the BME needs assessment due in 2013 will inform future service development.²¹

Healthy life expectancy and disability free life expectancy at age 65 years is similar for males in Brighton & Hove and in England, but longer for females. The majority of people aged 75 years and over in Brighton & Hove live with a long term condition, as do a significant proportion of those aged under 75 years (38% of males aged between 65-75 years). Those who are married, in a civil partnership or living as a couple were significantly less likely to have a limiting long-term illness (21%) than all respondents, those who were separated or divorced (42%) or widowed (56%) were significantly more likely to have a limiting long-term illness.¹⁶

There is a clear relationship between self perceived health and age, with the percentage of respondents who say they are in good or better health falling from 93% of 18-24 year old to 54% of those aged 75 years or over in 2012.¹⁶

Eating five a day is significantly more common in females (59%) than males (46%). For females, the percentage increases with age from 18-24 year (50%) to 65-74 years (75%) but falls in those aged 75 years or over. For males there is an increase in the percentage eating five a day from 32% at 18-24 years to 52% of 35-44 year olds, the figures for those aged 45-74 are then similar with a fall to 48% for those aged 75 years or over.¹⁶

The Integrated Household Survey 2009-2010 indicates that Brighton & Hove has the lowest level of religious belief in the country, however the data are not broken down by age or gender.

Males aged 50 years and over are more likely to be victims of crime than women aged 50 years and over.⁹

Nationally, 42% of carers are men and 58% women. This is reflected in the figures for carers aged 50 and over in the City; 43% of whom are men and 57% women.²²

Predicted future need

Although the proportion of older people living in the City has fallen in recent years, the population aged 65 years or over is predicted to increase and become more ethnically diverse. The largest projected increases are in the 70-74 and 90 and over age groups.²³

Independence is important to older people; older people's home care services are increasing in line with a decrease in care home placements. Assistive technology is being actively promoted demonstrating positive outcomes; however there are risks of increased isolation which can affect older people's wellbeing.

The City is currently a high user of care homes but is committed to providing alternative accommodation options, in particular extra care

²² Department of Health. Government Information for Carers. Available at: www.carers.gov.uk [Accessed 18/04/2013]

²³ Office for National Statistics. Interim 2011 based sub national population projections. <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tc%3A77-274527> [Accessed 12/06/2013]

²⁰ Brighton & Hove Private Sector House Condition Survey. 2008

²¹ Brighton & Hove Gypsy and Traveller Rapid Health Needs Assessment. 2012. Available at: <http://www.bhlis.org/needsassessments>

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housing. Ideally new models will include provision designed by older people, keeping them active and less socially isolated.

Baby boomers have different aspirations and are keen to lead service design, which could lead to innovative and inclusive solutions for older people.

What we don't know

We do not have information on all groups including ethnicity, religion, marital status and lack comprehensive information on sexual orientation.

Key evidence and policy

World Health Organization. Global age-friendly cities: a guide. 2007.

whqlibdoc.who.int/publications/2007/9789241547307_eng.pdf

NICE Guidance: PH16 Mental wellbeing and older people: 2008

<http://guidance.nice.org.uk/PH16>

Recommended future local priorities

1. There is a need to raise the profile of older people in the City and develop a joined up approach to service provision that places older people firmly at the core and emphasises prevention and early intervention - the WHO Age-Friendly City approach will provide a vehicle to take this forward, as will the Council's new Commissioning Prospectus approach to commissioning and co-ordinating day services for older people.
2. Older people's active participation and contribution to community groups, schools and other neighbourhood activities should be encouraged as it builds resilience.
3. Better partnership working between agencies that support older people would help to mitigate the risk of cuts in public spending – the Ageing Better partnership is a good example.
4. Services and benefits should be publicised in the right places to ensure that older people access them, with information in a range of formats – not just web based.
5. Loneliness and isolation of older people, including carers, BME and LGBT elders should be addressed along with increasing the number

of older people actively participating in a full range of activities and services. Some older people need to be assisted and accompanied to ensure they access services. Ways to provide such support need to be developed.

6. It is important to focus not just on the very elderly but also on the younger cohort of older people if future health and wellbeing problems and associated costs are to be reduced.
7. We need an organisational culture change across the City so that participation and engagement by older people is actively encouraged and older people are visible and involved as leaders in the City. Strategic involvement of older people in service design and delivery along with active promotion of positive images of ageing are important steps to taking this forward.

Key links to other sections

- Social connectedness
- Community resilience
- Community assets
- Older people – Social Care
- Emotional health and wellbeing
- Accommodation and support – older people
- Dementia

Further information

Ward L. Barnes M. Gahagan B. Well-being in old age: findings from participatory research. University of Brighton and Age UK Brighton & Hove. 2012.

<http://www.brighton.ac.uk/sass/older-people-wellbeing-and-participation/Full-report.pdf>

As Time Goes By: Thoughts on Well-being in Later Years. University of Brighton and Age UK Brighton & Hove. 2012

Brighton & Hove Annual Report of the Director of Public Health 2010: Resilience.

<http://www.bhlis.org/needsassessments/publichealthreports>

Last updated

May 2013

Why is this issue important?

Influenza, or 'flu', is a highly contagious acute viral infection that affects people of all ages. It typically starts suddenly with fever, chills, headache, aching muscles, extreme fatigue and a cough or other breathing difficulties. While most people recover without complications in 1-2 weeks, flu can cause serious illness and death, especially in the very young and the elderly. Flu epidemics occur mainly in the winter months and can result in widespread disruption to healthcare and other services. A vaccine is produced every year based on the strains of virus expected to be circulating.¹

Influenza immunisation has been recommended in the UK since the late 1960s, with the aim of directly protecting those in clinical risk groups at a higher risk of serious morbidity and mortality. In 2000, the policy was extended to include all people aged 65 years or over.

Uptake of the seasonal flu vaccine for those aged 65 and over has stalled in recent years. People in at risk groups are more than 15 times more likely to die from flu than healthy people, so it is important that as many patients as possible in these groups are vaccinated. The World Health Organization (WHO) has set a target that 75% of people aged 65 and over should be vaccinated against seasonal flu annually.

The pneumococcal vaccine (or pneumo vaccine for short) protects against pneumococcal infection. This infection can cause diseases such as pneumonia, septicaemia and meningitis. People aged 65 and over are routinely offered pneumococcal polysaccharide vaccine (PPV) to protect against pneumococcal disease.

Key outcomes

- **Population vaccination coverage (Public Health Outcomes Framework)**
- **Reducing excess winter deaths (Public Health Outcomes Framework)**

¹ Department of Health. Influenza [online]. Available at: <http://webarchive.nationalarchives.gov.uk/20130107105354/http://dh.gov.uk/health/category/policy-areas/public-health/influenza/> [Accessed 19/08/2013]

Impact in Brighton & Hove

The target for seasonal flu uptake for people aged 65 or over is 75%. In 2012/13, uptake in Brighton & Hove was 69.8%, which is a slight decrease from the 2011/12 figure of 70.4%. The uptake in Brighton & Hove was also lower than the figures for England as a whole of 73.4% in 2012/13 and 74.0 in 2011/12.^{2,3}

Local inequalities

There is currently limited evidence to show whether one equality group has lower vaccination uptake than another. However practices in the east of the City, which is generally considered to be the most deprived locality, had lower flu uptake rates (68.1%) than either the central (70.8%) or west (70.5%) localities.

Predicted future need

As more people live longer there will be an increasing number of older people requiring the seasonal and pneumococcal vaccinations.

What we don't know

It is not clear why older people in Brighton & Hove are less likely to accept the offer of a flu vaccination than elsewhere.

A flu vaccination programme for young children, aged two and three years will start in autumn 2013, and part of its aim is to reduce the risk of children passing flu on to older people. The impact this will have on the number of older people getting flu is, as yet, unclear.

Responsibility for commissioning the childhood, seasonal flu and pneumococcal (for older people) vaccination programmes has moved to NHS England who will be able to commission services from alternative providers as appropriate (for example, community pharmacies) as well as GPs. The potential impact of these changes on increasing population coverage is unknown

² Department of Health. Influenza immunisation uptake monitoring programme, England, winter 2011/12. June 2012. Available at: <http://webarchive.nationalarchives.gov.uk/20130107105354/http://immunisation.dh.gov.uk/flu-imms-uptake-monitoring-prog-eng-winter-201112/> [Accessed 19/08/2013]

³ Department of Health. Influenza immunisation uptake monitoring programme, England, winter 2012/13. 2013. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203238/SeasonalFluData_GPs_Jan13_acc.pdf [Accessed 19/08/2013]

Key evidence and policy

The Department of Health Seasonal Flu Plan sets out a coordinated and evidence based approach to planning for and responding to the demands of seasonal flu across England.⁴

Each year, the Chief Medical Officer (CMO) sends out a seasonal flu letter containing information about the seasonal flu immunisation programme, which is used to plan local seasonal flu immunisation programmes.⁵

ImmForm is the system used by the Department of Health, the NHS and Public Health England to record data in relation to uptake against immunisation programmes and incidence of flu-like illness; and to provide vaccine ordering facilities for the NHS.⁶

Recommended future local priorities

1. Primary care needs to increase uptake in people aged 65 years or over to ensure that the target of 75% coverage is met.
2. GP practices should ensure accurate uptake records are kept, at risk patients are identified and timely invitations are sent for vaccination appointments.
3. Primary care needs to ensure that immunisation appointments are accessible to all who require them and that patients are provided with up-to-date information on the need to be immunised.
4. Further work should be done on opportunistic vaccination and developing outreach services for hard to reach groups.

Key links to other sections

- Immunisation (Children and young people)
- Ageing well

Further information

Department of Health. Immunisation against infectious disease, 3rd ed. London: DH. 2006.: <https://www.gov.uk/government/organisations/public-health-england/series/immunisation-against-infectious-disease-the-green-book>

National Institute for Health and Care Excellence (NICE) PH21. Reducing the differences in the uptake of immunisations (including targeted vaccines) including children and young people aged under 19. London: NICE. 2009. Available at: <http://guidance.nice.org.uk/PH21/Guidance/pdf/English>

CMO Letters providing details of the Pneumococcal vaccination campaign:

CMO Letter 2003 announcing the introduction of the new pneumococcal immunisation programme for older people:

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefmedicalofficerletters/DH_4032608

CMO Letter 2004 updating changes to the recommendations for pneumococcal immunisation:

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefmedicalofficerletters/DH_4087289

The Pneumococcal disease chapter in the 'Green Book' (chapter 25)

<https://www.gov.uk/government/publications/pneumococcal-the-green-book-chapter-25>

Last updated

July 2013

⁴Department of Health. Key vaccine information: Seasonal flu [Online]. Available at:

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/PublicHealth/Immunisation/Keyvaccineinformation/DH_104070 [Accessed on 26/08/2012]

⁵Department of Health and Public Health England. Chief Medical Officer seasonal flu letters. Available at:

<https://www.gov.uk/government/organisations/public-health-england/series/immunisation> [Accessed on 18/08/2013]

⁶Public Health England. Immform help sheets. Updated 2012. Available at: <https://www.gov.uk/government/organisations/public-health-england/series/immform> [Accessed 18/08/2013]

7.3.11 Osteoporosis and falls

Why is this issue important?

Falls and fractures are a common and serious problem affecting older people, with high levels of personal and financial cost. In England one in three women and one in five men aged 65 and over fall each year, with those people having a 60% chance of falling again.¹ Falls and fragility fractures are associated with high mortality, morbidity, and cost. Annual costs to health and social care in the UK of fragility fracture care are over £2bn.¹ For a typical CCG the occupied bed days for people aged 75 and over with fall and fracture are high and exceeds the combined numbers for heart attack, acute coronary syndrome and stroke. Projections show that based on current trends, by 2036, there could be as many as 140,000 hospital admissions for hip fracture a year in the UK - this would be an increase of 57% on 2008 admissions.¹

The lifetime risk of osteoporotic fracture in 50 year old British white women has been estimated at 14% for the hip, 11% for the spine, and 13% for the radius. Bone Mineral Density (BMD) decreases with age, which consequently increases the risk of osteoporosis. Osteoporosis is most common in older white women.¹ The latest NICE guidance² estimates that after the menopause, the prevalence of osteoporosis increases markedly with age, from approximately 2% at 50 years rising to more than 25% at 80 years.

Falling rates are higher in older women than older men and higher in care homes, where there is increased likelihood of co-morbidity. This has been calculated to be as high as 1.5 falls per bed with as many as 75% of nursing home residents falling annually, twice the rate of older people living in the community.³

National standards and evidence-based guidelines provide support for falls services to shift to focussing on prevention, which can prevent the risk of a first fall, reduce the risk of subsequent falls and consequently, reduce death and disability from fractures. Whilst the number and length of stay of falls-related admissions have not increased over the past five years, falls and fractures have a sizeable impact upon the local health economy.¹

Evidence from national audits of falls and bone health shows that assessment and treatment of

Brighton & Hove JSNA Summary 2013

patients as recommended by NICE is too frequently not delivered and that the quality of falls and fracture services varies across England.¹

Increased rates of falling and the severity of the consequences are associated with growing older and the rising rate of falls is expected to continue as the population ages. In England, the number of people aged over 65 is due to rise by a third by 2025, the number of people over 80 will double and the number aged over 100 will increase fourfold. A significant rise in falls and associated fractures is therefore likely without preventive interventions.

Preventing older people from falling is a key challenge for the NHS and local authorities. All local organisations working with older people, including statutory and voluntary service providers are a part of the solution and should be supported to understand their contribution to reducing the number of falls locally.³

Key outcomes

- ***Hip Fractures in over 65s (Public health outcomes framework)***
- ***Falls and injuries in the over 65s (Public health outcomes framework)***
- ***Improving recovery from fragility fractures (NHS outcomes framework)***
- ***Helping older people to recover their independence after illness or injury (NHS outcomes framework/Adult Social Care outcomes framework)***

Impact in Brighton & Hove

Since 2009, Brighton & Hove has had an integrated Osteoporosis and Falls Prevention Service provided by Sussex Community Trust. A Falls and Osteoporosis scoping report revealed that whilst the number and length of stay of falls-related admissions have not increased over the past five years, falls and fractures have a sizeable impact upon the local health economy.¹

In 2011/12, there were 870 fracture related falls admissions and 692 non-fracture related falls admissions in Brighton & Hove. 2012/3 saw month on month reductions in both areas, particularly in non-fracture related falls. Fracture related falls

¹ NHS Brighton & Hove. Falls Prevention Strategy 2012.

² <http://www.nice.org.uk/CG021>

³ <http://www.kmpho.nhs.uk/jsna/falls/>

7.3.11 Osteoporosis and falls

admissions for 2012/3 totalled 825 and non-fracture related falls admissions were 374. This would indicate that the changes to the care pathway are making a significant difference.

The most recent comparative Public Health Outcomes Framework data is for 2011/12 (and do not reflect the more recent data highlighted above). This indicates that:

- The rate of injuries due to falls in people aged 65 and over in Brighton and Hove was higher than the value for England (2,270 per 100,000 compared with 2,028 per 100,000 for England).
- The rate of hip fractures in people aged 65 and over in Brighton and Hove was similar to the value for England (455 per 100,000 compared with 457,100 per 100,000 for England).

Where we are doing well

Brighton & Hove has a citywide falls prevention and osteoporosis service. Over the past year additional resources have been allocated to the service to address the priorities identified by the Falls Service Review. This has enabled:

- a new post focussed on prevention education with care homes, training and supporting care homes and developing their prevention agenda
- a part time fracture liaison post is strengthening in the fracture liaison service
- additional funding for the rapid response falls pathway
- partnership working with SECAMB on the new IBIS referral system to reduce conveyance to and hospital admissions for non fracture related falls

As a result of these initiatives, there has been a 50% reduction in non-fracture related falls and a slight reduction in fracture related falls.

The City Council is developing a telecare project to support safe and independent lifestyles using assistive and telecare technology supported by a 24/7 response centre. The project works in partnership with all sectors to increase referrals and raise the profile of telecare products such as falls detectors, bed/chair occupancy sensors and environmental sensors.⁴

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Albion in the Community's 'Standing Tall' programme provides a community based exercise programme to improve strength, balance and flexibility and reduce falls in older adults. Last year, following a successful review, additional funding was given to Albion to develop step down (moving on) exercise classes.

In addition, a multi-agency Falls and Osteoporosis Steering Group has been set up.

Local inequalities

There is no readily available osteoporosis and falls data on protected characteristic groups.

Predicted future need

This issue is likely to grow as more people live longer and the number of older people increases. Prevention will become even more important.

What we don't know

There is no readily available VOICE data on osteoporosis and falls.

Key evidence and policy

NICE clinical practice guideline for the assessment and prevention of falls in older people. 2004 <http://www.nice.org.uk/nicemedia/pdf/CG021fullguideline.pdf>

NICE TAG 161 Osteoporosis secondary prevention including strontium ranelate. 2011 <http://www.nice.org.uk/ta161>

NICE TAG 160 Osteoporosis primary prevention. 2011 <http://guidance.nice.org.uk/TA160>

Department of Health Best Practice Guidance: Urgent Care Pathways for Older People with Complex Needs http://www.akaz.ba/Klinicki_put/Dokumenti/DH_080136.pdf

British Orthopaedic Association: The Care of Fragility Fracture Patients. 2007 <http://www.fractures.com/pdf/BOA-BGS-Blue-Book.pdf>

National Hip Fracture Database (NHFD) <http://www.nhfd.co.uk/>

Department of Health. The National Service Framework for Older People. 2001.

⁴ More information available: <http://www.brighton-hove.gov.uk/carelinkplus>

7.3.11 Osteoporosis and falls

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066.

Active for life: Promoting physical activity with older people guideline. Health Development Agency. 2003.

http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/hda_publications.jsp?o=159

Department of Health. The prevention package for older people. 2009.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146

Recommended future local priorities

The focus going forward will be to:

- develop pathways and improve integrated working between the acute and community sectors
- further build the preventative agenda in partnership with statutory, voluntary and private sector providers
- continue to develop the urgent care pathway
- increase early detection of osteoporosis and strengthen the fracture liaison service
- continue to invest in telecare and other assistive technologies

Key links to other sections

- Older people – social care
- Ageing well

Further information

Age UK and National Osteoporosis Foundation. Breaking Through: Building Better Falls and Fracture Services In England. 2012. Available from: <http://www.ageuk.org.uk/Global/PublicAffairsparliamentary/BreakingThroughBuildingBetterFallsandFractureServicesInEngland20022012.pdf>

The prevention package for older people. DH. 2009.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146

Last updated

August 2013

Why is this issue important?

Brighton & Hove has fewer older residents compared to the national picture (13% 65 years or over compared to 16% for England). However, there is the same percentage of people aged 85 years or over in Brighton & Hove as in England (2.2% of the population).¹

This section concerns the needs of the most vulnerable older people in the city. Commissioners are working on a Market Position Statement which will be available early 2014. It is designed to contain information and analysis that will be useful for stakeholders particularly those who are planning services for vulnerable older people. It will contain information on: Home Care, Care Homes (including Care homes with nursing), Extra care housing, Short term community services, Shared Lives and Telecare.

Key outcomes

- **Enhancing quality of life for people with care and support needs (Adult Social Care Outcomes Framework)**
- **Delaying and reducing the need for care and support (Adult Social Care Outcomes Framework)**
- **Ensuring that people have a positive experience of care and support (Adult Social Care Outcomes Framework)**
- **Enhancing quality of life for people with long term conditions (NHS Outcomes Framework)**
- **Health-related quality of life for older people (Placeholder Public Health Outcomes Framework)**
- **Fuel Poverty (Public Health Outcomes Framework)**

Impact in Brighton & Hove

Home Care – An assessment of the impact of Home Care on the city will be possible once the Market Position Statement has been completed. This will include information about the local home care

market and the services that are provided to enable people to remain in their own home for as long as possible. Home care services provide assistance with personal care, practical tasks and support for informal carers. There are different levels of support available, from maintaining and improving levels of independence, to providing high levels of support to people who are highly dependent, including End of Life Care. The Market Position Statement will include information about the unregulated market for Personal Assistants, including the Support with Confidence Scheme, as well as more traditional regulated home care provision.

Care Homes - An assessment of the impact of care homes will be possible once the Market Position Statement has been completed. This will include an update on homes where nursing is not provided, (residential) care homes which provide accommodation, meals and personal care such as help with washing, eating and giving medication. It is expected that this will evidence a declining need for this type of provision. There will also be an update on **care homes registered for nursing** that provide personal care and also have a qualified nurse on duty twenty-four hours a day to carry out nursing tasks. It is expected that this will reference significant changes in the market for this type of provision.

Extra Care Housing - An assessment of the impact of Extra Care Housing will be possible once the Market Position Statement has been completed. New forms of sheltered housing and retirement housing have been pioneered in recent years to meet the needs for older people. Extra Care Housing is housing designed with varying levels of care and support available on site. People who live in Extra Care Housing have their own self contained homes, their own front doors and rights to occupy the property.

Short term community services - An assessment of the impact of Short term Community Services will be possible once the Market Position Statement has been completed. There continues to be an emphasis on short stay rehabilitation and reablement services. These short term community services are provided in beds based in care homes and in the community through support from a multi disciplinary team. This service enables older

¹ Office for National Statistics. Population Estimates for England and Wales, Mid-2011 (2011 Census-based). Released: 25 September 2012. Available at <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-262039> [Accessed 17/07/2013]

7.3.12 Older people - Social Care

people leaving hospital to maximise their independence.

The council currently has four care homes which all provide short term services. These include beds for carer respite as well as short term services.

Shared Lives - An assessment of the impact of Shared Lives on the city will be possible once the Market Position Statement has been completed. Shared Lives is a regulated service where an individual lives as part of a family and joins in with their community life. In many cases a disabled or older person becomes a permanent part of a supportive family. Shared Lives has traditionally been a service for adults with learning disabilities, but it is increasingly being used for people with a range of disabilities or illnesses and for older people. It is expected that this section will reference a growth of Shared Lives for older people.

Telecare - An assessment of the impact of Telecare on the city will be possible once the Market Position Statement has been completed. Telecare is the name given to a range of equipment and sensors designed to assist people to live more independently and safely. It supports a range of health and social care needs and is predominately used by older people and physically less able people although can be used by users of all ages. The systems can provide support in a less intrusive way and helps to build confidence in daily living.

Where we are doing well

The Market Position Statement will provide information on where we are doing well.

Local inequalities

Older lesbian, gay, bisexual and transgender people have reported that they sometimes experience discrimination, particularly in communal accommodation.

The oldest owner occupiers (85+) are more likely than all other older people to move into communal establishments that may offer less independence, which could be due to a shortage of private sheltered or extra care housing schemes that also provide an element of support.

Predicted future need

Although the proportion of older people living in the City has fallen in recent years, the population aged 65 years or over is predicted to increase and become more ethnically diverse.

The population of people aged 65 years or over in the City is predicted to increase by 4,133 from 35,849 in 2011 to 39,982 by 2021 (an increase of 12%). The largest projected increases are in the 90 year or over (48%) and 70-74 (24%) age groups (Table 1).² This will have implications for housing need.

Table 1: Population aged 65 years or over 2011 and 2021 projection, with percentage change

	2011	2021	% change
All 65+	35,849	39,982	12%
65-69	9,715	10,114	4%
70-74	7,862	9,783	24%
75-79	6,697	7,373	10%
80-84	5,572	5,522	-1%
85-89	3,719	3,808	2%
90+	2,284	3,382	48%

Source: Office for National Statistics. Interim 2011 based sub national population projections.

<http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-274527>

What we don't know

The Market Position Statement will highlight gaps in information.

Key evidence and policy

To be updated in the Market Position Statement.

² Office for National Statistics. Interim 2011 based sub national population projections. <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-274527> [Accessed 12/06/2013]

Recommended future local priorities

Recommended priorities will be reviewed once the outcomes of the Market Position Statement are known.

1. Services should engage with communities to reduce isolation & improve support particularly among those with poor mobility
2. Information on housing, finance, adaptations, assistive technology, help with repairs, domestic services, personal care & regular services such as shopping & gardening should be easily accessible
3. Older people with specific care needs or poor mobility need support to access appropriate housing including adaptations, moving home & isolation
4. Improved heating & insulation of homes is needed to tackle fuel poverty & excess winter deaths
5. Continued development & support of sheltered housing is required, including expanding the numbers of people with care needs that the sheltered housing sector is able to support
6. Outreach support to older people in general needs housing is needed to optimise their housing situation/ability to live independently/prevent housing breakdown, including adaptations. This requires a joint approach to allocation of resources.
7. Service commissioners should work together to identify opportunities to support independent living.
8. Support for adaptations needs to be prioritised
9. Extra care housing & other supported accommodation options as an alternative to residential care for older people need to be explored further
10. Other approaches to enabling older people to live independently need to be pursued, e.g. assistive technology, shared living, key ring schemes, and co-housing

Key links to other sections

- Fuel poverty
- Care of older people
- Ageing well
- Housing

Further information

Older people, wellbeing and participation 2013
<http://www.brighton.ac.uk/sass/older-people-wellbeing-and-participation/resources/?PageId=25>

Adult Social Care Survey 2012

<http://www.brighton-hove.gov.uk/index.cfm?request=c1260975>

Gilbertson J et al. Good housing and good health? Care Services Improvement Partnership and the Housing Corporation.

Brighton and Hove Housing Needs Survey 2005

Available from: http://www.brighton-hove.gov.uk/downloads/bhcc/Final_Report.pdf

Brighton and Hove Supporting People Strategy 2011-15.

http://www.supportingpeopleinbrightonandhove.org.uk/downloads/spibah/strategy/Supporting_People_Strategy_2011-2015.pdf

ODI/University of Bristol. Better Outcomes, lower costs. 2007

Last updated

May 2013

Why is this issue important?

There are three NHS cancer screening programmes in England: breast, cervical and bowel. Screening programmes aim to detect cancer early when treatment is more likely to be effective. It is estimated that cervical screening saves 4,500 lives in England each year,¹ while breast screening saves 1,300.² Regular bowel cancer screening reduces the risk of dying from bowel cancer by 16%.³

Breast: The national breast cancer screening programme currently offers screening every three years to women aged 50-70 years. Those assessed, by a specialist in genetics or oncology, as being at higher risk of developing breast cancer are offered screening at a younger age (surveillance screening) and more frequently than the general population, at least until the age of 50 years. Women over 70 years can request screening but are not routinely invited. In a national randomised control trial to consider further age extension, half of the women aged 47-49 years and 71-73 years are also being invited over two screening rounds between 2010 and 2016.

Over the years there has been much debate as to whether breast cancer screening does more harm than good. A recent independent review of the evidence concluded that whilst there were around three over-diagnosed cases identified and treated for every one breast cancer death prevented, the UK breast screening programmes confer significant benefit and should continue.

Cervical: The national cervical cancer screening programme offers regular screening to women aged 25 to 64 years. Women are invited every three years until aged 49 years and then every five years.

Bowel: The national bowel cancer screening programme invites men and women aged 60 to 69 years to be screened every two years. Those over 70 years are sent a screening kit on request. From April 2010 the age range for bowel cancer

screening was extended to invite people up to their 75th birthday.

Key outcomes

- ***The percentage of women in a population eligible for breast screening at a given point in time who were screened adequately within a specified period (Public Health Outcomes Framework)***
- ***The percentage of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period (Public Health Outcomes Framework)***
- ***Bowel (an indicator is under development) – (Public Health Outcomes Framework)***

Impact in Brighton & Hove

Breast: There are 28,000 women eligible for breast screening in Brighton & Hove. The local programme is provided by Brighton & Sussex University Hospitals' Trust. In England around eight per 1,000 women screened will be found to have breast cancer,⁴ which equates to around 75 Brighton & Hove women per year.

In 2011/12 the proportion of eligible women who had been screened within the previous three years was 70.3% in Brighton & Hove, compared with 77.4% in South East Coast Strategic Health Authority and 77.0% in England.

Cervical: There are 81,600 women eligible for cervical screening in Brighton and Hove. Women are invited for screening by the cervical screening programme office but this is carried out in GP surgeries. In 2011/12, 77.2% of the eligible women were screened at least once in the previous five years (coverage) which was lower than both the South East Coast Strategic Health Authority and England rates (80.2% and 78.6% respectively); figure 1 shows coverage was lower for both younger (25-49 years) and older (50-64 years) women. The proportion of abnormal results (the positivity rate) in Brighton and Hove (5.7%) was

¹ Cancer Research UK. Cervical screening: The facts. Department of Health.

² The Independent UK Panel on Breast Cancer Screening. The Benefits and Harms of Breast Cancer Screening: An Independent Review. A report jointly commissioned by Cancer Research UK and the Department of Health (England). October 2012.

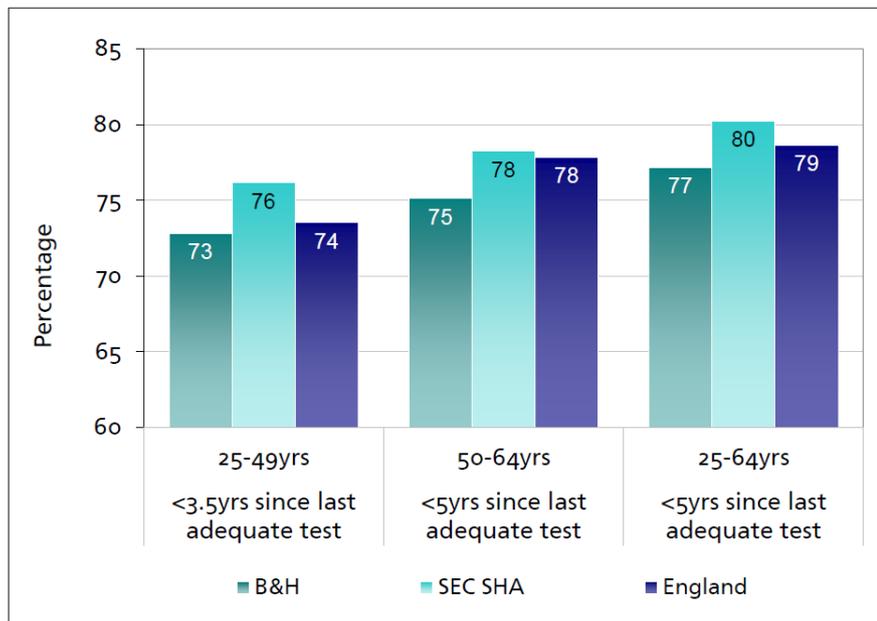
³ Cochrane Database of Systematic Reviews, 2006. Screening for colorectal cancer using the faecal occult blood test: an update.

⁴ Health and Social Care Information Centre. Breast Screening Programme, England 2011-12, February 27, 2013.

7.4.1 Access to cancer screening

lower than both the South East Coast SHA (6.1%) and England (6.3%).⁵

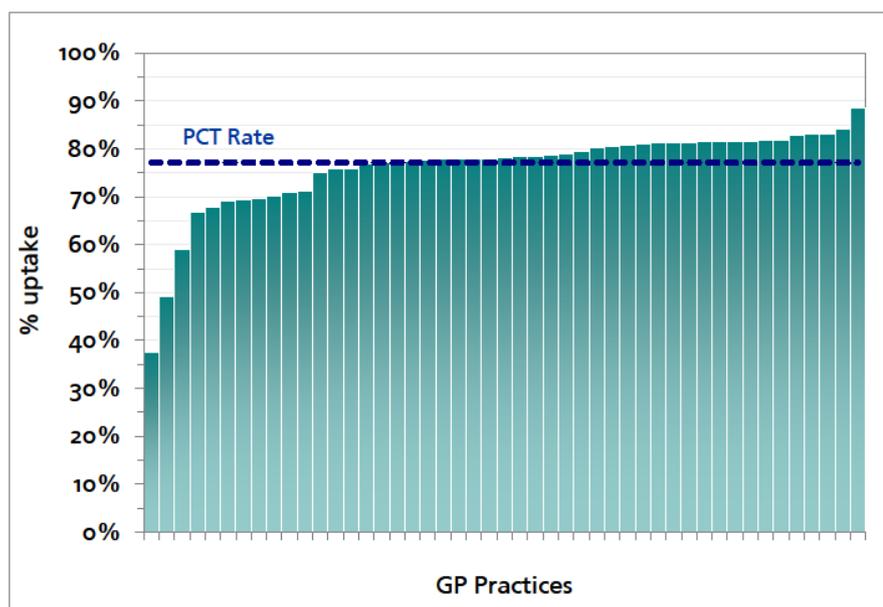
Figure 1: Cervical screening coverage in Brighton and Hove, South East Coast SHA and England, 2011-12.



Source: Information Centre for Health and Social Care

Figure 2: shows that cervical screening coverage varies considerably by GP practice, ranging from 38% to 89% in 2012-13.

Figure 2: Cervical screening coverage (%) by GP practice 2011-12.



Source: Primary Care Support Services

The Quality and Outcomes (QOF) based coverage in Brighton and Hove for 2011-12 was 81.9% which is higher than that reported for the national screening programme (77.2%). This is because QOF coverage allows GPs to ‘exception report’ (exclude from the figures). The exception rate for cervical screening in Brighton and Hove in 2011-12 was higher (8.6%) than the South East Coast SHA and England rates (5.6% and 5.4% respectively). In addition to clinical criteria and informed dissent, GPs can exception report if a patient does not attend on at least three occasions in the previous 12 months. Locally there is a trend for higher exception reporting in more deprived populations.

Bowel: There are 24,100 people eligible for bowel screening in Brighton & Hove. Age extension across Sussex has been delayed but should be

introduced by June 2013/14 and will include another 9,600 Brighton & Hove residents. There are three sites in the Sussex bowel cancer screening programme; the one serving Brighton & Hove is provided by Brighton & Sussex University Hospitals’ Trust. In 2010/11 the average uptake of bowel cancer screening in Brighton & Hove was 53%, compared with 58% across Sussex, and as nationally it is higher for women than men. As yet there are no formal national statistics for bowel cancer screening.

It is estimated that for every 1,000 people screened, 20 will be positive for faecal occult blood (276 at 60% uptake in Brighton & Hove) and 85% will take up the offer of a colonoscopy (235 in Brighton & Hove). Of those undergoing colonoscopy, around half will have a normal result (118), three-eighths will have polyps (88) and one eighth will have bowel cancer (29) detected.⁶

⁵ NHS Information Centre for Health and Social Care. Cervical Screening Programme, England 2011-12. <https://catalogue.ic.nhs.uk/publications/screening/cervical/cerv-scre-prog-eng-2011-12/cerv-scre-prog-eng-2011-12-rep-v1.1.pdf>

⁶ NHS Cancer Screening Programmes. The NHS Bowel Cancer Screening Programme (NHS BCSP) Information for Primary Care. <http://www.cancerscreening.nhs.uk/bowel/bowel-ipc-leaflet.pdf>

Public voice: A 2010 local cancer awareness survey found that awareness of the NHS breast and cervical screening programmes was significantly lower in Brighton and Hove than nationally; whereas awareness of the bowel cancer screening programme was significantly higher.⁷

The bowel cancer screening programme routinely collects feedback from those people with positive screens who are required to attend the hospital. In 2011/12 there was an 80% response rate with 95% agreeing/ strongly agreeing that they were treated with dignity and respect during their visit and more than 90% of respondents agreeing/ strongly agreeing that all their questions were answered by the screening practitioner.

Where we are doing well

A recent Quality Assurance visit found that the breast screening unit has one of the best clinical performances in the country

Cervical cancer screening coverage in Brighton and Hove increased by 1% between 2010/11 and 2011/12 whereas the rate in the South East Coast SHA area remained unchanged and the England rate increased by only 0.1%.

Bowel cancer screening up-take is increasing and is now above the national average.

Local inequalities

The National Cancer Equality Initiative Annex⁸ (NCIN 2012) summarises the evidence-base on inequalities in cancer screening.

Deprivation: As nationally awareness of cancer screening programmes in Brighton and Hove is lower amongst socially deprived groups.

Gender: As nationally men have lower awareness of cancer screening programmes than women, which is to be expected as men are only eligible for bowel screening.⁹ However uptake of bowel screening is also lower in men than women.

BME: National evidence shows that screening uptake is generally lower in minority ethnic groups. Local data is not available by ethnicity.

LGBT: Many lesbian women and their health professionals are unaware of their need for cervical screening.¹⁰ A Brighton & Hove survey showed that a quarter of 130 lesbian and bisexual respondents had never been screened or were screened more than five years ago (26% Britain) and only 21% regularly checked their breasts (26% Britain).¹¹

Predicted future need

Responsibility for the commissioning and quality assurance of national screening programmes transferred to Public Health England (PHE) in April 2013. PHE staff have been seconded to NHS England Area Teams (ATs) to discharge this function; the AT for Brighton and Hove is the Surrey Sussex Area Team. These changes require new partnerships to be forged and new systems to be established so that Brighton and Hove City Council and the Health and Wellbeing Board can be assured of screening performance locally.

Depending on the findings of the current randomised controlled trial, age extension of breast cancer screening may be rolled out nationally after completion in 2016 resulting in increased demand on local services.

Following the introduction of HPV test of cure into the cervical screening programme, laboratory services in Sussex were reconfigured in April 2013 to ensure they continued to meet the quality assurance requirements for the programme. These changes may impact on programme performance particularly regarding the timeliness of results. HPV primary screening is currently being piloted and may result in changes to the NHS Cervical Screening Programme in the future.

The demand for colonoscopies is increasing annually and this increase is expected to continue. The age extension for bowel cancer screening as well as cancer awareness work will increase this

⁷ Lake Market Research. Cancer Awareness and Early Diagnosis Initiative CAM Final Results. NHS Brighton and Hove: April 2006.

⁸ National Cancer Intelligence Network. Evidence to March 2010 on cancer inequalities in England. June 2010. Available from <http://www.ncin.org.uk/equalities/docs/100614-NCIN-Inequalities.pdf> [Accessed 04/04/12]

⁹ Lake Market Research. Cancer Awareness and Early Diagnosis Initiative CAM Final Results. NHS Brighton and Hove: April 2006.

¹⁰ Fish J. Cervical screening in lesbian and bisexual women: a review of the worldwide literature using systematic methods. Leicester: DeMontfort University. June 2009. Available at: <http://www.cancerscreening.nhs.uk/cervical/publications/screening-lesbians-bisexual-women.pdf> [Accessed 08/05/2012]

¹¹ Prescription for Change: Lesbian and bisexual women's health check 2008. http://www.stonewall.org.uk/what_we_do/research_and_policy/3101.asp [Accessed on 26/08/2012]

demand still further. Flexible sigmoidoscopy is to be introduced into the screening programme as a one off test for people from 55 years of age in 2015/16. These developments will put pressure on services.

What we don't know

We do not have local information on cancer screening uptake by protected characteristic groups with the exception of age and gender.

Key evidence and policy

National screening programmes are introduced if recommended by a policy review which looks at all the available evidence and appraises against a number of agreed criteria.¹²

Recommended future local priorities

1. Brighton & Hove City Council to establish working relationships with the NHS England Surrey Sussex Area Team (AT) together with assurance processes and mechanisms for joint working.
2. Ensure the NHS England Surrey Sussex Area Team (AT) report screening performance to the Health and Wellbeing Board on a quarterly basis.
3. Brighton and Hove CCG to ensure GPs promote NHS screening programmes to their eligible practice populations and work to reduce variation in uptake - particularly in cervical screening which is carried out in GP surgeries and is consistently below the England average.
4. Sussex Community Trust commissioned service (cancer health improvement team) to continue to tackle inequalities of access and uptake of cancer screening programmes through a targeted programme of work.
5. Public Health England to ensure age extension for bowel cancer screening (now overdue) is introduced into the Sussex programme at the earliest possible opportunity.

Key links to other sections

- Cancer

Further information

NHS Breast Screening Programme 2012 Annual Review

<http://www.cancerscreening.nhs.uk/breastscreen/publications/2012review.html>

NHS Cervical Screening Programme 2012 Annual Review

<http://www.cancerscreening.nhs.uk/cervical/publications/2012review.html>

There is as yet no Bowel Cancer Screening Programme 2012 Annual review.

<http://www.cancerscreening.nhs.uk/bowel/news/index.html>

Last updated

June 2013

¹² UK National Screening Committee. Criteria for appraising the viability, effectiveness and appropriateness of a screening programme.
<http://www.screening.nhs.uk/criteria>

7.4.2 Preventable sight loss

Why is this issue important?

Almost two million people in the UK are living with sight loss (vision being 50% less than perfect) and by 2020 this number is predicted to increase by 22%. Nationally, eye health will be particularly influenced by changes in population demographics because over 80% of sight loss occurs in people aged over 60.¹ Costs and demands on the NHS are high with ophthalmology having the second highest number of outpatient attendances in 2010/11.²

Health outcomes of eye disease are significantly better if detected and treated early. Key causal conditions for sight loss are:

- Glaucoma, a family of diseases which have characteristic structural changes in the optic nerve head and the visual field. Ocular hypertension (OHT, raised eye pressure) is a key risk factor.
- Cataract, a clinically significant frosting of the eye's natural lens.
- Diabetic retinopathy, caused when diabetes affects the blood vessels in the retina. The NHS Diabetic Eye Screening Programme aims to reduce the risk of sight loss in people with diabetes by identifying diabetic retinopathy early and ensuring patients are offered effective treatment where necessary.
- Age-related macular degeneration (AMD) is an age-related change without any obvious cause which occurs in the central area of the retina of people over 50.

Key outcomes

- **Preventable sight loss – AMD, glaucoma and diabetic retinopathy (Public Health Outcomes Framework)**
- **Access to non-cancer screening programmes: proportion of those offered screening for diabetic retinopathy who attend a digital screening event (Public Health Outcomes Framework)**

¹ Access Economics. Future Sight Loss UK 1:Economic Impact of Partial Sight and Blindness in the UK Adult population;2009.

² UK Vision Strategy. JSNA template and guidance for eye health and sight loss. July 2012

Impact in Brighton & Hove

In 2010/11, there were 980 people registered blind and 660 registered partially sighted with Brighton & Hove City Council. 70 new blind people were registered in 2010/11 and 50 partially sighted.³

Table 1. Estimated prevalence of sight conditions in Brighton & Hove, 2011/12

Condition	Estimated Prevalence
Age-related macular degeneration (AMD)	2,314 (3%) ⁴
Glaucoma	2,292 (1.5%) ⁴
Cataracts	2,422 (2%) - 8,115 (7%) ⁴
Low vision	3,197 (4%) ⁴
Diabetic Retinopathy	9,972 ⁵

Source: See references 4 and 5

Based on data from the Diabetic Retinopathy Screening Programme 9,972 people known to have diabetes also had retinopathy. This will be an underestimate because three will also be people with undiagnosed diabetes in the population with retinopathy who are not known to the screening service.

In the year up to March 2012, 82% of those who had been offered screening for diabetic retinopathy attended a screening event.⁵

The other main sight loss conditions in Brighton & Hove are cataract, glaucoma and AMD.⁶

In Brighton & Hove for 2008-10 rates of Certification of Visual Impairment related to diabetes were higher than average (3.7 per 100,000) and Brighton & Hove is in the second highest quintile for all PCTs in England.

³ Health and Social Care Information Centre. Registered Blind and Partially Sighted People. <https://catalogue.ic.nhs.uk/publications/social-care/vulnerable-adults/peop-regi-blin-part-sigh-eng-11/peop-regi-blin-part-sigh-eng-11-coun-tab.xls> [Accessed 28.05.13]

⁴ National Eye Health Epidemiological Model (NEHEM) using 2001 census data. Available at: www.eyehelthmodel.org.uk [Accessed 28.05.13]

⁵ Department of Health. Diabetic Retinopathy data. Based on number of patients with diabetes identified with retinopathy by PCT Screening Programme. Q4 2012

⁶ NHS Brighton & Hove. Rapid needs assessment: primary care in Brighton & Hove. 2011.

7.4.2 Preventable sight loss

A local rapid needs assessment for community eye care conducted in 2011⁶ reported that:

- There are estimated to be 1,300 people potentially eligible for cataract surgery. There were 1,208 referrals to the Sussex Eye Hospital from the community. This may suggest that a high proportion of those eligible are receiving services.
- In the population aged 50 or over, an estimated 7,841 people would be expected to have Ocular hypertension if they were measured using pneumotometry (non-contact testing). They have an increased risk of developing glaucoma.
- Estimates indicate that there will be at least 100 new cases each year of “wet” Age-related macular degeneration (development of new blood vessels). In 2009, 77 patients commenced treatment.

Where we are doing well

The 2011 local rapid needs assessment reported that:

- There were high levels of patient satisfaction with cataract services as suggested by local audit
- Qualitative interviews with local service providers showed generally high satisfaction with locally-enhanced services (LES) for cataract direct referral and post-operative care, repeat testing of Ocular hypertension and Age-related macular degeneration and the Community Optometrist
- Median waiting time for cataract surgery at the Sussex Eye Hospital was 56 days in 2009 (lower than the national median)
- Sussex Eye Hospital had a new in-house multi-disciplinary shared care glaucoma and Ocular hypertension clinic using Community Optometrists within the hospital setting

Local inequalities

The prevalence and incidence of sight loss rises considerably after the age of 75 years. As at March 2011,³ there were 980 people in the city registered as seriously sight impaired, of which 630 were aged

over 75. There were 660 people registered as sight impaired, of which 435 were aged over 75.

National evidence shows that there is a higher rate of glaucoma and AMD in Black ethnic groups, a higher rate of diabetic retinopathy in South Asian populations and higher cataract prevalence in deprived areas.²

Nationally there is a high estimated prevalence rate of sight loss amongst adults with learning disability, but there is a lower than expected number of people registered as sight impaired / seriously sight impaired who are recorded as having a learning disability on their Certificate of Visual Impairment registration (20 people in 2011).³

Predicted future need

By 2020 the number of people in the UK living with sight loss (vision being 50% less than perfect) is predicted to increase by 22% (from the current estimate of almost two million people).¹

Need for cataract treatment may increase due to the effects of smoking, an ageing population and deprivation.

The number of people aged 60 years or over is expected to increase by 9% from 48,554 in 2011 to 53,026 in 2021. With the biggest percentage change in the 90 and over age group (a 48% increase from 2,284 people in 2011 to 3,382 people in 2021).⁷

What we don't know

The proportion of elderly patients fallen or at risk of falls with the primary cause being sight loss. National evidence suggests that 47% of falls sustained by blind and partially sighted people are directly attributable to sight loss.⁸

We have limited knowledge of health inequalities, for example, the number of housebound people and the extent to which their eye care needs are met.

We have no information on equalities data in relation to blind and partially sighted people.

⁷ Office for National Statistics. Interim 2011 based sub national population projections. <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-274527> [Accessed 12/06/2013]

⁸ Boyce T. Falls – costs, numbers and links with visual impairment. RNIB 2011.

7.4.2 Preventable sight loss

Key evidence and policy

UK Vision Strategy (2008) Royal National Institute of Blind People - developed in response to the World Health Assembly VISION 2020 resolution to reduce avoidable blindness.

<http://www.vision2020uk.org.uk/ukvisionstrategy/>

NICE guidance on glaucoma (Clinical Guideline 85) was published in 2009 and covers the diagnosis, treatment and care of adults with “chronic open angle glaucoma,” OHT and those at high risk of developing glaucoma.

<http://publications.nice.org.uk/glaucoma-cg85>

Recommended future local priorities

1. Encourage regular sight tests to help to prevent longer term visual impairment.
2. Commissioners to strengthen use of the glaucoma/Ocular hypertension repeat-testing Local Enhanced Service (reported in the local rapid needs assessment to reduce new referrals to ophthalmology by 60%).
3. Consider ways for Community Optometrists and primary care services to improve links so they are able to effectively refer patients for services e.g. smoking cessation, falls clinics and NHS Health Checks.

Key links to other sections

- Falls and osteoporosis
- Smoking
- Diabetes
- Adults with Physical disabilities or sensory impairments
- Adults with learning disabilities

Last updated

May 2013

Why is this issue important?

Good oral health makes an important contribution to appearance, self-esteem and quality of life.

Missing or decayed teeth and ill-fitting dentures can make people feel self-conscious and lead to loss of confidence and social isolation. The most common oral diseases, tooth decay and periodontal disease, can both cause pain and infection as well as eventual tooth loss.¹

Nationally adult oral health has been improving over the last 30 years, so that more people are retaining their teeth for longer. This means that many adults will continue to suffer from dental decay and periodontal disease and will have increasing demands for restorative dentistry.²

Key outcomes

- **Ensuring people have a positive experience of care (NHS Outcomes Framework)**
 - **Patient experience of NHS Dental Services**
 - **Improving access to NHS Dental Services**

Impact in Brighton & Hove

The most recent local data on the dental health of adults in is from a 2001 East Sussex, Brighton & Hove Health Authority self-reported questionnaire and clinical examination. The only other data available is the national Adult Dental Health Survey 2009, broken down to South East Coast Strategic Health Authority (SHA) reporting level.

Nationally 16-34 year olds have good dental health. 35-44 year olds start to require higher levels of treatment and 45-54 year olds have significant dental needs as fillings need replacing. By 55-64 years complex dental work is required and levels of periodontal disease increase. More of the 65 plus age group will retain their teeth and require complex restoration work; with increasing numbers requiring domiciliary dental care.

The 2001 adult dental survey found that the mean for decayed and unsound teeth was 0.7 compared with 1.5 for the UK. The mean number of filled

teeth was 11.5 compared with seven for the UK and 17% wore dentures. These figures should be treated with caution as it was a very small sample.²

The proportion of residents accessing dental services has increased since 2007. The PCT average is lower than 63% of the access target suggested by the South East Coast SHA. Between March 2010 and March 2012 147,826 patients were seen by dentists in Brighton & Hove. In late 2010, well over 90% of people who requested an NHS dental appointment were able to get one.

During 2012/13, Sussex Community Trust trained 301 staff in Nursing Homes in oral health promotion in 27 training sessions.³

In the City Tracker Survey 2013, 79% of residents rated themselves as fairly or very satisfied with NHS dentists.⁴ This satisfaction rate was 66% for 55-64 year olds. In March 2013, 91% of patients were satisfied with the dentistry they had received, compared to 92% for both England and the SHA. Whilst 85% reported they were satisfied with the time they had to wait for an appointment, lower than both England and the SHA.⁵

Where we are doing well

Sussex Community Trust's Oral Health Promotion Team has continued to deliver a comprehensive range of oral health promotion activities to vulnerable adults and training for staff. The Oral Health Champions Network for dental practice staff continued to meet to enhance their oral health promotion work in 2012. Staff reported the Stop Smoking session generated new referrals.

General Dental Practitioners have implemented Delivering Better Oral Health and are following the prescribed patient care pathways. A Restorative Dental Consultant post has been established at with Brighton & Sussex University Hospitals NHS Trust for two years, to help meet the increasing restorative dental needs of the local population.

Local inequalities

The 2001 East Sussex, Brighton & Hove adult dental survey found men had twice as many decayed

¹ Department of Health. Choosing Better Oral Health. A Health Plan for England. 2005.

² NHS Brighton and Hove. Oral Health Needs Assessment. 2008. <http://www.brightonandhove.nhs.uk/healthprofessionals/dentistry/documents/OHNAFinalversionDec08.doc> [Accessed on 26/08/2012].

³ Sussex Community NHS Trust. Oral Health Promotion Team performance data. 2012/13

⁴ Brighton & Hove Strategic Partnership. City Tracker Survey. Wave 3. March 2013. Available at: www.bhllis.org/surveys [Accessed 13/08/2013]

⁵ NHS Dental Services. Vital Signs for NHS Brighton and Hove. March 2013.

7.4.3 Oral health (Adults)

teeth as women, and women had more filled teeth than men.²

Adults from lower socio-economic groups have higher levels of dental caries.² Historically, dental services in the City have been located in areas of low deprivation and high population density along the coast and have been sparse in areas of high deprivation. In recent years new services have opened in the more deprived east locality.

In the 2008 Oral Health Needs Assessment over half of Brighton & Hove dental practices were not wheelchair accessible.²

There are a number of wards where access could be improved; these include North Portslade, Brunswick and Adelaide, Central Hove and Hollingdean and Stanmer.²

Local services have reported an inequality in access to emergency dental services for the homeless population, in terms of having the means to make appointments and travel to them.

During 2012/13 the Oral Health Promotion Team had 36 contacts with substance misusers. It made weekly visits to First Base, The Rough Sleepers Team, YMCA Clock Tower Sanctuary and Project Anti-freeze, generating 597 contacts. Visits are made to Gypsy and traveller sites twice a year, leading to 30 contacts in 2012/13. In residential homes and day centres for people with learning disabilities 17 training sessions were held for staff.

Predicted future need

An increasing number of adults in their 50s will have restorative dental needs in the next 20 years.²

What we don't know

There is no recent public voice available.

In the absence of a recent local epidemiological dental survey of adults we do not have up to date local information on the condition of adult teeth in the city. Therefore there is no equalities data available.

Key evidence and policy

Choosing Better Oral Health¹ outlines key interventions for improving oral health in children and adults: Fluoride, improving diet and reducing sugar intake, encouraging preventative dental care,

reducing smoking, increasing early detection of mouth cancer, and reducing dental injuries.

http://webarchive.nationalarchives.gov.uk/+/dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4123251

Cochrane reviews outline the evidence for the use of fluoride.^{6,7}

<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002278/abstract;jsessionid=353C0593BD75551685F45629699446F2.d03t03>

<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002279/abstract;jsessionid=9C23EC94A9743434DF1E0F37D7B36E57.d03t02>

Delivering Better Oral Health is an evidence-based toolkit for delivering prevention in dental practices.⁸

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_102331

Recommended future local priorities

1. NHS England to support General Dental Practitioners in promoting adults' oral health in their dental practices.
2. Ensure people with long-term conditions requiring residential or domiciliary care, also have their oral health needs assessed.
3. Assess the unmet oral health needs of the homeless for emergency dental care.

Key links to other sections

- Oral health (Children and young people)
- Healthy weight (Adults and older people)
- Ageing well

Further information

Brighton & Hove Oral health needs assessment 2008. www.bhlis.org/needsassessments

Last updated

May 2013

⁶ Marinho VC, Higgins JP, Sheiham A, Logan S. 2003. Fluoride toothpastes for prevent dental caries in children and adolescents. Cochrane Database of Systematic Reviews. Issue 2. Art. no: CD002278 DOI: 10.1002/14651858.

⁷ Marinho VCC, Higgins JPT, Logan S, Sheiham A. 2007. Fluoride varnishes for preventing dental caries in children and adolescents. Cochrane Database of Systematic Reviews. Issue 2. Art. no: CD002279. DOI: 10.1002/14651858

⁸ Department of Health. Delivering Oral Health. An evidence based toolkit. 2nd edition April 2009.

7.4.4 Suicide prevention

Why is this issue important?

Deaths by suicide are not inevitable. An inclusive society that avoids the marginalisation of individuals and which supports people at times of personal crisis will help to prevent suicides.¹

In England, one person dies every two hours as a result of suicide.¹ The highest risk is among men in their 40s,¹ so many years of life may be lost. When someone takes their own life, the effect on their family and friends is devastating. Every suicide affects a number of people directly and often many others indirectly.

A national strategy for preventing suicide was published on 10 September (World Suicide Prevention Day) 2012. This strategy identifies the following high risk groups:

- young and middle-aged men;
- people in the care of mental health services, including inpatients;
- people with a history of self-harm;
- people in contact with the criminal justice system;
- specific occupational groups, such as doctors, nurses, veterinary workers.

Key outcomes

- **Suicide rate (Public Health Outcomes Framework)**

Impact in Brighton & Hove

Brighton & Hove has had a higher rate of deaths from suicide than England for the past century.²

Information about deaths by suicide among our residents is available from the Office for National Statistics³; HM Coroner for Brighton & Hove also keeps records of the deaths which take place within her jurisdiction.

¹ Department of Health and HM Government. Preventing suicide in England: a cross-government outcomes strategy to save lives. London: HM Government; 2012 [online]. Accessed 2013 May. Available at URL: <https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england>

² Scanlon T, Memon A, Dorling C, Walker A. 100 years of suicide in Brighton and Hove, England. J Epidemiol Community Health. 2011 Aug;65(Suppl 1):A158.

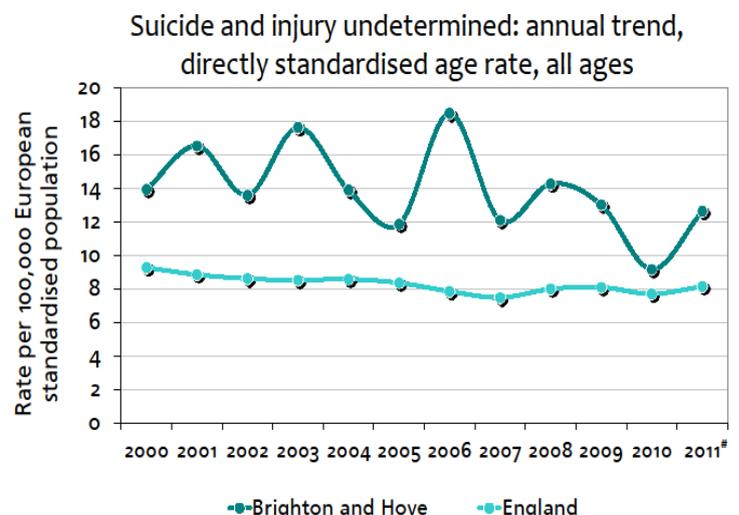
³ Health and Social Care Information Centre. Indicator Portal: Compendium of Population Health Indicators [online]. Available at: <https://indicators.ic.nhs.uk/webview/> [Accessed 2013 May]

The most recent three-year aggregated rates available from ONS are based on 2009-11 and are published provisionally because of changes to the codes used to record these deaths and because of changes to population estimates following the 2011 census.

The provisional standardised rate for deaths from suicide and injury undetermined for Brighton & Hove residents is 11.1 per 100,000. This is 41% higher than the rate for England of 7.9 per 100,000. Brighton & Hove ranks 10th in the country, a relative increase from 2008-10, when the City ranked 20th amongst local authorities.

Annual rates are based on small numbers and are therefore less reliable than trends based on three-year aggregates. In 2011, 38 deaths for our residents were identified by ONS; the rate has risen in 2011.

Figure 1: Suicide and injury undetermined: annual trend, directly standardised age rate, all ages 2000-2011



Source: Office for National Statistics: Vital statistics 2011.

The trend shown in Table 1 should be interpreted with caution, as the 2011 rate uses revised population figures based on the 2011 census, and previous years population estimates have not yet been revised. However, given the increase in the population, an underestimate of the population in previous years would be expected to show a disproportionately high rate.

The local audit of Coroner's records shows that for deaths where the verdict was suicide, the most common method used was hanging:

7.4.4 Suicide prevention

Table 1: Method for Brighton & Hove deaths with suicide verdict 2003-2010

	Number	%
Hanging	94	46%
Poisoning	54	27%
Jumping	17	8%
Other	38	19%

Source: Audit of records, HM Coroner Brighton & Hove

Table 1 above shows the proportions for deaths with a suicide verdict only; if the wider group of verdicts including open and narrative are included, the proportion of deaths by self-poisoning rises from 27% to 29%.

Table 2, below, shows the most common place for deaths to take place, by far, is at home.

Table 2: Place of death for Brighton & Hove deaths with suicide verdict 2007-2010

	Number	%
Home	63	72%
Beach / cliff / water	9	10%
Railway lines, station or crossing	3	3%
Other	13	15%

Source: Audit of records, HM Coroner Brighton & Hove

The combination of these factors – place and method - makes preventive action such as barriers less likely to be effective. Prevention will need to address the underlying causes of the impulse or wish to die.

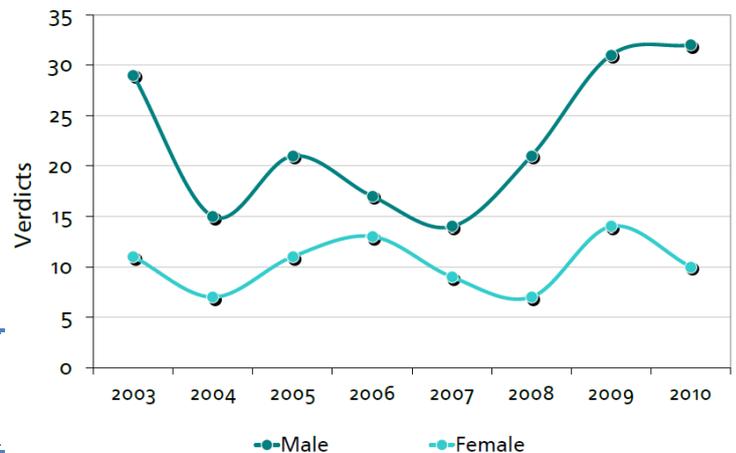
Local inequalities

Audit of the Coroner’s records provides a more detailed understanding of high risk groups among the local population and the circumstances surrounding their deaths. 203 deaths with a suicide verdict and 262 deaths with a narrative, suicide or open verdict between the years from 2003 – 2010 were included in the analysis.

Age: The local pattern for age groups most at risk mirrors the national pattern: the highest risk is in those aged 35 – 49, with a significant secondary risk group in the elderly.

Gender: The gap between male and female rates was narrower in Brighton & Hove in the mid-decade but appears to be widening again, with female rates much lower than male rates in 2009 and 2010. Nationally, men are three times more likely to die from suicide than women.¹

Figure 2: Suicide verdicts 2003 – 2010 by gender



Source: HM Coroner, Brighton & Hove

Lesbian, gay, bisexual and transgender (LGBT):

The Count Me In Too survey of LGBT people in the City⁴ found that 23% have had suicidal thoughts with 7% attempting suicide in the past five years. Risks of suicide and suicidal vulnerabilities vary: those who identified as bisexual, queer or ‘other’ in terms of sexuality, trans people, young people, those who feel isolated, those on a low income, abuse survivors, the homeless and those who are disabled and/or long-term health impaired are more likely to report having experienced suicidal thoughts or to have attempted suicide.

The audit of local Coroner’s records appears to show that the proportion of deaths by suicide among the LGBT community at 11% is lower than the proportion of people identifying as LGBT in the population at 17%. However, information about sexual orientation is not systematically recorded as part of the Coroner’s records so this may be an under-estimate.

⁴ Browne K, Lim J. Count Me In Too survey. Brighton: Brighton University; 2010. [online].. Available: http://www.realadmin.co.uk/microdir/3700/File/CMIT_MentalHealth_Report_Final_29.5.08.pdf [Accessed 27/03/2012].

7.4.4 Suicide prevention

Ethnicity: The local audit suggests that there are more deaths among Black Africans and fewer among Asian or Mixed groups than would be predicted given our proportion of these groups in the city. However, numbers are very small, so this may not be reliable.

Deprivation: The local audit of deaths with suicide, or relevant open or narrative verdicts shows a higher proportion in the most deprived quintile (30%) than the least deprived quintile (15%), based on home postcode. Of those who died, 38% were unemployed compared to 8% in the overall population of the city; 19% were retired.

Other risks:

The local audit found a high proportion of people with a mental or physical health problem: 23% had a physical health problem; 11% suffered chronic pain. A national report found that at least 10% of the suicides in the UK are by chronically or terminally ill people.⁵

From 2007-10, 70% of people included in the local audit had a mental health diagnosis and 57% had a history of previous self-harm or suicide attempts. Depression was the most common diagnosis, recorded in over 50% of deaths.

Stressful life events are identified nationally as a risk factor and the local audit confirms this: 18% had financial problems, 57% had difficulties in their primary relationships, 22% had suffered significant bereavements; 6% had lost a close relative or friend to suicide in their lifetime.

The local audit showed that around half of people taking their own lives had an alcohol or a drug misuse problem. A similar proportion had suffered abuse or had a history of being violent themselves. Over one in ten had a history of offending.

People living alone are at increased risk of suicide: 53% of people who died were living alone; 36% of our residents live in one-person households, according to the 2011 census.

Carers appear to be under-represented: only 1% of people who died by suicide were carers.

Where we are doing well

We are fortunate to have a local Coroner willing to allow access to the records of local inquests. Much of the detailed local information needed to inform prevention work is dependent on this access.

The city has a local strategy to prevent suicides; a multi-agency group steers its implementation. The history of high suicide rates has led to local investment in prevention initiatives including:

- Meetings between clinicians involved in providing care for an individual, following a death by suicide, to identify any learning that could be shared.
- A pack for all GP practices including a local risk assessment questionnaire.
- Suicide prevention training for frontline staff working with high risk groups.
- Work towards a Suicide Safer City, aiming to encourage people to talk about suicidal feelings and to reduce stigma.
- Support and resilience building work with higher risk groups such as young people identifying as LGB or Trans or people living in East Brighton.
- Online round-the-clock support for people with low level mental health problems or suicidal feelings.
- An audit of people presenting with self-harm at A&E to identify gaps or risks in the service; improved access to urgent care;
- Improved safety at the Mill View hospital, in line with independent recommendations, including changes to the reception area;
- A multi-agency working group to address high rates of self-harm among young people;
- Celebrations to mark World Suicide Prevention Day each year in the city.

Predicted future need

Future trends are hard to predict, however times of economic hardship are linked to higher rates of suicide and national incidence has risen since 2008. The local rate also rose in 2011, the last year for which ONS information is currently available.

⁵ Bazalgette L, Bradley W, Ousbey J. The truth about suicide. London: DEMOS; 2011.

7.4.4 Suicide prevention

What we don't know

Coroner's verdicts vary between areas and we do not fully understand the impact of this on local data, especially the increased use of narrative verdicts. New advice for Coroners on coding for deaths by poisoning, drug dependence and use of narrative verdicts. Furthermore, local rates will need to be adjusted for the 2011 census. The impact of all these factors on local trends is unclear at present.

Views and commentary from local communities, especially from groups at higher risk, would help to inform strategy priorities.

Key evidence and policy

The national strategy, Preventing Suicide in England, identifies the following groups for whom a tailored approach to mental health is necessary if their suicide risk is to be reduced:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system;
- survivors of abuse or violence, including sexual abuse;
- veterans;
- people living with long-term physical health conditions;
- people with untreated depression;
- people who are especially vulnerable due to social and economic circumstances;
- people who misuse drugs or alcohol;
- lesbian, gay, bisexual and transgender people;
- Black, Asian and minority ethnic groups and asylum seekers.

The Scottish government social research department has published useful advice on risk and protective factors.⁶

Recommended future local priorities

The suicide prevention action plan for Brighton & Hove is agreed by the multi-agency Suicide Prevention Strategy Group each year. For 2013-14, there are four key priorities:

1. Analysis of the Coroner's records to identify local risks and patterns, with trends over time;
2. Shared learning from review of deaths by suicide, to identify any action that might prevent such deaths in future;
3. Risk reduction among people who self-harm;
4. Support for those bereaved by suicide or concerned about others at risk.

The action plan also records local progress against the six key areas for action priorities identified in the national strategy:

1. Reduce risk of suicide in key high-risk groups;
2. Tailor approaches to improve mental health in specific groups;
3. Reduce access to the means of suicide;
4. Provide better information and support to those bereaved or affected by a suicide;
5. Support the media in delivering sensible and sensitive approaches to suicide and suicidal behaviour;
6. Support research, data collection and monitoring.

Key links to other sections

- Substance misuse
- Mental health
- Dual diagnosis
- Social connectedness
- Emotional health and wellbeing
- Alcohol

Last updated

May 2013

⁶ The Scottish Government, 2008. [online] Accessed 2013 May. Available at URL: <http://www.scotland.gov.uk/Publications/2008/11/28141444/5>

Why is this issue important?

A learning disability is a reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone for their whole life.¹

People with a learning disability tend to take longer to learn and may need support to develop new skills, understand complex information and interact with other people.¹

People with certain specific conditions can have a learning disability too. For example, people with Down's syndrome and some people with autism have a learning disability.¹

It is estimated that nationally for every 1,000 people, 20 will have a learning disability.² This is likely to increase as people with learning disabilities are living longer. People with learning disabilities often experience poorer health and poorer healthcare than the general population.³ They are more excluded from the workplace than any other group of disabled people.²

Key outcomes

- **Employment for those with a long-term health condition, including those with a learning difficulty/disability or mental illness (Public Health Outcomes Framework)**
- **Enhancing quality of life for people with care and support needs (Adult Social Care Outcomes Framework)**
- **Delaying and reducing the need for care and support (Adult Social Care Outcomes Framework)**
- **Ensuring that people have a positive experience of care and support (Adult Social Care Outcomes Framework)**
- **Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm (Adult Social Care Outcomes Framework)**

¹ Mencap. <http://www.mencap.org.uk/definition%20> [Accessed 24.04.12]

² Public Health England. Improving Health and Lives. <http://www.improvinghealthandlives.org.uk/numbers/howmany/> [Accessed 25.04.12]

³ Mencap. <http://www.mencap.org.uk/all-about-learning-disability/information-professionals/health> [Accessed 24.04.12]

Impact in Brighton & Hove

Based on national prevalence rates, there were an estimated 4,400 adults aged 18-64 years with a learning disability living in Brighton & Hove in 2011, with around 6% with a severe learning disability.⁴

In 2012/13, 768 people aged 18 to 64 with learning disabilities were known to the local authority in Brighton & Hove.⁵

In 2012/13, of the 768 people with a learning disability aged 18 to 64 living in Brighton & Hove who were known to the City Council, 600 (78%) were living in settled accommodation (where a person can reasonably be expected to stay as long as they want) and 168 (22%) were living in non-settled accommodation (where residents do not have security of tenure).⁷

Some people with learning disabilities are placed in residential care outside of the city due to a lack of specialist accommodation and insufficient supported accommodation options. When local vacancies arise however, they are being moved back where possible.

Adults with learning disabilities have a higher prevalence of gastrointestinal cancer, early onset dementia, overweight, obesity and osteoporosis, as well as difficulty with eating, drinking and swallowing. One in three has unhealthy teeth and gums. Due to increasing life expectancy, people with learning disabilities are now more likely to develop long-term conditions such as diabetes.⁶ Supporting adults with learning disabilities with food choices is a key action identified in the Brighton & Hove Food Strategy and by the Learning Disabilities Partnership Board.

Where we are doing well

A framework agreement (a select provider list) has been commissioned to expand the range of services for people with challenging behaviour and complex needs locally; two new services are being commissioned as a result.

⁴ Institute of Public Care. Projecting Adults Needs and Service Information (PANSI). Available at: www.pansi.org.uk (password required) [Accessed 04/01/2012]

⁵ Health and Social Care Information Centre. ASC-CAR 2012-13 Guidance.

⁶ Emerson E, Baines S (2010). Health Inequalities and People with Learning Disabilities. Improving Health and Lives: Learning Disabilities Observatory. PPT presentation, available at: http://www.improvinghealthandlives.org.uk/uploads/doc/vid_7479_IHaL2010-3HealthInequality2010.pdf [Accessed Jan 2011].

7.5.1 Learning disabilities

In 2012, there were 1,055 adults with learning disabilities recorded on GP practice registers. This figure has increased by 418 people since 2007.⁷ Every adult on the learning disability register is entitled to an annual health check. In 2011/12, 534 people received an annual health check, compared with 251 in 2008/09. A higher proportion of Brighton & Hove residents with learning disabilities (55%) had an annual health check compared with England (53%) and the region (41%) in 2011/12.⁸

Service users and carers were asked for their views on local GP and hospital services as part of the 2012 Big Health Check. Many people felt that they had enough time when they visited their GP; some people and their carers did not realise they could have an annual health check or felt they or the person they support was healthy already; and compared to feed back given in 2011 there was an increase in people and their carers reporting that they could have longer appointments and/or see the same GP or nurse with about the same number of people reporting they did not receive any extra help from their GP practice.

There was a decrease in people reporting having used the hospital in the previous year compared to 2011, fewer people with a learning disability report that the hospital was good at helping them, while more carers reported the hospital as being good at supporting the person they care for. As in 2011 many people and their carers indicated the learning disability liaison nurses had been good at helping them.

In Brighton & Hove in 2010/11, 102 people (13%) with a learning disability were in paid employment.⁷

Local inequalities

Of the 768 people with a learning disability aged 18-64 years living in Brighton & Hove who were known to the City Council, 456 were male and 312 were female.

⁷ Health and Social Care Information Centre. Quality and Outcomes Framework. 2011/12. Available at: <http://www.hscic.gov.uk/searchcatalogue?productid=9592&q=learning+disability&sort=Relevance&size=10&page=1#top> [Accessed 21.05.13]

⁸ Brighton & Hove City Council: 2012/13 data provided by Adult Social Care performance team.

Nationally learning disabilities are three times more prevalent in South Asians than in other ethnic groups.⁹

Both nationally and in Brighton & Hove, learning disabilities are more prevalent in the 18-34 year old age groups.⁴

Some GP practices have lower prevalence rates for the number of people with learning disability on registers, which may be a health inequality linked to deprivation.

Engagement with people with learning disabilities who use day services and their carers highlighted very little knowledge about direct payments and personal budgets.

Predicted future need

It is estimated that there will be a 3% increase in the number of adults with learning disability in the next 5 years and a 5.1% increase in the next 10 years, with the highest increase amongst people aged 55 and over and those with more severe learning disabilities.⁴

There will be an estimated additional 70 people with moderate or severe learning disabilities in the next 10 years.⁴

Table 1: Estimated number of people with learning disability in Brighton & Hove, 2011 to 2030

	2011	2015	2020	2030
Learning disability	4,363	4,450	4,536	4,729
Moderate or severe learning disability	980	1,004	1,033	1,107

Source: Institute for Public Care. PANSI www.pansi.co.uk

It is estimated that in the next five years there will be an increase of between 54 to 135 people with a learning disability eligible for local social care and a further increase of between 89 to 244 by 2020.¹⁰

⁹ Emerson et al (1997). Is there an increased prevalence of severe learning disabilities among British Asians?, Ethnicity and Health 2: 317-321

¹⁰ Emerson E, Hatton C (2010). Estimating Future Need for Adult Social Care Services for People with Learning Disabilities in England, Centre for Disability Research.

7.5.1 Learning disabilities

What we don't know

There is no evidence available on sexual orientation or religious belief.

Key evidence and policy

Valuing People Now (2009) forms the basis of a national three year strategy setting key targets on accommodation, employment and person centred plans.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215891/dh_122387.pdf

There is little data available on cost-effectiveness of services for people with learning disability, but a UK study has shown that 74% of social care costs are spent on accommodation.¹¹ A US study suggests semi-supported living is more cost-effective than residential care.¹²

Psychological therapies, annual health checks and supported employment policies are all cost-effective.¹³

Recommended future local priorities

1. The learning disability commissioning plan will be revised and implemented to meet the needs for current and future accommodation and support options.
2. The Adult Learning Disability JSNA recommendations should continue to be implemented to meet unmet needs relating to information, housing, social care and employment; and focus on those in transition with the most complex needs.
3. The community learning disability team, specialist mental health nurse and hospital learning disability liaison team should continue to support and promote the health of people with learning disabilities.
4. Further work needs to be carried out to ensure that people with learning disabilities and their

carers have information about and access to personal budgets and direct payments.

Key links to other sections

- Carers
- Employment and unemployment
- Housing
- Good nutrition and food poverty
- Children and young people with disabilities and complex health needs
- Healthy weight (Adults and older people)
- Adults with autistic spectrum conditions
- Physical and sensory disabilities
- Dementia
- Primary care
- End of life care

Further information

Brighton & Hove JSNA for Adults with Learning Disability. March 2011.

<http://www.bhlis.org/resource/view?resourceId=1079>

Improving Health and Lives – Learning Disabilities Public Health Observatory.

<http://www.improvinghealthandlives.org.uk/>

Mencap <http://www.mencap.org.uk/>

Brighton & Hove Learning Disabilities Profile

<http://www.bhlis.org/profiles/profile?profileId=210&geoTypeId=>

Last updated

June 2013

¹¹ Strydom A, Romeo R, Perez-Achiaga N, Livingston G, Kind M, Knapp M, Hassiotis A (2010). Service use and cost of mental disorders in older adults with intellectual disability. *British Journal of Psychiatry*, 196: 133-138.

¹² Felce D, Perry J, Romeo R, Robertson J, Meek A, Emerson E, Knapp M (2008). Outcomes and costs of community living, semi-independent living and fully staffed group homes (2008). *American Journal of Mental Retardation*, 87-101.

¹³ NHS Brighton & Hove and Brighton & Hove City Council. JSNA for Adults with Learning Disability. March 2011. Available at www.bhlis.org/needsassessments

7.5.2 Adults with physical and sensory disabilities

Why is this issue important?

The 2010 Equality Act defines disability as “a physical or mental impairment that has a ‘substantial’ (completing a task takes much longer than it usually would) and ‘long-term’ (12 months or more) negative effect on ability to do normal daily activities”.¹

The social model of disability highlights the social, environmental and attitudinal barriers faced by people with disabilities, which can restrict their activity and participation in society.²

People with physical disabilities are more likely to live in poverty and experience problems with housing, transport, hate crime and harassment. Policies and actions to increase independence and enablement are important in supporting good outcomes.³

Sensory disabilities include blindness, deafness, or a severe vision or hearing impairment, or a combination of these. There are almost two million people with visual impairments in the UK⁴ and more than ten million with some form of hearing loss, of whom approximately 8% have severe to profound deafness.^{5,6}

The 2011 Census data identifies that just under five million people in England and Wales said that they have a long-term health problem or disability which affects their day-to-day activities, by limiting them a lot. Locally this figure was 7% of the population (20,445 people).⁷

It is estimated, by the Royal National Institute of Blind People (RNIB), that there are almost two million people living with sight loss in the UK.⁸

Research has suggested, within UK, that the “cost” of interventions for deaf and hearing impaired

people is approximately £214,000 for every 1,000 people affected, over the course of a lifetime.⁹

The prevalence of sight loss increases with age and can lead to a loss of independence and increased risk of poverty. It is estimated that nationally three out of four blind or partially sighted older people live in poverty or on its margins, compared with one in four across all older people.¹⁰

It is estimated that in 2012, within England, there were 2.5 million adults (aged 18–64 years) with a moderate physical disability. This is projected to increase to 2.7 million by 2020. The figures related to severe physical disability are nearly 745,211 people in 2012, projected to increase to 790,936 by 2020.⁵

Key outcomes

- ***People with mental illness or disability in settled accommodation (Public Health Outcomes Framework)***
- ***Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness (Public Health Outcomes Framework)***
- ***Enhancing quality of life for people with long term conditions (NHS Outcomes Framework)***
- ***Preventable sight loss (Public Health Outcomes Framework)***
- ***Enhancing the quality of life for people with care and support needs (Adult Social Care Outcomes Framework)***
- ***Ensuring that people have a positive experience of care (Adult Social Care Outcomes Framework)***

Impact in Brighton & Hove

Applying national figures to the local population, it is estimated that in Brighton & Hove in 2012 there were:

- 13,173 people aged 18-64 with a moderate physical disability and 3,660 with a severe

¹ Great Britain. Equality Act 2010. Chapter 15. London: stationary office.

² Union of the Physically Impaired Against Segregation, 1975

³ NHS Brighton & Hove and Brighton & Hove city council. Joint Strategic Needs Assessment. Adults aged 18 to 64 years with physical disabilities. April 2009.

⁴ RNIB. www.rnib.org.uk/professionals/Pages/professionals.aspx [Accessed 28.03.12].

⁵ Institute of Public Care. Projecting Adults Needs and Service Information (PANSI). Available at: www.pansi.org.uk (password required)

⁶ Institute of Public Care. Projecting Older People Population Information System available at www.poppi.org.uk (password required)

⁷ Office for National Statistics. Census 2011.

⁸ Royal National Institute for Blind People.

www.rnib.org.uk/professionals/health/Pages/health_professionals.aspx

⁹ Deafness Research UK. Deafness – the facts. 2009

¹⁰ RNIB (2004) Unseen: Neglect, isolation and household poverty among older people with sight loss.

7.5.2 Adults with physical and sensory disabilities

physical disability. Of these, 7,531 have a moderate or serious personal care disability⁵

- 122 people aged 18-64 with a serious visual impairment and 3,294 aged 65 or over with a moderate or severe visual impairment
- 5,841 people aged 18-64, and 16,303 aged 65 or over, with a moderate or severe hearing impairment; and 48 people aged 18-64 and 455 aged 65 or over, with a profound hearing impairment³

In 2011, 980 Brighton & Hove residents were registered as Blind (630 were aged 75 or over). Of these, 145 people were recorded as having an additional disability (110 aged 65 or over), including 50 with physical disabilities, five with a learning disability and 35 recorded as deaf.¹¹

Brighton & Hove City Council Adult Social Care provided services to 4,496 people in 2012/13, 62% of those were to people with Physical Disabilities.¹²

The report "Enabling Deaf Spaces: Deaf people in Brighton and Hove city" (2012) suggests there may be up to 700 deaf people using specialist hearing services in the city.¹³

The Countability¹⁴ research project, commissioned by public service providers and led by the Fed Centre for Independent Living, started with one question: *What barriers, challenges and opportunities are experienced by disabled adults, aged 18-65, who live in Brighton and Hove?* Participants reported a range of unmet needs including:

- social isolation
- lack of disability awareness in the health service and lack of involvement in own treatment
- long waits for home adaptations

- long waits for appropriate social housing and living in unsuitable homes
- difficulties with using buses and poor street environment for wheelchair and scooter users
- difficulties with employment and volunteering
- fear of crime and feeling unsafe in parts of the City
- complex benefit forms and a lack of information about entitlements

Participants who were deaf and hearing impaired reported that a lack of provision of sign language interpretation and lack of inclusion of deaf people in community groups was a barrier to participation. They also felt health professionals needed a better understanding of their communication needs. These points were reiterated in the Enabling Deaf Spaces report,¹³ as well as the lack of a focal meeting space for deaf people. Participants with visual impairments felt there were access barriers preventing them from using community venues and joining community groups.

In 2012/13, 88 people were accepted as statutorily homeless whose priority need was classified as 'physical disability'. This represented 17.4% of all homeless acceptances in 2012/13, which is higher than the average England.¹⁵

Where we are doing well

The Countability research provided insight into the needs of local people with disabilities. It suggests priorities to improve services to better meet the needs of people with disabilities. It also highlights local assets (including the importance of peer support) and some good practice in services such as the NHS.⁶

In 2012/13, 149 Disabled Facilities Grant-aided adaptations were completed in private sector homes, and 850 major adaptations in Council homes.¹⁶

¹¹ Health and Social Care Information Centre.

www.ic.nhs.uk/webfiles/publications/009_Social_Care/Regblind11/Registered_Blind_and_Partially_Sighted_Council_level_tables_31_March_2011.xls. [Accessed 29.03.12].

¹² Brighton & Hove City Council. Adult Social Care Local Account. 2013.

Available at: <http://www.brighton-hove.gov.uk/sites/brighton-hove.gov.uk/files/4614%20Local%20Account%20adult%20social%20care%20document%20-%20r11.pdf> [Accessed 13/05/2013]

¹³ Walker J. Enabling Deaf Spaces: Deaf people in Brighton and Hove city. The Fed and University of Sussex. February 2012.

¹⁴ Hastie J. Countability: Barriers and opportunities for disabled people in Brighton & Hove. The Fed. 2012.

¹⁵ BHCC Housing Statistical Bulletin http://www.brighton-hove.gov.uk/downloads/bhcc/housing/2011-12_Q4_Statistical_Bulletin.pdf

[Accessed on 26/08/2012].

¹⁶ The Housing Adaptations Service (Housing Commissioning) includes an Occupational Therapy team and technical team, commissioning all major housing adaptations (council and private sector) where the resident has a long term, substantial disability.

7.5.2 Adults with physical and sensory disabilities

Other services commissioned by Brighton & Hove City Council Housing Commissioning include an alarm system for ten clients with physical disabilities within housing association accommodation and ten units of ‘floating support’ for people within their own home who have both sight and hearing loss.

The City Council introduced the Lifetime Homes Standard in 2001 to ensure that all new housing built in Brighton & Hove is accessible and adaptable to changing household needs. 10% of all new affordable homes are also built to the authority’s new wheelchair standard. Accessible Housing and Lifetime Homes, was adopted in March 2008, and sets standards higher than national requirements.¹⁷

There is a national and local commitment to the Personalisation agenda, ensuring that support for people with disabilities is person-centred, and increases their choice and control. The move from commissioned service to self directed support enables individuals to purchase their own social care services via Direct Payments. The use of Direct Payments has increased locally and there is a local pilot to explore Personal Health Budgets. There are currently just under 500 adults accessing support from Adult Social Care via a Direct Payment (ASCOF, 2013).

Local inequalities

The proportion of people claiming Disability Living Allowance (DLA) has historically been highest in the East Brighton and Queens Park wards suggesting that need is highest in the east of the city.¹⁸ In November 2012 there were 12,550 DLA Claimants in Brighton & Hove, (aged 18 years or over) compared with 9,480 in the same period in 2005.¹⁹

There were no BME service users within housing commissioned physical / sensory disability services in 2010/11. In 2011/12, 94% of Disabled Facilities Grant applicants were white British.

In the Count Me in Too survey (2006) of Lesbian, Gay, Bisexual and Trans (LGBT) people, 15% identified themselves as having a long-term health impairment or physical disability.²⁰ They requested improved accessibility of LGBT spaces for the disabled and greater acceptance, understanding and information. The survey also highlighted the problems of access to services reported by deaf people. It was reported that both mainstream and deaf organisations could be antagonistic to LGBT people and asked for: less prejudice and more understanding; less loud music in venues; better access in general; more and better information; and wider use of British Sign Language. The Enabling Deaf Spaces¹³ report also called for main stream services to have better access to British Sign Language and interpreters and more deaf centric events, venues and festivals.

There were no LGBT service users within housing commissioned physical / sensory disability services in 2010/11. In 2011/12, 1% of Disabled Facilities Grant applicants were LGBT service users.

Predicted future need

Tables 1 and 2 summarise the projections for changes in the local population of people with disabilities (based on applying national prevalence estimates to expected demographic changes).

Brighton & Hove	2012	2020
Moderate disability (18-64 yrs)	13,173	14,096
Serious disability (18-64 yrs)	3,660	3,978
Moderate or serious personal care disability (included in moderate and serious disability above)	7,531	8,154

Source: Institute for Public Care. www.pansi.org.uk

Brighton & Hove	2012	2020
Serious visual impairment (18-64 yrs)	122	127
Moderate or severe visual impairment (65+)	3,294	3,569
Registrable eye condition (75 +)	1,171	1,267

¹⁷ Housing Strategy. 2009-2014. Brighton & Hove City Council.

¹⁸ Disability living allowance (DLA) is a non-means-tested, non-contributory benefit which can be claimed by a UK resident aged under 65 years who has personal care and/or mobility needs as a result of a mental or physical disability.

¹⁹ Office for National Statistics. Benefit Claimants DLA. June 2013

²⁰ Browne and Lim. Count Me In Too: LGBT lives in Brighton and Hove. General Health: Additional Findings Report; 2008.

7.5.2 Adults with physical and sensory disabilities

Moderate or severe hearing impairment (18-64 yrs)	5,841	6,483
Profound hearing impairment (18-64 yrs)	48	55
Moderate or severe hearing impairment (65+)	16,303	17,678
Profound hearing impairment (65+)	455	502

Source: Institute for Public Care. PANSI and POPPI. www.pansi.org.uk and www.poppi.org.uk

The proportion of the population with co-occurring impairments is predicted to increase as the aging population lives longer. The rate of people with co-occurring severe deaf and blind impairments is predicted to rise from 212 people per 100,000 in 2010, to 343 per 100,000 by 2030.²¹

It is estimated, by the Royal National Institute of Blind People (RNIB), that the almost two million people living with sight loss in the UK is predicted to double by 2050.⁸

From 2012, the Government’s Welfare Reform programme introduced significant changes to benefits impacting on people with physical disabilities and sensory impairments (such as Disability Living Allowance and Industrial Injuries Disablement benefit). There are also changes to housing-related benefits. This potentially increases the need for housing-related support around benefit, debt and rent arrears issues to ensure that people’s independent living is maintained.

What we don’t know

Much of the data on the numbers of people with physical disabilities in Brighton & Hove is based on national data and may not be a reflection of local needs.

There is limited data on health service activity related to people with physical disabilities.

We don’t know the number of younger people likely to develop early onset physical disabilities each year, and the strategic commissioning support which will be required.

There is limited local voice data available on the provision of services for people with sensory

impairments (this group was under-represented in the Countability research).

There is no local data available on social deprivation, learning disability, BME groups, gender reassignment or the other remaining protected characteristic groups.

National data suggests; there are 36,000 people aged 16-49 who are severely or profoundly deaf, and a total of around 1.15 million with any hearing loss in the same age group. Around the age of 50 the proportion of people with hearing loss begins to increase sharply.³ Age-related damage to the cochlea is the single biggest cause of hearing loss: 71% of over 70 year-olds and 42% of over 50 year-olds have some form of hearing loss.

From the age of 40, a higher proportion of men than women develop hearing loss. This is probably because more men have been exposed to high levels of industrial noise. Among people over the age of 80, more women than men have hearing loss, due to women living longer on average.³

We don’t know about the specific health and social care needs of deaf people based upon recent local data.¹³

Some Black and Minority Ethnic (BME) groups are at higher risk of developing eye conditions:

- African and African Caribbean ethnic groups are four times more likely to develop Glaucoma and are also at higher risk of developing Age Related Macular Degeneration under 60 years
- People of South Asian ethnicity are at a higher risk of developing cataracts
- African, African Caribbean and Asian ethnic groups are at a higher risk of developing diabetic eye disease

There is evidence to suggest that some BME groups may experience higher levels of hearing loss. This is especially true of recent immigrants from regions with greater levels of poverty, poor healthcare and low levels of immunisation against diseases such as rubella.³

Key evidence and policy

Key national policy relating to physical and sensory disability includes:

²¹ Emerson E and Robertson J. Estimating the number of people with co-occurring vision and hearing impairments in the UK. Centre for Disability Research. April 2010.

7.5.2 Adults with physical and sensory disabilities

- The Disability Discrimination Act (2005)²²
- National Service Framework for long-term conditions (DH, 2005)²³
- Improving the life-chances of disabled people (Cabinet Office, 2005)²⁴
- RNIB report on visual impairment²
- Standards for services for people who are deaf blind, or have a dual sensory impairment (Sense, supported by DH)²⁵
- Independent Living; a cross Government strategy about independent living for disabled people, (Office for Disability Issues, 2008)

Recommended future local priorities

The Countability Project (2012) recommended focus on the following areas:

1. reducing social isolation;
2. increasing physical access to venues and providing sign language, more information on what's available and more choice of social activities
3. increasing continuity in nursing care in hospital or support with personal care
4. increasing disability awareness amongst health service staff and the police, particularly mental health and deaf awareness for the latter
5. more preventative mental health services and talking therapy
6. more social care support in the home and a reduction in the wait for adaptations
7. review of the social housing allocation process for progressive conditions
8. discrimination and the lack of suitable accommodation in the private rented sector
9. an increase in accessible buses and disabled parking spaces; and the removal of obstacles in the street environment

²² www.legislation.gov.uk/ukpga/2005/13/contents [Accessed 27.04.12]

²³ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4105361 [Accessed 27.04.12]

²⁴ webarchive.nationalarchives.gov.uk/+http://www.cabinetoffice.gov.uk/media/cabinetoffice/strategy/assets/disability.pdf [Accessed 27.04.12]

²⁵ www.sense.org.uk/Resources/Sense/Publications/Publications%20by%20topic/Publications%20for%20professionals/standardsforservices.pdf [Accessed 27.04.12]

10. support in finding and keeping a job
11. reasonable adjustments in the workplace
12. increased opportunities for volunteering
13. more support with the benefits process⁵

The Enabling Deaf Spaces¹³ report made sixteen recommendations including better engagement with the wider deaf community; improved access to British Sign Language and interpreters; central database of services for deaf people with personal budgets; deaf awareness training for frontline workers; deaf centric events; assessment and strategic co-ordination of the deaf community's needs, are just some of the recommendations.

Increased integrated working between Health and Social Care, to work towards the national outcomes frameworks (Adult Social Care, NHS, and Public Health). Including:

- Increased access to Self Directed Support options for adults accessing health and social care services – Personal Budgets; Direct Payments; and Personal Health Budgets.
- Increased uptake of Assisted Technology options, including Telecare.

Key links to other sections

- Carers
- Housing
- Children and young people with disabilities and complex health needs
- Preventable sight loss
- Adults with learning disabilities
- Musculoskeletal conditions
- Care of the elderly
- End of life care

Further information

Joint Commissioning Strategy for Physical Disability Services 2009-2012. Three year action plan. NHS Brighton and Hove and Brighton & Hove City Council.

JSNA for adults aged 18 to 64 years with physical disabilities. Final refreshed version April 2009. NHS

7.5.2 Adults with physical and sensory disabilities

Brighton and Hove and Brighton & Hove City Council. www.bhlis.org/needsassessments

Enabling Deaf Spaces: Deaf people in Brighton and Hove city. J Walker. 2012. The Fed and University of Sussex.

Action for Hearing Loss
www.actiononhearingloss.org.uk/

Sense www.sense.org.uk/

The Fed Centre for Independent Living
<http://www.bhfederation.org.uk/>

Last updated

August 2013

Conditions

Why is this issue important?

Autistic Spectrum Conditions (ASC) are developmental disorders and not mental health problems. If they are not identified and diagnosed in childhood, adults with Asperger Syndrome and High Functioning Autism in particular can struggle to receive the support they need to lead fulfilling and rewarding lives.¹

Nationally it is estimated that there is a prevalence of 1% amongst adults, with 433,000 adults in the UK having an Autistic Spectrum Condition.²

One of the key issues for adults with Autistic Spectrum Conditions is that without a clear pathway to services they risk falling into the gap between services for people with learning disabilities and services for people with mental health conditions. In addition, whilst we have insufficient data on how people with autistic spectrum conditions access social housing, some feedback from stakeholders suggests there may be potential barriers caused by eligibility criteria.

The number of people with Autistic Spectrum Conditions in full-time employment is very low, with research by Barnard et al (2001) estimating that 6% of all people with Autistic Spectrum Conditions are in full-time employment, and 12% of those with Asperger Syndrome or high functioning autism. At the lower functioning end of the spectrum this falls to an estimated 2% rate of employment.^{3 4} This compares with 49% of working people with disabilities and 81% of working age people with no disability in 2003.⁵

Key outcomes

- **People with mental illness or disability in settled accommodation (Public Health Outcomes Framework)**
- **Employment for those with a long-term health condition, including those with a learning**

difficulty/disability or mental illness (Public Health Outcomes Framework)

- **Enhancing the quality of life for people with long-term conditions (NHS Outcomes Framework)**
- **Reducing premature death in people with a learning disability (NHS Outcomes Framework)**
- **Enhancing quality of life for people with care and support needs (Adult Social Care Outcomes Framework)**

Impact in Brighton & Hove

There were an estimated 1,779 adults aged 18-64 years with autistic spectrum conditions in Brighton & Hove in 2011.⁶

Approximately 33% of adults with a learning disability also have an autistic spectrum condition.⁷ In 2010 the estimated number of adults with a learning disability thought to be living in Brighton & Hove was 5,053. Of these, between 1,010 (20%) and 1,667 (33%) are likely to have autism. These figures may be underestimates in view of the large proportion of young people within the City.⁸

There are likely to be 281 people on the adult social care learning disability database who also have an Autistic Spectrum Condition.⁵

In November 2010, Assert, a local voluntary organisation for people with Asperger Syndrome, were supporting 300 people both with and without formal diagnoses of Asperger Syndrome and High Functioning Autism.⁵

Some of the expressed needs identified by the Brighton & Hove Adults with Autistic Spectrum Conditions Survey 2011 included:

- Few respondents felt their GP understood their condition or medication requirements.
- They felt less safe during the day or after dark than the general adult population and two-thirds said they had been attacked, intimidated,

¹ Brighton & Hove City Council. Scrutiny panel on services for adults with autistic spectrum conditions. Report of the Adult Social Care and Housing Overview and Scrutiny Panel. March 2011.

² Knapp et al (2007) The Economic Consequences of Autism in the UK (Foundation for People with Learning Disabilities, 2007).

³ National Autistic Society Website [Accessed 2011a]

⁴ Barnard, J., Harvey, V., Prior, A., et al. Ignored or Ineligible: the Reality for Adults with Autistic Spectrum Disorders, The National Autistic Society, UK. 2001.

⁵ Office for National Statistics. Social trends no.34. London: Stationery Office. 2004.

⁶ Institute of Public Care. Projecting Adult Needs Information System.

Available at www.pansi.org.uk and Projecting Older People Population Information System available at www.poppi.org.uk [Accessed 07/02/ 2012]

⁷ Emerson E, and Baines S. The Estimated Prevalence of Autism among Adults with Learning Disabilities in England. Department of Health. 2010.

⁸ NHS Brighton and Hove and Brighton & Hove City Council. Adults with Autistic Spectrum Conditions Needs Assessment. 2011.

harassed or robbed and over half of these on more than one occasion.

- Concern that they did not meet the eligibility criteria for Adult Social Care and so could not access support. Half of respondents felt they did not receive support to live as independently as they would like.

The Adult Autism Strategy for England (2010) and the Brighton & Hove Adults with Autistic Spectrum Conditions JSNA (2011), identified needs for improvement in the following areas.^{5,9}

- Reviewing the care pathway to speed up the diagnostic process and take account of the needs of people with Asperger Syndrome or High Functioning Autism.
- Opportunities for further education.
- Information and support for adults with autism and their carers.
- Training of mental health, primary care and reception staff in identification and support needs of people with autism
- Improved transition planning
- Increased autism awareness amongst employers, police and the criminal justice system
- Housing provision to reflect the individual needs of people with Autistic Spectrum Conditions
- Data sharing across appropriate agencies to aid strategic planning

Where we are doing well

Local priorities and actions are defined in the Brighton & Hove Joint Commissioning Strategy for Adults with Autistic Spectrum Conditions 2012-2015.

This local strategy “sets out the longer-term direction and scope of how health and social care services and their partners can achieve better outcomes for adults with autism, their families and

carers”.¹⁰ The strategy is currently in the early stages of year two of its three year life:

Year 1 has focussed on improving the diagnostic and care pathway for adults with autism and improving the training and awareness of ASC in the workforce.

Years 2 and 3 will increase focus on the transition for people with autism as they move from being children to adults and local planning and commissioning of services. This will involve actions to improve services across sectors in health, housing, social care, employment, education and leisure.

In the first year of the strategy a new framework for Autism training for adult social care staff has been developed in conjunction with East and West Sussex County Councils, which includes a tiered approach according to level of knowledge required for role.

Also, a new diagnostic service is being commissioned and will commence in mid-2013. The proposed Brighton & Hove Neurobehavioural Service is being commissioned by the CCG in partnership with Brighton & Hove City Council and will be provided by Sussex Partnership NHS Foundation Trust. The service specification has been agreed and key professionals are currently being recruited to provide the service.

Local inequalities

There were an estimated 1,618 men and 172 women with Autistic Spectrum Conditions in Brighton & Hove in 2012.³ The numbers are greatest in the 25-44 year old age group (Table 1).

Autistic Spectrum Conditions are likely to be more prevalent in younger age groups as they were only formally recognised as a group of conditions in the late 1960s.¹¹ There may be older people with Autistic Spectrum Conditions who were never diagnosed as such.

⁹ Department of Health. Fulfilling and rewarding lives. The strategy for adults with autism in England. 2010.

¹⁰ Brighton & Hove Joint Commissioning Strategy for Adults with Autistic Spectrum Conditions. 2012-15. pg.3.

¹¹ Emerson E, and Baines S. The Estimated Prevalence of Autism among Adults with Learning Disabilities in England. Department of Health. 2010.

7.5.3 Adults with Autistic Spectrum Conditions

Table 1: Number of people estimated to have autistic spectrum conditions by age groups, Brighton & Hove, 2012

18-24 years	362
25-34 years	427
35-44 years	411
45-54 years	355
55-64 years	236
Total 18-64 years	1,791

Source: Institute of Public Care. Projecting Adult Needs and Service Information (PANSI) www.pansi.org.uk

*Figures may not sum to total due to rounding

Men are more at risk of developing Autistic Spectrum Conditions than women. Prevalence is estimated to be 1.8% in men and 0.2% in women.¹²

Predicted future need

The number of people with autistic spectrum conditions is expected to continue to increase (Table 2), and to reach almost 1,900 by 2025.

Table 2: People aged 18-64 predicted to have autistic spectrum conditions, by age and gender, projected to 2025, Brighton & Hove

	2012	2015	2020	2025
Males	1,618	1,645	1,679	1,710
Females	172	174	176	177
Total	1,791	1,819	1,855	1,887

Source: Projecting Adult Needs and Service Information (PANSI) www.pansi.org.uk

The number of people aged 25-34 years with an autistic spectrum condition is likely to peak in 2020 and start to decrease thereafter. An increase in 35-44 year olds is expected from 2025.

The above figures do not take account of the number of adults with Asperger Syndrome/High

Functioning Autism who do not receive support from Adult Social Care, because they do not meet the existing eligibility criteria, but who still require ongoing support with their daily lives.

It is not known how many adults with Autistic Spectrum Conditions currently managed by the mental health services will require on-going support.

What we don't know

We don't have an accurate figure for the number of people with autism using local services because there has been no statutory requirement to code autism on service databases.

Recording has however commenced within the Social Care IT system which will record all non mental health service users. A commitment has been reached to begin coding people on the housing register and for those accessing mental health services.

There is insufficient data available about disability, sexual orientation, ethnicity, gender reassignment or other protected characteristics groups.

Little is known about the prevalence or support needs of older adults with autism.

Key evidence and policy

The most recent national policy guidance is *Fulfilling and Rewarding Lives: The Strategy for adults with autism in England*. Department of Health 2010 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113369

National Institute for Health and Care Excellence. Autism in adults (CG142). Autism: recognition, referral, diagnosis and management of adults on the autism spectrum. 2012 <http://guidance.nice.org.uk/CG142>

Recommended future local priorities

The Brighton & Hove Commissioning Strategy for adults with autism 2012-15 includes the following priorities:

1. Increased awareness and understanding of autism amongst health and social care staff

¹² Health and Social Care Information Centre. Autism Spectrum Disorders in adults living in households throughout England: Report from the Adult Psychiatric Morbidity Survey 2007. 2009

Conditions

- including those in key roles; primary care and the criminal justice system.
2. Identification and diagnosis of autism in adults, leading to assessment of need for relevant services.
 3. Review the transition planning process.
 4. Strong local leadership to “champion” the needs of adults with autism.
 5. Planning and commissioning to reflect the evidence base and be integrated with other strategic commissioning plans.
 6. Involvement of carers of adults with autism in planning and decision making processes that affect the person they care for (with their consent), and their own needs identified and assessed with signposting to relevant support services.
 7. A collaborative approach that values and harnesses the knowledge, skills and views of adults with autism, their families and carers, the third sector, other professionals and partner organisations.

Key links to other sections

- Education
- Employment and unemployment
- Health in the workplace
- Young offenders
- Crime and safety
- Housing
- Noise pollution
- Emotional health and wellbeing
- Mental health
- Adults with learning disabilities
- Adults with physical disabilities and sensory impairments
- Primary care

Further information

Adults with Autistic Spectrum Conditions Needs Assessment. NHS Brighton & Hove and Brighton & Hove City Council. 2011.

www.bhlis.org/resource/view?resourceId=1076

Draft Adults with Autistic Spectrum Conditions Strategy

[http://present.brighton-hove.gov.uk/Published/C00000151/M00003308/AI00023534/\\$Item50AdultswithASCDRAFTvs8app1.doc.pdf](http://present.brighton-hove.gov.uk/Published/C00000151/M00003308/AI00023534/$Item50AdultswithASCDRAFTvs8app1.doc.pdf)

Last updated

June 2013

Why is this issue important?

Diabetes mellitus is a broad term used to describe conditions in which the amount of glucose in the blood is too high. This has serious effects on the body, in particular causing damage to blood vessels resulting in damage to various organs. There are two main types of diabetes, known as Type 1 and Type 2 (the latter accounting for nine in 10 cases). Action can be taken to help people reduce their risk of developing diabetes: most cases of Type 2 diabetes are linked to lifestyle and are preventable.

Effective self management and healthcare improve outcomes of people with diabetes.¹ However, if the condition is not well managed it can result in complications including kidney failure, blindness, coronary heart disease (CHD), stroke, foot ulcers and amputations, and sexual dysfunction in men. As a result, diabetes has a significant impact on the quality and length of life.

The cost of diabetes to health and social care services is high. It is estimated to account for 11% of total NHS spend² with £2 billion a year spent on inpatient care for people with diabetes and accounting for one in five CHD, renal and foot admissions.³

The prevalence of diabetes is increasing nationally because of increased levels of obesity, an aging population and a growing number of people of South Asian ethnicity.

Key outcomes

- **Recorded diabetes (Public Health Outcomes Framework)**
- **Excess weight in adults (Public Health Outcomes Framework)**
- **Health-related quality of life for people with long-term conditions (NHS Outcomes Framework)**

¹The National Institute for Healthcare and Excellence. NICE pathways. Diabetes Overview. [Accessed on 26/08/2012]. Available at <http://pathways.nice.org.uk/pathways/diabetes>

²NHS Diabetes. Factsheet 35. Inpatient Care for People with Diabetes: the economic case for change. [Inpatient Care for People with Diabetes: The Economic Case for Change, Nov 2011 \(PDF 180.5KB\)](http://www.nhs.uk/Assets/Inpatient_Care_for_People_with_Diabetes_The_Economic_Case_for_Change_Nov_2011_PDF_180.5KB)

³National Diabetes Support Team fact sheet: no 10: Working together to reduce length of stay for people with diabetes. NDST (2005).

Impact in Brighton & Hove

Every year the number of people diagnosed with diabetes increases.⁴ In March 2012, 9,936 people (aged 17 years or over) in Brighton & Hove were recorded as having diabetes by their GP, compared with 9,457 in 2011, 9,120 in 2010 and 8,642 in 2008. This is a prevalence of 3.3% compared with 2.9% in 2008.⁵

Modelled data⁶ suggests that there are an estimated 13,754 people aged 16 and over with diagnosed and undiagnosed diabetes in Brighton & Hove in 2013. This gives a prevalence rate of 6.3%, double the rate for Quality and Outcomes Framework (QOF) registered prevalence. There is however a variance in the confidence intervals for the modelled predicted prevalence, ranging from 4.3% to 9.2% in certainty levels. It should be noted that the difference between modelled estimates and figures recorded on GP disease registers may be due to local variations not captured by the model and not solely under-diagnosis or under-recording of diagnoses. The modelled data also includes an additional year group of 16 year olds.

If obesity continues to rise at the same rate in the population it is estimated by 2030 that 17,842 or (7.4%) of the 16 and over population will have diabetes; compared to 16,588 (6.9%) if obesity remained at 2010 levels.⁷

It is difficult to estimate the impact on local mortality. In the 2007-08 National Diabetes Audit Mortality Analysis, 210 deaths in all age groups are counted as due to Type 2 diabetes. This gives an SMR of 140 higher than the England background population (100) but a lower SMR than the other National Diabetes Audit patients at 98.⁸

⁴Health and Social Care Information Centre. Quality and Outcomes Framework 2011-12, PCT level. Available at: <http://www.hscic.gov.uk/catalogue/PUB08722> [Accessed 10.05.13]

⁵Health and Social Care Information Centre. Quality and Outcomes Framework 2011-12, Disease Prevalence. <https://catalogue.ic.nhs.uk/publications/primary-care/qof/qual-outc-fram-11-12-pct/qual-outc-fram-11-12-pcts-prev.xls>

⁶APHO. Diabetes Prevalence Model, cited in YPHO Diabetes Community Health Profile: Brighton and Hove. 2012

⁷Diabetes prevalence model for local authorities in England <http://www.yhpho.org.uk/DEFAULT.ASPX?RID=154049>

⁸National Diabetes Audit Analysis 2007-08. [Accessed 10.05.13] Available at <http://www.hqip.org.uk/assets/NCAPOP-Library/Diabetes-Audit-Mortality-Audit-Report-2011-Final.pdf>

7.5.4 Diabetes

Table 1: Brighton & Hove PCT Type 1 & 2 patients receiving all nine NICE recommended care processes, 2010-11. (%) is the median score for all PCTs.

	All care processes	Under 55 - all care processes	55 years + all care processes
Type 1	39% (39%)	32% (33%)	56% (52%)
Type 2	43% (58%)	36% (49%)	45% (60%)

Source: Health and Social Care Information Centre. National Diabetes Audit 2010-11. Report 1.

42% of local patients included in the 2010/11 National Diabetes Audit⁹ received all nine of the National Institute of Healthcare and Excellence (NICE) recommended checks (the lowest quartile for performance) compared with 54% in England.

Patients with Type 1 diabetes aged under 55 years are less likely to receive all the NICE recommended care processes, than those with Type 2. However as they get older, people with Type 1 are more likely than Type 2s to receive all their recommended care processes. Brighton & Hove Type 2 patients are less likely to receive all nine NICE recommendations than those in other PCTs in the national audit.

The views of local patients were reviewed in the 2010 JSNA for adults with diabetes: care plans & patient information were two key areas where the need to improve locally was indicated.¹⁰

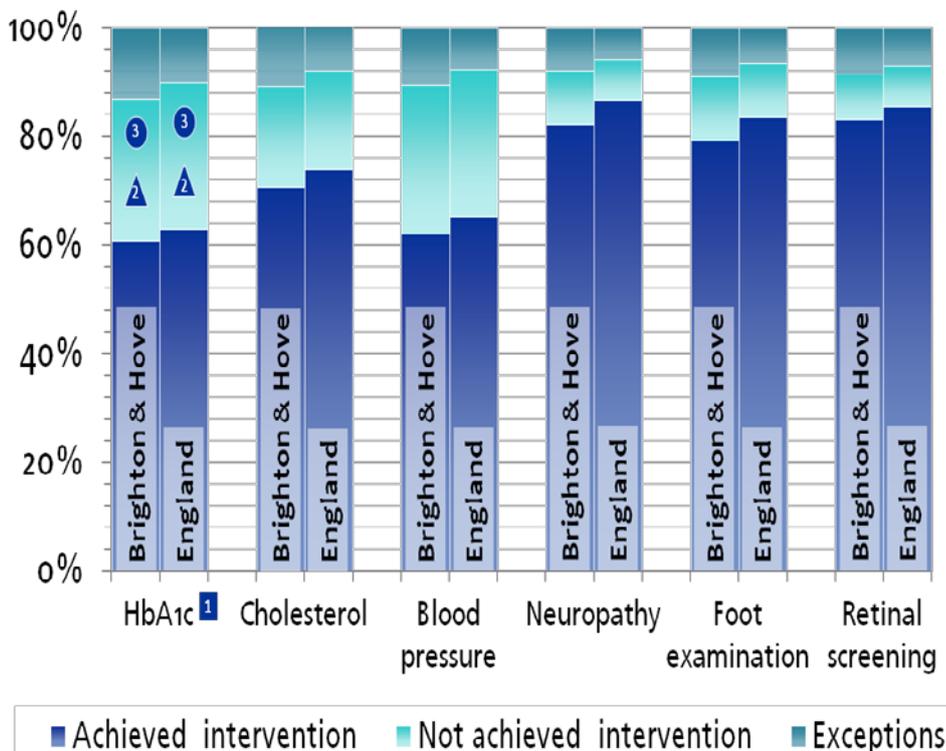
Analysis of Quality & Outcomes Framework (QOF) data (Figure 1) collected by GPs suggests that treatment and care processes are achieved in a lower proportion of people than in England and similar PCTs. The

main factor explaining this is a high level of 'exception reporting'.

The Diabetes Foot Disease Profile shows no significant difference from the England average for major and minor lower limb amputations. There were 27 major amputations in Brighton & Hove CCG between 2009 and 2012 and 56 minor amputations. This represents 0.9 per 1,000 major amputations (England CCGs 0.92) and 2.0 per 1,000 minor amputations (England CCGs 1.68),¹¹ however all such amputations are preventable.

The proportion of diabetes patients with excess length of stays in hospital was significantly higher than for England in 2009/10 at 24%. The proportion of diabetes patients requiring emergency readmission to hospital within 28 days of discharge in 2009/10 was significantly higher than England, at 86%.

Figure 1. Achievement of treatment and care processes for patients on the Diabetes Register, 2011/12



Key: 1. HbA1c -7.5% 2. HbA1c - 8% 3. HbA1c - 9%
Source: Quality & Outcomes Framework, 2011/12

⁹ Health and Social Care Information Centre. National Diabetes Audit 2010/11: Dashboard V2.0. 2011. Available at: <https://catalogue.ic.nhs.uk/publications/clinical/diabetes/nati-diab-audi-pct-lhb-anal-10-11-eng-sec/nda-audi-pct-lhb-eng-sec-brig-pct-10-11-rep.pdf>
¹⁰NHS Brighton & Hove and Brighton & Hove City Council. Joint Strategic Needs Assessment for adults with diabetes in Brighton & Hove <http://www.bhlls.org/needsassessments> [Accessed on 26/08/2012].

¹¹ Public Health England. Diabetic Foot Disease Profile. 2013. Available at: http://yhpho.york.ac.uk/diabetesprofiles/foot/ccg_pdfs/09D_Diabetes_Foot_care_Profile_201112.pdf

Each year a sample of the diabetes inpatient population is surveyed as part of the national inpatient diabetes audit. In 2012, 92 inpatients with diabetes at Royal Sussex County Hospital (RSCH) were included in the audit. As these are relatively small numbers the findings should be treated with caution but 13.5% of these patients had Type 1 and 39.3% had Type 2 diabetes. Issues identified include a low proportion of patients receiving a foot assessment within 24 hours of admission, 8.9% in 2012, down from 12.3% in 2010. Only 6.7% receiving an assessment during their hospital stay in 2012.¹² Of those admitted with foot disease only 21.4% were visited by the Multi Disciplinary Team within 24 hours in 2012. 58.3% of the patients surveyed in 2012 experienced at least one medication error and of the patients on insulin 40.3% experienced a prescription or management error. In 2012, patients had on average 3 out of 7 “good diabetes days,” when the frequency of blood glucose monitoring was appropriate and no measurement was >11mmol/L and <4mmol/L.¹²

Patients also answer questions on patient experience in the national audit. The proportion of patients at RSCH reporting they could take control of their diabetes while in hospital decreased from 62.4% in 2010 to 50.5% in 2012 but the proportion reporting they were involved in designing their care or treatment plan had increased from 23.2% in 2010 to 39.8% in 2012. There still remains a large proportion of patients who are not involved or don't perceive themselves to be involved in their own care planning.¹²

Brighton & Hove also had the highest value costs per patient for insulin total net ingredients and for blood testing net ingredient costs (NIC) in 2010/11.¹³ However, quarterly data up to September 2012, shows that Brighton & Hove had lower costs for blood glucose testing strips (652.8 NIC per 1000 patients) than the median for Southern PCTs (683.8 NIC per 1000 patients) and median for national PCTs (728.9 NIC per 1000 patients).¹⁴ QIPP quarterly data up to December

2012, shows that on average Brighton & Hove prescribes more items of long/intermediate insulin analogues (93.5) than the SHA (83.2) and more hypoglycaemic agents (87.6) than the SHA mean (84.4).¹⁵

In the 2009/10 National Diabetes Audit 12.5 per 1,000 patients required diabetic retinopathy treatments compared to 4.2 for England and 5.8 for comparator groups.¹⁶

Where we are doing well

Of people with diabetes included in the National Diabetes Audit in the city, five per 1,000 had had a stroke in the previous year compared with seven per 1,000 in England; three per 1,000 had a myocardial infarction in the previous year compared with six per 1,000 in all PCTs in the cluster. However this might be partly explained by the younger age distribution of the Brighton & Hove population.

Brighton & Hove have a range of services available to support obese and overweight people (who are at increased risk of diabetes) with weight loss: Active for Life, Shape up, Weight Management Clinics, MEND, ZestERS, and Health Walks.¹⁷

Local inequalities

There are significant health inequalities related to diabetes. It is more common in people living in the more socially deprived areas of the city.¹⁰

The main fixed risk factors relate to age, gender and ethnic group: The rate of onset of Type 2 diabetes increases with age, diabetes is more common in men and in certain ethnic groups: up to six times more common in people of South Asian descent and up to three times more common in those of African and African-Caribbean descent.¹⁸

In the Health Counts Survey 2012, slightly less BME respondents ate five portions of fruit or vegetables a day (47%) compared to White British

¹² Health and Social Care Information Centre. National Diabetes Inpatient Audit. 2012. <http://www.hscic.gov.uk/catalogue/PUB10506> [Accessed 10.07.13]

¹³ Public Health England. NHS Atlas of Variations: Diabetes. SEPHO. <http://www.sepho.org.uk/extras/maps/NHSAAtlasDiabetes/atlas.html>

¹⁴ NHS Business Authority. http://www.nhsbsa.nhs.uk/PrescriptionServices/Documents/PPDPrescribingAnalysisCharts/Endo_Dec_12_-_Blood_Glucose_Strips.xls

¹⁵ QIPP quarterly data October – December 2012.

¹⁶ Public Health England. Diabetes Community Health Profile 2009/10 http://yhpho.york.ac.uk/diabetesprofiles/PDF2012/5LQ_Diabetes%20Profile.pdf

¹⁷ NHS Brighton & Hove and Brighton & Hove City Council. Directory of Health and Wellbeing services www.brighton-hove.gov.uk/healthy-living-directory

¹⁸ Department of Health. Who gets diabetes - Health Inequalities http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationpolicyandguidance/browsable/DH_4899972

7.5.4 Diabetes

respondents (54%) and a higher proportion of BME classified themselves as a healthy weight (59%) compared to White British (52%).¹⁹

Predicted future need

The increasing number of people diagnosed with diabetes each year is expected to continue as modelled estimates suggest that one in two people who currently have diabetes have not had their condition diagnosed and the total projected modelled estimate of prevalence of diabetes (diagnosed and undiagnosed) is expected to increase in comparison to registered prevalence by 56% between 2013 (from 9,936 registered prevalence 2011/12 to 17,842 modelled prevalence 2030) as a result of changes in risk factors (in particular overweight & obesity) and the population age structure.

Diabetes is projected to account for 17% of total NHS expenditure by 2037.²⁰

What we don't know

Why modelling suggests that the level of undiagnosed diabetes is greater than average.

We do not have data on diabetes in relation to some equalities groups - trans, religion, carers, and by disability.

Key evidence & policy

All relevant guidance is collated at http://www.diabetes.nhs.uk/national_guidance/

NICE guidance on Type 1 (CG15) & Type 2 (CG66) diabetes plus relevant updates.

Recommended future local priorities

1. Uptake of prevention initiatives (such as NHS Health Checks) by the groups most at risk of diabetes (e.g. Black and Minority Ethnic groups) should be reviewed.
2. The reasons for high exception reporting should be explored and action taken to tackle the issue.

3. The interface between hospital, community & primary care should be further explored to ensure care pathways are working effectively.
4. The uptake (and completion rate) of patient education programmes should be reviewed.
5. Initiatives to increase awareness of diabetes should be considered.

Key links to other sections

- Healthy weight
- Smoking
- Physical activity
- Preventable sight loss
- Coronary heart disease
- Primary care
- Variations in effective healthcare

Further information

Diabetes Community Health profiles
<http://yhpho.york.ac.uk/diabetesprofiles/default.aspx>

JSNA for adults with diabetes in Brighton & Hove
<http://www.bhlis.org/needsassessments>

NHS Diabetes <http://www.diabetes.nhs.uk/>

Diabetes UK. Diabetes in the UK 2012: Key statistics on diabetes.

<http://www.diabetes.org.uk/Documents/Reports/Diabetes-in-the-UK-2012.pdf>

Last updated

May 2013

¹⁹ NHS Brighton & Hove and Brighton & Hove City Council. Health Counts. 2012. Available at: www.bhlis.org/surveys [Accessed 13/08/2013]

²⁰ Hex, N., Bartlett, C., Wright, D., Taylor, M., Varley, D. Estimating the current and future costs of Type 1 and Type 2 diabetes in the United Kingdom, including direct health costs and indirect societal and productivity costs. *Diabetic Medicine*. In press.

7.5.5 Coronary heart disease

Why is this issue important?

Nationally coronary heart disease is the single main cause of death, accounting for more than one in five deaths in men and one in six deaths in women.

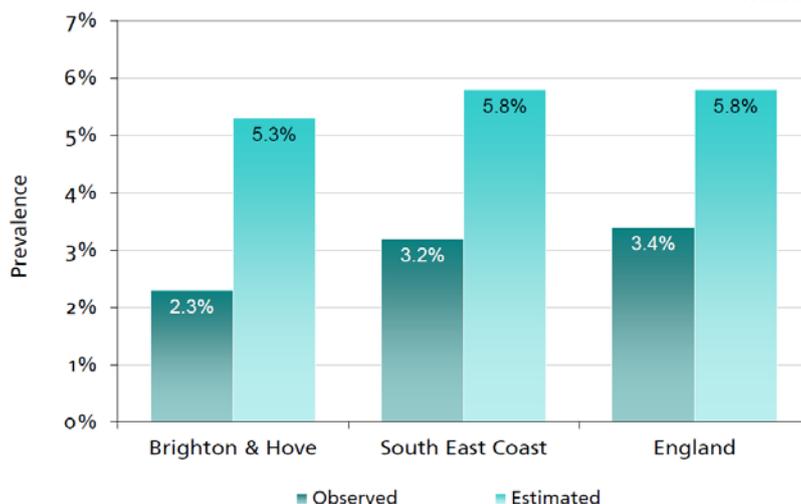
Key outcomes

- **Reduced numbers of people living with preventable ill-health and people dying prematurely, while reducing the gap between communities – mortality from all cardiovascular diseases (Public Health Outcomes Framework)**
- **Preventing people from dying prematurely (NHS Outcomes Framework)**

Impact in Brighton & Hove

In 2011/12 Brighton & Hove GP registers recorded 7,021 patients with coronary heart disease (2.3%).¹ This observed prevalence was 44% of the estimated prevalence, compared with 58% for England and 56% for South East Coast (Figure 1).

Figure 1: GP registered prevalence in 2011/12 and estimated prevalence



Source: South East Public Health Observatory. Cardio Vascular Disease Health Profile 2012/13

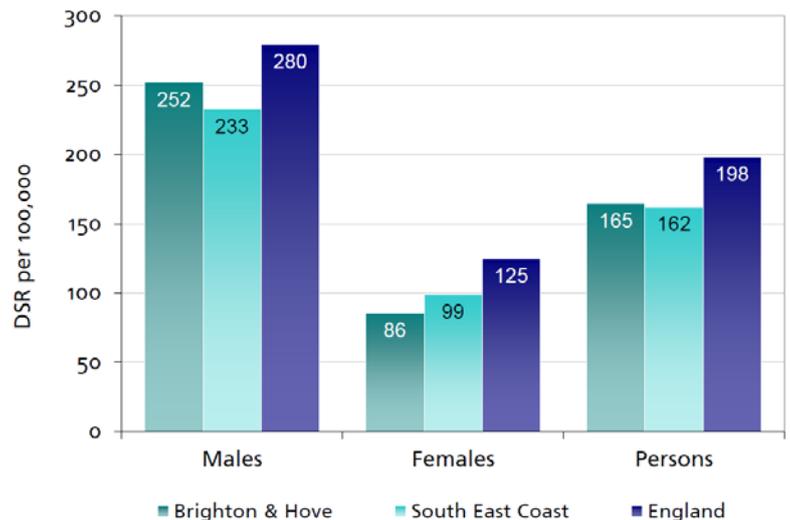
This suggests there may be under-reporting or under-diagnosis on GP registers although it should be noted that differences between modelled estimates and prevalence recorded on GP disease

¹ Information Centre for Health and Social Care. Quality and Outcomes Framework. <http://www.hscic.gov.uk/catalogue/PUB08722>

registers may be due to local variations not captured by the model.

Overall, coronary heart disease was the main cause of death for 218 people in Brighton & Hove in 2011, approximately 10% of all deaths.²

Figure 2: Coronary heart disease emergency admission rates (DSRs), for all ages, 2011/12



Source: South East Public Health Observatory. Cardio Vascular Disease Health Profile 2012/13

In 2014, the directly standardised mortality rate for coronary heart disease in Brighton & Hove is predicted to be 80.7 per 100,000 population for males and 26.9 for females; this is a 10 year

decrease of 46% for males and 59% for females. In England, the mortality rate is predicted to decrease by 46% to 83.8 per 100,000 for males over the same 10 years and by 49% to 36.9 for females. The rates for the South East Coast are predicted to decrease by 49% for males to 71.7 and by 53% to 30.9 for females.³

In 2011/12 there were a total of 498 emergency admissions for coronary heart disease in the city. This was a rate of 164.5 per 100,000 population, lower than England (198.3) and South East Coast (162.1) (Figure 2). As expected, considering the 10 year decrease in mortality from coronary heart disease, the emergency admission rate in Brighton & Hove has also decreased, by 14% between

² Office for National Statistics Vital Statistics tables (VS3) and Public Health Mortality Files

³ South East Public Health Observatory. Cardiovascular disease local authority health profile: Brighton & Hove. 2012/13. Available at: http://www.sepho.org.uk/NationalCVD/docs/00ML_CVD%20Profile.pdf [Accessed 15/08/2013]

7.5.5 Coronary heart disease

2004/05 and 2011/12. This compares to a 23% decrease in England and the South East Coast.³

Local interventions to reduce coronary heart disease risk include improved diagnosis and management of hypertension, diabetes and hyperlipidaemia; NHS Health Checks for adults aged 40-74 years; the “Health, Work and Wellbeing” programme for men over 40; and lifestyle interventions for smoking, obesity, substance misuse and physical activity.

Where we are doing well

Smoking is one of the biggest risk factors for coronary heart disease and although rates are still above the national average in Brighton & Hove, the Health Counts survey has shown that rates have been dropping over the past two decades with only 14% of the population now smoking every day. Low physical activity levels is another risk factor for coronary heart disease and the proportion of adults meeting recommended levels has also increased from 15% in 2003 to 24% in 2012.⁴

Table 1: NHS Health Checks coverage in 2011/12

	% of eligible population offered a check	% uptake among those offered
Brighton & Hove	15.9%	48.9%
East Sussex	9.5%	43.5%
Hastings & Rother	7.0%	32.8%
West Sussex	7.8%	37.2%
South East Coast	7.2%	40.0%
England	13.9%	51.6%

Source: Cardiovascular disease Local Authority health profile 2012.³

Brighton & Hove offered a higher proportion of its population an NHS Health Check in 2011/12 than

⁴ NHS Brighton & Hove and Brighton & Hove City Council. Health Counts Survey 2012. Taken from: NHS Brighton & Hove and Brighton & Hove City Council. Annual Report of the Director of Public Health Brighton & Hove. 2012/13. Available at: <http://www.brighton-hove.gov.uk/content/health-and-social-care/health/public-health-annual-report> [Accessed 15/08/2013]

the South East Coast area and England. Uptake among those offered was also higher than the South East Coast, although slightly lower than England (Table 1).

Local inequalities

The emergency admission rate for coronary heart disease in 2011/12 for people living in the most deprived areas of Brighton & Hove was 260.6 per 100,000. This is 2.2 times greater than the rates for persons living in the least deprived areas of Brighton & Hove (119.2 per 100,000). Across England emergency admission rates for persons who live in the most deprived areas are also 2.2 times greater compared to people living in the least deprived areas.⁵

Male coronary heart disease emergency admission rates were 2.9 times greater than for females.⁶

South Asians living in the UK (people from India, Pakistan, Bangladesh and Sri Lanka) have a higher premature death rate from coronary heart disease (46% higher for men; 51% higher for women).⁷

Predicted future need

Whilst rates of coronary heart disease continue to decrease, the population in the UK is ageing. Age is an important risk factor for coronary heart disease and prevalence increases with age. Both male and female populations of people over 55 years are expected to have increased by 2030, bringing a possible increased prevalence of coronary heart disease.

What we don't know

We don't have voice for local coronary heart disease patients and carers. There is no data on sexual orientation, gender reassignment or other protected characteristic groups.

Key evidence and policy

The National Service Framework for coronary heart disease sets out standards to secure best practice:

⁵ HES, Health and Social Care Information Centre, ONS, Department of Communities and Local Government (DCLG)

⁶ Hospital Episode Statistics (HES), Health and Social Care Information Centre ONS

⁷ British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford. Coronary heart disease statistics. Mortality. 2008 edition.

7.5.5 Coronary heart disease

Brighton & Hove JSNA 2013

- reducing heart disease in the population
- preventing coronary heart disease in high-risk patients in primary care
- treating heart attack and other acute coronary syndromes
- investigating and treating stable angina
- revascularisation
- managing heart failure
- cardiac rehabilitation.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4057525.pdf

Other cardiac NICE guidance and quality standards that are being implemented locally include: Delivery of 24/7 primary angioplasty model of care; heart failure and chest pain national guidelines and delivery of cardiac rehabilitation commissioning recommendations.

Recommended future local priorities

1. Continue targeted lifestyle interventions including NHS Health Checks.
2. Public Health to continue to monitor mortality, with a particular focus on health inequalities, and explore ways of targeting health inequalities through local enhanced services, including those aiming to reduce coronary heart disease.
3. Cardiac Care Services in NHS Sussex key actions to be implemented: cardiac strategy; risk assessment of gaps in cardiac rehabilitation and strengthening patient and public involvement.

Key links to other sections

- Carers
- Main causes of death
- Physical activity
- Healthy weight
- Smoking
- Alcohol
- Stroke
- End of life care

Further information

Cardiovascular disease profiles

<http://www.sepho.org.uk/NationalCVD/NationalCVDProfiles.aspx>

Last updated

August 2013

7.5.6 Stroke

Why is this issue important?

Stroke is the second most common cause of death in England and Wales, accounting for one in fourteen deaths in men and one in 10 deaths in women. It is also the single largest cause of disability.

Key outcomes

- **Under 75 mortality rate from all cardiovascular diseases including stroke (Public Health Outcomes Framework)**
- **Preventing people from dying prematurely (NHS Outcomes Framework)**
- **Improving recovery from stroke (NHS Outcomes Framework)**
- **Proportion of people feeling supported to manage their condition (NHS Outcomes Framework)**
- **Improving functional ability in people with long-term conditions (NHS Outcomes Framework)**

Impact in Brighton & Hove

In 2011/12 there were 3,898 patients on GP registers in Brighton & Hove recorded with stroke, equivalent to an all age (crude) prevalence of 1.3%.¹ This observed prevalence is 56% of the estimated prevalence of 2.3%. In the South East Coast area 1.8% of people on GP registers have had a stroke which is 69% of the estimated prevalence of 2.6% and in England as a whole 1.7% of all people on GP registers have had a stroke which is 68% of the estimated 2.5%.² This suggests there may be under-reporting or under-diagnosis of stroke on GP registers although it should be noted that differences between modelled and recorded prevalence could also be due to local variations not captured by the model.

Stroke was the main cause of death for 146 people in Brighton & Hove in 2010.³ This was approximately 7% of all deaths in that year.

There is a downward trend in deaths from stroke. In 2014, the mortality rate for stroke in Brighton &

Hove is predicted to be 31.9 per 100,000 for males and 25.5 for females, which is a 10 year decrease of 43.3% for males and 39.9% for females. The rates in South East Coast are predicted to decrease by 46.3% for males to 28.2 per 100,000 and by 44.5% to 27.6 for females. In England as a whole, the mortality rate is predicted to decrease by 44.4% to 33.1 per 100,000 for males over the same 10 years and by 41.7% to 31.9 for females.²

Figure 1: GP registered prevalence in 2011/12 and estimated prevalence



Source: South East Public Health Observatory. Cardio Vascular Disease Health Profile

In 2011/12 the emergency admission rate for stroke, all persons, in Brighton and Hove was 87.9 per 100,000 (330 admissions). This is lower than England (89.5 per 100,000) but higher than South East Coast (80.5 per 100,000). Despite the decrease in mortality from stroke, the emergency admission rate for stroke in Brighton & Hove has increased by 13.3% between 2004/05 and 2011/12 while in England it has increased by 3% and in South East Coast it has increased by 3.5%.⁴

GP performance for 2011/12 showed that for most indicators (including recording and control of cholesterol, % hypertension patients given a cardiovascular risk assessment and the % non-haemorrhagic stroke patients taking anti-coagulants) local performance was significantly lower than the England average.⁵ However, the differences were generally small, such as for % non-haemorrhagic stroke patients taking anti-coagulants which was 92.6% in Brighton & Hove compared to 93.6% in England as a whole.

¹ http://www.sepho.org.uk/NationalCVD/docs/00ML_CVD%20Profile.pdf

² http://www.sepho.org.uk/NationalCVD/docs/00ML_CVD%20Profile.pdf

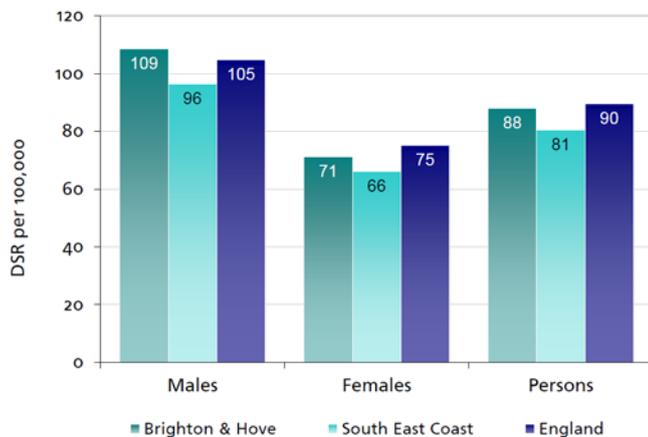
³ Office for National Statistics Vital Statistics tables (VS3) and Public Health Mortality Files

⁴ HES, Health and Social Care Information Centre, ONS, DCLG

⁵ Quality and Outcomes Framework 2011/12

7.5.6 Stroke

Figure 2: Stroke emergency admission rates (DSRs), for all ages, 2011/12



Source: Hospital Episode Statistics (HES): Information Centre for Health and Social Care

Key priorities for primary prevention of stroke include:

- Identifying and controlling high blood pressure
- Stopping smoking
- Improving diet and physical activity
- Managing risk in those with greater than 20% 10-year cardiovascular disease (CVD) risk. The NHS Health Check programme aims to identify and manage CVD risk in people aged 40-74.

Atrial fibrillation (AF, a type of irregular heartbeat) is a risk factor for stroke. NICE have identified that better identification and effective treatment of patients with this condition could prevent 6,000 strokes and save 4,000 lives.

The Stroke Association have also highlighted the importance of the emotional impact of stroke in a report *Feeling Overwhelmed* and urged the consideration of the psychological needs of survivors. However, the 2012 Sentinel Stroke National Audit showed that patients do not have access to a clinical psychologist at the Royal Sussex County Hospital.

Where we are doing well

Deaths from stroke have fallen significantly over the last 15 years, in line with the national trend.

During 2010 the Care Quality Commission reviewed how services across the country help people who have had a stroke (and their carers and family

members) after they leave hospital. Services in Brighton & Hove were ranked 2nd out of 151 PCTs.⁶

The 2012 Sentinel Stroke National Audit⁷ showed that over 8 audit domains including communication with patients and carers and organisation of care, the Royal Sussex County Hospital scored 71 compared to a national average of 73.3. This scored them in the middle half of all Trusts compared to the 2010 audit when they ranked in the upper quartile.

The Brighton & Hove CCG Operating Plan for 2013/14 reported that the proportion of patients spending 90% of their hospital stay on a stroke unit in 2012/13 was 87.77% which is higher than the planned proportion of 80%. The Proportion of people at high risk of Stroke who experience a TIA and were assessed and treated within 24 hours was also higher than the planned figure of 60% at 75.86%.

Local inequalities

The emergency admission rate for stroke in 2011/12 for persons who live in the most deprived areas of Brighton and Hove was 107.1. This is 1.1 times greater than the emergency admission rates for persons who live in the least deprived areas of Brighton and Hove (96.4). This was less of a difference than in England as a whole, where the emergency admission rates for persons who live in the most deprived areas are 1.8 times greater than people who live in the least deprived areas and in the South East Coast where the difference was 1.7 times greater.

Emergency admission rates for stroke were significantly higher than for men than women in Brighton & Hove, at 108.5 per 100,000 for men and 71.2 for women. Deaths from stroke are also higher for men than women.

Nationally there is known to be higher prevalence of stroke in some Black and Minority Ethnic groups, notably Black Caribbean men.⁸

⁶ CQC review of stroke services <http://www.cqc.org.uk/organisations-we-regulate/special-reviews-and-inspection-programmes/thematic-reviews/stroke-services> [Accessed on 26/08/2012].

⁷ <http://www.rcplondon.ac.uk/stroke/transparency/ssnap>

⁸ Primatesta and Brookes (1999) Health Survey for England: the health of minority ethnic groups: Cardiovascular disease

7.5.6 Stroke

Predicted future need

Whilst rates of death from stroke continue to decrease, the population in the UK is ageing. Age is an important risk factor for stroke and prevalence increases with age. Both male and female populations of people over 55 years are expected to have increased by 2030, bringing a possible increased prevalence of stroke and national projections suggest that the number of people living with a long-term health condition caused by stroke will increase by 20% between 2011 and 2030 (1,259 to 1,507).⁹ This may increase the need for services supporting people to maintain independence following a stroke.

What we don't know

There is no data for some equality groups (e.g. sexual orientation and the trans population).

Key evidence and policy

NICE Clinical Guideline 68 (2008)

<http://www.nice.org.uk/CG68>

The Accelerating Stroke Improvement Programme includes the following key areas of work:

- AF detection, risk stratification and optimal treatment
- Direct admission to a stroke unit and time spent on a stroke unit
- Timely brain scan
- Timely and effective management of Transient Ischaemic Attack
- Psychological support
- Joint care planning
- Review at six months
- Early supported discharge (ESD)

<http://www.improvement.nhs.uk/stroke/AcceleratingStrokeImprovement/tabid/134/Default.aspx>

Recommended future local priorities

1. Continue targeted lifestyle interventions to reduce stroke risk including NHS Health Checks.
2. Ensure equitable uptake by men and people from BME groups of stroke prevention initiatives.
3. Continue to implement Accelerating Stroke Improvement programme locally.

Key links to other sections

- Carers
- Physical disability and sensory impairment
- Smoking
- Healthy weight
- Physical activity
- Ageing well
- Older people – social care

Further information

South East Public Health Observatory CVD Profiles
<http://www.sepho.org.uk/NationalCVD/NationalCVDProfiles.aspx>

Last updated

July 2013

⁹ Projecting Older People Population Information System; Projecting Adult Needs and Service Information www.poppi.org.uk; www.pansi.org.uk based on reported stroke in the General Household Survey. [Accessed on 26/08/2012].

7.5.7 Respiratory disease

Why is this issue important?

Respiratory diseases are the third main cause of death after circulatory diseases and cancer in the UK.¹

Respiratory diseases include asthma, Chronic Obstructive Pulmonary Disorder (COPD), bronchitis, emphysema, pneumonia and respiratory tract infections. They are one of the main causes of emergency hospital admissions and death.² An estimated 3 million people are affected by COPD in the UK. About 900,000 have been diagnosed and an estimated 2 million people have COPD that remains undiagnosed.³ The cost to the NHS of treating COPD is over £1 billion each year.⁴

The UK has one of the highest prevalence rates of childhood asthma in the world, around one in 11 children having asthma symptoms.⁵

The Health Development Agency in 2004 estimated that 85% of COPD-related deaths could be attributed to smoking.²

Key outcomes

- **Under 75 mortality rate from respiratory diseases (Public Health Outcomes Framework/ NHS Outcomes Framework)**
- **Health-related quality of life for people with long term conditions (NHS Outcomes Framework)**
- **Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) (NHS Outcomes Framework)**
- **Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s. (NHS Outcomes Framework)**
- **Emergency admissions for children with lower respiratory tract infections (NHS Outcomes Framework)**

¹ Inhale. Interactive health atlas for lung conditions in England. Available at: <http://www.inhale.nhs.uk/> [Accessed 5.05.13]

² London Health Observatory: Respiratory Disease. Available at http://www.lho.org.uk/LHO_Topics/Health_Topics/Diseases/RespiratoryDisease.aspx [Accessed 30.04.12]

³ National Institute for Health and Care Excellence (NICE). Clinical Guideline 101. COPD. January 2012.

⁴ British Lung Foundation. <http://www.lunguk.org/blf-services/blf-services>. [Accessed 03.04.12]

⁵ South East Public Health Observatory, ChiMat, DMIT. Children with long term conditions in the South East Coast SHA. Emergency hospital admissions for asthma, diabetes and epilepsy, 2009/10.

Impact in Brighton & Hove

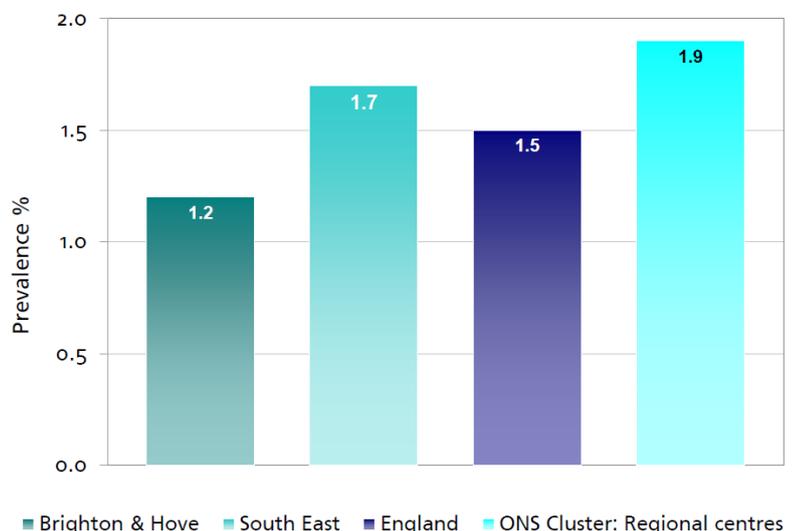
In Brighton & Hove respiratory diseases are the third main cause of death after circulatory diseases and cancer (265 deaths in 2011, 13% of all deaths).⁶

In 2011, there were 66 deaths in Brighton & Hove in under 75s as a result of respiratory disease (10% of all deaths under 75 years).⁶ The CCG had a mortality rate from respiratory disease of 31 per 100,000. This is higher than the England rate of 27.3 per 100,000.¹

COPD and pneumonia are the most common causes of respiratory disease deaths. In 2011, there were 3,583 people recorded as having COPD on the GP registers. The recorded prevalence is 1.2%, which is lower than the England average of 1.7%. The level of recorded prevalence ranges from 1.7% to 14.7% amongst GP practices; the level has been increasing probably due to an improvement in recording.¹

Figure 1. Prevalence of COPD (%) 2011/12

Source: QOF data 2011-12. Inhale CCG profiles

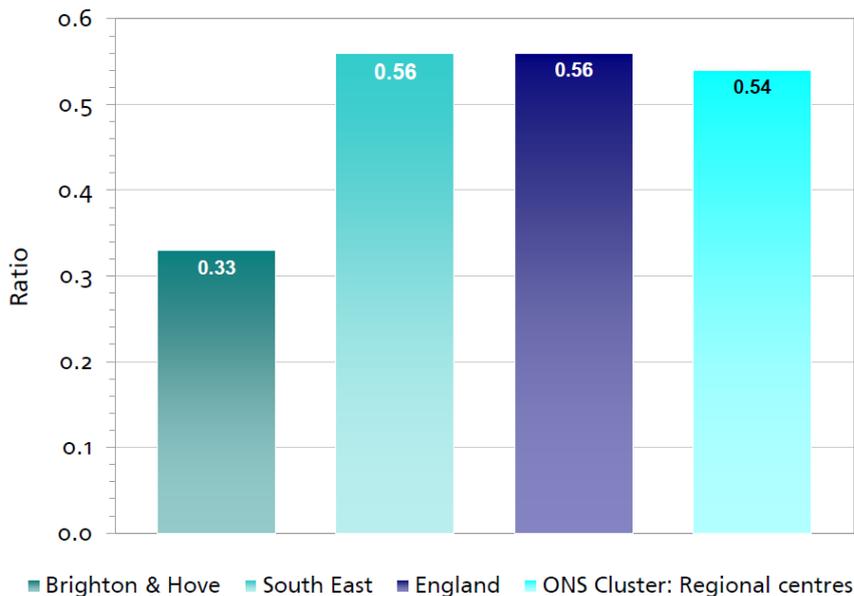


The level of reported prevalence of COPD is lower than the expected prevalence, likely to be due to under diagnosis and recording. Studies suggest that only 60% of potential COPD cases in an area are actually diagnosed. In Brighton & Hove CCG the ratio of recorded prevalence to expected prevalence is 0.32, this is lower than England, South of England Commissioning Region and ONS cluster.¹

⁶ Office of National Statistics. Vital Statistics Tables (VS3). 2011.

7.5.7 Respiratory disease

Figure 2. Ratio of Reported/Expected prevalence of COPD %



Source: QOF data 2011-12. Inhale CCG profiles

COPD patients are often admitted as emergency cases and about 20% are readmitted within 30 days of discharge following a previous admission. In Brighton and Hove CCG 21.7% of patients were readmitted in an emergency within 30 days of discharge for COPD. This is lower than the ONS cluster average of 22.4% but higher than the Region (19.5%) and England (21.2%).¹

COPD is the second most common cause of emergency admission to hospital and one of the most costly diseases in terms of acute hospital care in England.⁷ Three of the highest emergency admission rates for GP practices in Brighton are from practices in the more deprived areas, with an emergency admission ratio ranging from 168.6 to 174.9 compared with an England value of 78.3 for GP practices with a similar profile.⁸

In 2011, there were 16,845 people in Brighton and Hove recorded as having asthma on GP registers. 985 of these people were aged 14-19 years and had a record of smoking status in previous 15 months. 85% of patients on the asthma register had a diagnosis with measures of variability or reversibility, lower than England (87%). 76% of asthma patients had received a review in the

previous 15 months, lower than England (78%).

94% had had their smoking status recorded in the previous 15 months, lower than England (95%). 91% had been offered smoking cessation advice or referral, compared to 93% for England.¹

NICE clinical guideline 101 includes a review of clinical costs of treating COPD. A study by Britton et al (2000/01) estimates annual costs per patient by severity (Mild: £149.68 per year; Moderate £307.4 per year; Severe £1,307.10 per year).⁹

In Brighton & Hove the emergency admission rate for asthma among 0-18 year olds was 214.5 per 100,000 in 2009/10, compared with 230.2 for England. Brighton & Hove was in the

second best performing quartile nationally.⁵

Brighton & Hove has significantly higher emergency bed days (394.3 per 100,000) for childhood asthma than the England average, placing it in the worst performing quartile nationally. It also has significantly higher average length of stay than England, at 1.86 days per admission compared with 1.23. This also places it in the worst performing national quartile.⁵

In 2009/10, it was estimated that Brighton & Hove PCT would save £39,604 if emergency admission rates for asthma among 0-18 year olds were reduced to the average for the lowest eight PCTs in England.⁵

Smoking prevalence in Brighton and Hove is 23.1%, higher than the prevalence for England (22.9%) in 2011/12.¹⁰ This will have an impact on the prevalence of respiratory diseases.

The Health Counts Survey 2012 included questions on limiting long term illnesses, some of the respondents will have included people with respiratory diseases such as COPD. The proportion saying they have a limiting long-term illness has decreased between 1992 and 2012 from 31% to 26%.

⁷ South East Public Health Observatory. Inequalities in primary care: what can analysis of QOF data reveal? Summary report for Brighton and Hove PCT. July 2011

⁸ Emergency admissions for COPD – MSAO based estimates 2003/04 to 2007/08

⁹ Britton M. The burden of COPD in the U.K.: results from the Confronting COPD survey. *Respir Med.* 2003; 97(Suppl C):S71-S79.

¹⁰ NHS Brighton and Hove and Brighton & Hove City Council. Health Counts Survey 2012. Available at: www.bhlis.org/surveys [Accessed 15/08/2013]

Where we are doing well

The CCG continues to work on implementing the Shortness of Breath care pathway with South East Coast Ambulance Service (SECAmb).

The Community Respiratory Team now provides a Home Oxygen Assessment and Review Service for all patients requiring home-based oxygen.

The Community Respiratory Team and SECAmb piloted a data sharing project in 2012, which alerted ambulance crews to respiratory patients via the IBIS system. This enabled CRT staff to make home visits and avoid unnecessary hospital admissions in response to emergency call outs. This service is now being rolled out to all appropriate respiratory patients.

Brighton & Hove performs relatively well for adults in terms of admission rates for asthma.

A management plan and care pathway for the treatment of acute wheeze/asthma in children over 1 year in primary care, has been developed and is in the process of being implemented.

In line with NICE clinical guidelines for COPD,¹¹ cascade training workshops were held for GP practice staff in 2012/13, to ensure every practice had at least one appropriate healthcare professional/assistant trained in inhaler technique: 43 practices have received the training so far and it will be rolled out across health and social care.

In line with NICE clinical guidelines for COPD,¹¹ in 2012/13, GP practices were encouraged to assess suitable COPD patients with COPD for self-management plans for coping with exacerbations. As well as a written plan there is a standby course of antibiotics and prednisolone with instructions on when to use them; this should reduce the risk unnecessary hospital admissions.

Local inequalities

The Health Counts Survey 2012, found that more people with limiting long term illness (some of whom will have respiratory diseases) lived in the most deprived quintile in the city (38%) compared to 22% living in the least deprived quintile.

Across England, there is some evidence of a relationship between admission rates for asthma and levels of deprivation, with admission rates tending to be higher in areas of deprivation. However, compared with elsewhere in England, South East Coast CCGs perform relatively well in this area.³

Nationally, prevalence rates appear to be increasing in women and to have reached a plateau for men.²

Mortality from COPD reflects social inequalities, with men aged 20–65 years in unskilled manual occupations being 14 times more likely to die from COPD than those in professional occupations.²

The prevalence of COPD increases with age (Table 1).

Table 1: Estimated modelled prevalence of COPD in Brighton & Hove and England 2012

Age	Brighton & Hove	England
16-44 years	1.80%	1.25%
45-64 years	5.69%	4.09%
65-74 years	11.48%	8.20%
75+	11.9%	8.82%

Source: East of England Public Health Observatory, December 2012

Nationally hospital admission rates for COPD have risen for all age groups since 1994 except for the under 45s. Rates for the over 85s almost doubled between 1994 and 2005.²

Modelled prevalence of COPD based on 2009 ONS population estimates by ethnic group estimates that 4.6% of White and Mixed race adults aged 16 years or over in Brighton & Hove had COPD (3.7% in England), compared with 3.8% of the Black population (4.0% in England) and 2.3% of the Asian population (2.3% in England).¹²

Predicted future need

The prevalence of respiratory disease increases with age. In the Health Counts Survey 2012, 67% of

¹¹ National Institute for Health and Care Excellence (NICE). CG101. Chronic obstructive pulmonary disease (update): full guideline. October 2010. Available at:

<http://guidance.nice.org.uk/CG101/Guidance/pdf/English>

¹² East of England Public Health Observatory. COPD prevalence estimates. December 2011

7.5.7 Respiratory disease

those aged 75 years or over had a limiting long term illness. Both male and female over 55 years populations are likely to have increased by 2030 and this will increase the number of people living with respiratory disease.

What we don't know

We do not have voice evidence for Brighton & Hove respiratory patients.

We do not have data about ethnicity, sexual orientation or religion/faith groups for people with respiratory disease.

We need to know more about why Brighton & Hove has higher than national average emergency bed days and length of stay rates for 0-18 year olds with asthma.

Key evidence and policy

NICE issued updated guidance on the management of COPD in 2010 and the Department of Health published an Outcomes Strategy for people with COPD and asthma in England in 2011. NICE also published 13 quality standards for COPD in 2011.

Recommended future local priorities

1. Partners and stakeholders to review hospital admissions and readmissions for COPD discharges with BSUH.
2. Partners and stakeholders to assess the need for and appropriate use of pulmonary rehabilitation
3. CCG to review management of asthma in adults in community settings – including a primary care learning audit and development of guidelines for primary care for dealing with moderate exacerbations.
4. CCG to roll out inhaler technique training across the city for key professionals, parents and carers.

Key links to other sections

- Carers
- Main causes of death
- Air quality
- Smoking
- Children and young people with disabilities and complex health needs
- Care of the elderly
- End of life care

Further information

NICE Guidance CG101. Chronic obstructive pulmonary disease (update): full guideline <http://guidance.nice.org.uk/CG101/Guidance/pdf/English>

NICE COPD quality standards <http://www.nice.org.uk/media/714/EC/COPDQualityStandard.pdf>

An outcomes strategy for COPD and asthma in England. 2011. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128428.pdf

East of England Public Health Observatory modelled estimates of COPD prevalence. 2011. <http://www.apho.org.uk/resource/item.aspx?RID=111122>

SEPHO. ChiMat. DMIT. Children with long term conditions in the South East Coast SHA. [http://www.sepho.org.uk/Download/Public/14369/1/South_East_Coast_SHA_children_with_long-term_conditions_report_\(Nov-2011\).pdf](http://www.sepho.org.uk/Download/Public/14369/1/South_East_Coast_SHA_children_with_long-term_conditions_report_(Nov-2011).pdf)

Last updated

May 2013

Why is this issue important?

Every year in England 250,000 people are diagnosed with cancer and around 130,000 die from the disease. It is one of the main causes of death and incidence is rising as the population ages. Cancer is also the main cause of death in England in the under 75s.

The most common cancer in females is breast cancer and in males prostate cancer; the second and third most common cancers in both females and males are lung and colorectal cancer.¹

Despite improvements in cancer survival and mortality in recent decades, outcomes in the UK are poor compared with the best in Europe. If cancer survival rates in England were to match the European average, 5,000 lives could be saved each year and if they matched the European best 10,000.²

If premature mortality is to be reduced, then prevention of cancer is as important as treatment. Tobacco smoking remains the most important avoidable cause of cancer in the UK, followed by diet, excess body weight, alcohol consumption (these four accounting for 34% of cancers occurring in 2010), exposure/conditions at work, sunlight and sunbeds, infections, radiation, inactivity, not breastfeeding and Hormone Replacement Therapy (HRT). Less than 5% of cancer is genetically linked.³ As cancers are caused by multiple factors acting simultaneously, they can be prevented by intervening on single or multiple risk factors.^{4,5}

Diagnosis at an early stage, when treatment is generally more effective, is also key to improving survival rates.

¹ ONS Cancer Registration Statistics, England, 2011. 26 June 2013. [Accessed 16.8.13] Available from http://www.ons.gov.uk/ons/dcp171778_315795.pdf

² Department of Health. Improving Outcomes: A Strategy for Cancer. Second Annual Report 2012.

³ Cancer Research UK. Are all Cancer Hereditary? [Accessed on 16.8.13] Available from <http://cancerhelp.cancerresearchuk.org/about-cancer/cancer-questions/are-all-cancers-hereditary>

⁴ DM Parkin, L Boyd and LC Walker. The Fraction of Cancer Attributable to Lifestyle and Environmental Factors in the UK 2010. Br Jnl of Cancer (2011) 105, S77-81.

⁵ Cancer Research UK Attributable risk - data visualisation of the results. [Accessed 16.8.13] Available from <http://info.cancerresearchuk.org/cancerstats/causes/comparing-causes-of-cancer/visualisationoftheresults/>

Key outcomes

- **Reduce the rate of mortality from all cancers, in people under 75, by at least 20% from the baseline rate in 1995-97. Target to be achieved by 2009-11 (Department of Health 1997).**
- **Age-standardised mortality rate from all cancers for persons aged under 75 per 100,000 population (Public Health Outcomes Framework)**
- **Age-standardised rate of mortality that is considered preventable from all cancers in persons less than 75 years of age per 100,000 population (Public Health Outcomes Framework)**
- **Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed (Public Health Outcomes Framework)**
- **Reducing premature mortality from the major causes of death including one and five year survival from colorectal cancer, breast cancer, and lung cancer; under 75 mortality from cancer (NHS Outcomes Framework 2013/14)**

Impact in Brighton & Hove

Incidence: Between 2008 and 2010, the age standardised incidence rate in Brighton & Hove for all ages (388 per 100,000) was the same as the national average (387). It was slightly higher for those aged under 75 years (314 compared with 306 in England). Trend data suggests that the incidence for all cancers combined is increasing, however this is more apparent in females than males.⁶

Around 1,175 people in the city are diagnosed with cancer each year; of these over half are for the four main cancers (185 female breast, 135 prostate, 143 lung and 136 colorectal cancers). Trend data is not generally available at local level. At a national, regional and strategic health authority (SHA) level the incidence of female breast cancer is relatively stable; prostate cancer is increasing (likely due to increase in identification as more men have Prostate Specific Antigen (PSA) testing); lung cancer is decreasing in males but increasing in females; and colorectal cancer is relatively stable.

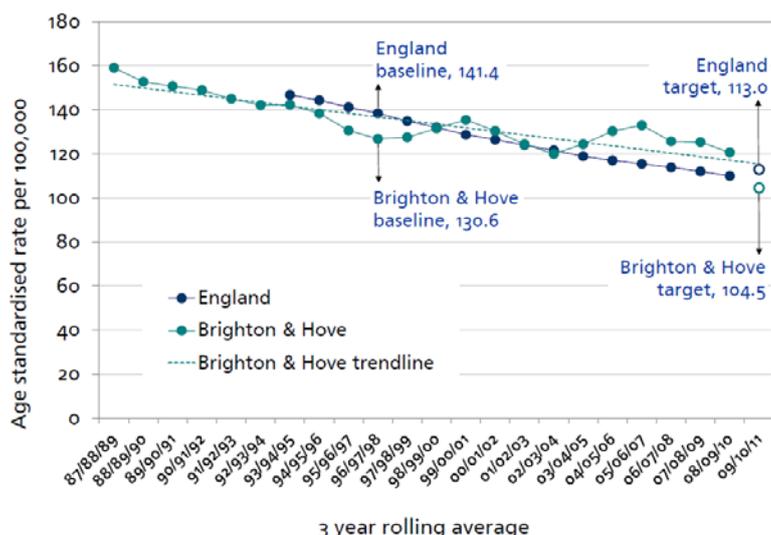
⁶ Cancer Research UK. Cancer incidence for all cancers combined. December 2012. [Accessed 16.8.13] Available from <http://www.cancerresearchuk.org/cancer-info/cancerstats/incidence/all-cancers-combined/#Trends>

7.5.8 Cancer

Mortality: In 2011 cancer was responsible for 29% of all deaths (613 deaths) in Brighton & Hove and was the main cause of death, 3% higher than deaths from circulatory disease. Lung cancer is responsible for most cancer deaths as it is both a common cancer and has poor survival rates (due to late diagnosis in more than two-thirds of people).

Premature mortality: The age standardised mortality rate for people aged under 75 years is higher in Brighton & Hove (120 per 100,000) than in England (110). Whilst the England rate has declined steadily since the 1995-97 baseline (as it has in Sussex Cancer Network) this is not the case in Brighton & Hove. Since 2003-2005 Brighton & Hove has been above the England average (and is consistently higher than Sussex Cancer Network).

Figure 1: Cancer mortality – age standardized rates and targets (under 75s)



Source: Office for National Statistics

Although the trend is downwards, it is very unlikely the 20% reduction target will be met (Figure 1). Premature mortality rates (under 75) in Brighton & Hove have declined (since the 1995-1997 baseline) for female breast cancer, prostate cancer, lung cancer in males, and colorectal cancer in both males and females. However mortality has increased for lung cancer and upper gastrointestinal cancer in females.

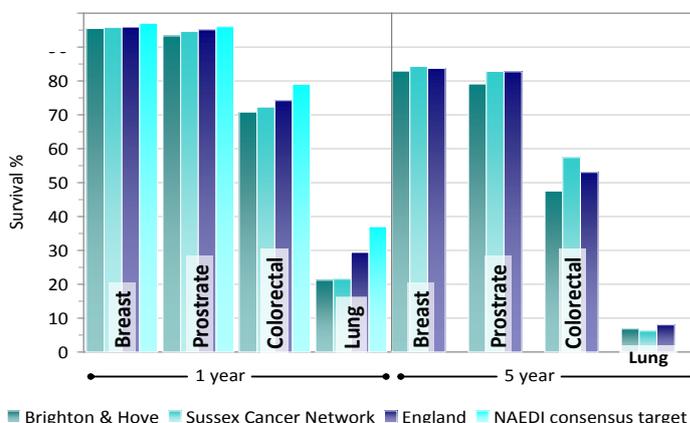
Survival rates

The one year survival rate⁷ for all cancers combined, diagnosed in 2009, is 64.1%⁸. However rates vary by tumour site, and gender.

For breast, prostate and colorectal cancers the one year and five year relative survival rates in Brighton & Hove are similar to the Sussex Cancer Network and England averages (Figure 2). For lung cancer the one year survival rate in both Brighton & Hove and Sussex Cancer Network is significantly lower than the England average and has a considerable way to go in all areas before reaching International best practice [National Awareness and Early Diagnosis Initiative (NAEDI) consensus target]. The five year rate in Brighton & Hove and Sussex Cancer Network is not significantly different from the national rate.

A new index of cancer survival at one year after diagnosis has been created to enable PCTs to measure the effectiveness of cancer services at a local level over time. It is adjusted for differences in the profile of resident cancer patients by age, sex and cancer type so that the index is intended to change only if cancer survival actually changes. Figure 3 suggests that although survival in Brighton & Hove is lower than England, it is gradually improving.

Figure 2: One year and five year relative survival for common cancers (2004-08 and alive end 2009)



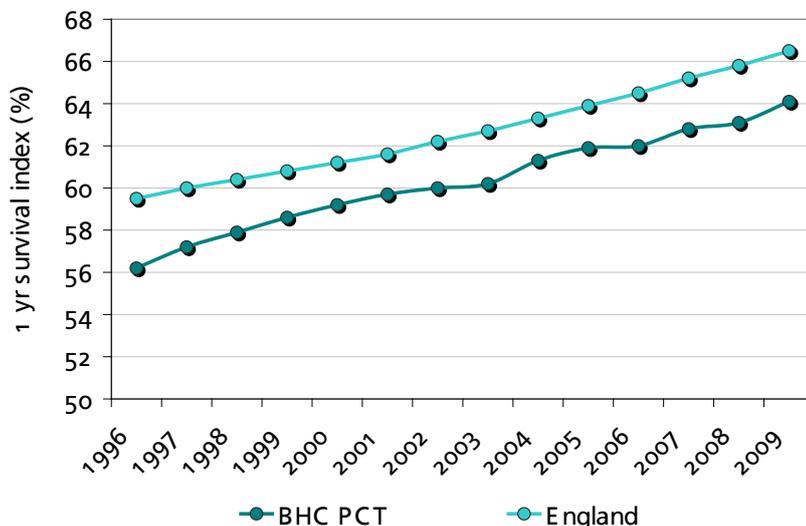
Source: Cancer e-Atlas data by NHS health boundaries 2012

⁷ One year relative survival is a measure of stage at presentation and quality of initial care. Five year survival takes into account the whole pathway and can be taken as a proxy for cure.

⁸ Combined cancer survival by primary care trusts, Patients diagnosed in 1996-2009, followed up to 2010. Available at: <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tc%3A77-241178> [Accessed 30/08/13]

7.5.8 Cancer

Figure 3: One year survival index (%) for all cancers combined, by calendar year of diagnosis: all adults (15-99 years), England and Brighton & Hove PCT.



Source: ONS Statistical Bulletin, August 2011.⁹

Public voice: A survey of population awareness of cancer in 45–70 year olds in the city in 2010¹⁰ found that recall of possible cancer symptoms locally was low (under 34%) with the exception of a lump or swelling (61%) and was significantly lower than nationally for a number of key symptoms such as lump, change in appearance of a mole, cough and weight loss. Recognition of symptoms when prompted was considerably higher.

The majority of residents said they would contact their doctor within two weeks if they had symptoms. However more residents locally than nationally said they would delay this for a month or more. In line with national findings the most widely endorsed barriers to presenting to the GP locally were ‘worry about what the doctor might find’, ‘difficulty in making an appointment’ and ‘worry about wasting the doctor’s time’. These barriers were significantly lower locally than nationally.

Smoking was the most commonly recalled risk factor (63%), although awareness was significantly lower than nationally (82%), followed by drinking alcohol (where local awareness exceeded national) and eating a poor diet. Recall of risk factors when

prompted was much higher. Lifestyle was seen as the biggest contributor to cancer (63%) followed by genetic inheritance (23%), environmental factors (5%), chance (4%) and age (4%).

The 2010 national patient experience survey showed that care and treatment at Brighton & Sussex University Hospital trust (BSUH) could be improved, particularly in terms of timeliness of first hospital appointment, and communication (written and verbal) about diagnostic tests, results, diagnosis, and treatment. There was also room for improvement on support available, treatment by hospital doctors, information given before leaving hospital, and home support, hospital care as a day/out-patient, and care from general practice. Hospital care and

treatment was generally good although privacy could be improved. Patients regarded treatment by nurses and clinical nurse specialists highly. A repeat survey in 2012 revealed that, nationally, scores have improved on most questions, with the most significant increases in positive scores seen on information and communication issues.

Spend: Programme budgeting information shows that Brighton & Hove PCT investment in cancer remained the same for 2011/12 as in 2010/11. For 2011/12 spend on ‘cancers and tumours’ is the fourth highest area of spend, exceeding that of ONS cluster PCTs, the Strategic Health Authority and England, ranking 17th out of 151 PCTs. Analysis by sub-categories shows that the PCT spend ranks 5th for breast cancer, 99th for lower gastrointestinal cancer, 100th for lung cancer and 124th for urological cancers (which includes prostate cancer).¹¹

Local inequalities

Age: Incidence increases with age for most cancers, yet older people may not be aware of their increased risk and may have lower awareness of cancer symptoms than younger groups.¹²

⁹ Office for National Statistics. Statistical Bulletin: Index of Cancer Survival for Primary Care Trusts in England - Patients diagnosed 1996-2009 and followed up to 2010. 13th December 2011. [Accessed 22.08.13] Available from http://www.ons.gov.uk/ons/dcp171778_247272.pdf

¹⁰ Lake Market Research. Cancer Awareness and Early Diagnosis Initiative CAM Final Results. NHS Brighton and Hove: April 2010.

¹¹ Department of Health. Spend and Outcomes Factsheets 2010/11 and 2011/12, Brighton and Hove City PCT. [Accessed 30.08.2013] Available from http://yhpho.org.uk/quad/pcts1011/5LQ_PB1011%20Profile.pdf

¹² National Cancer Intelligence Network. Evidence to March 2010 on cancer inequalities in England. June 2010. [Accessed 30.08.13] Available from <http://www.ncin.org.uk/view?rid=169>

7.5.8 Cancer

Lower awareness of risk factors for older ages was seen in the local awareness survey.¹⁰ Reduction in cancer mortality has been much less marked for the over 75s than the under 75s. Cancer survival decreases with age and there is evidence that older people's cancers are investigated and treated less intensively.¹²³

Gender: Cancer incidence and mortality is higher in men than women but, due to women's longer life expectancy, more women than men are living with or beyond a diagnosis of cancer. Men have a lower awareness of the signs and symptoms of cancer, which was confirmed by the local survey: women were more likely than men to report emotional barriers would prevent them going to the doctor with symptoms e.g. 'being too scared' or 'too embarrassed'.¹⁰ More men than women die at home which is probably due to a younger age at death and hence increased likelihood of having a spouse available to care for them. Men also generally report more favourably on their care than women.¹²³

Socio-economic deprivation:

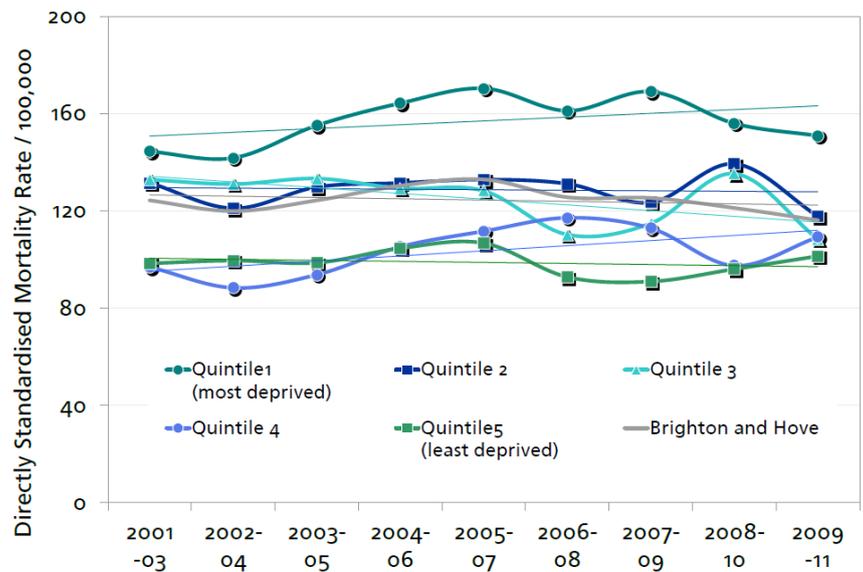
Incidence and mortality from cancer is considerably higher in the more deprived groups, largely due to lifestyle factors, especially higher smoking rates. There is a clear survival gap between the most and least deprived.¹²³ Mortality rates from cancer are higher in the more deprived populations of Brighton & Hove although the gap between the most and least deprived quintiles appears to be widening (Figure 4).

Awareness of the signs and symptoms of cancer is lower amongst socially deprived groups, which was confirmed by the local survey.¹⁰ There is some evidence to suggest that there may be differences in NHS treatment between socio-economic groups although later stage at presentation and co-morbidities are also responsible for excess mortality in the more deprived. People from more deprived social groups are less likely to die at home than the more affluent.¹²

Ethnicity: Awareness of cancer is generally lower in Black and Minority Ethnic (BME) groups than amongst White men and women. Deprivation is

likely to be a factor as well as cultural issues. Women from BME) groups are more likely to present with more advanced breast cancers and have poorer survival than White women.¹²³ Locally non-white residents were more likely to perceive barriers to help-seeking.¹⁰

Figure 4: Mortality from under 75 cancers: 3 year rolling averages 2001/03 to 2009/11



Source: Office for National Statistics

Sexuality: Differences in health-related behaviours among lesbian, gay, bisexual and transgender (LGBT) people may lead to differences in cancer incidence. Perceptions of risk and healthcare seeking behaviour may also vary.¹² However evidence is lacking as information on sexuality is not routinely collected by the NHS.

Disability: There is no national information on variations in cancer incidence, treatment and outcomes for people with a disability. People with learning disabilities appear to have a similar age standardised incidence rate for all cancers combined but incidence by tumour site may be different. There is some evidence for increased cancer incidence associated with some mental illnesses, which is associated with increased cancer mortality.¹²

Religion: No local or national information available.

Predicted future need

Whilst cancer is predominantly a disease of old age, Brighton & Hove has a relatively young population. Projections suggest that this pattern

7.5.8 Cancer

will remain, hence we may not see an increase in cancer incidence in Brighton & Hove.

The incidence of some cancers is increasing - for instance, lung cancer and upper gastrointestinal cancer in females, likely to be related to lifestyle factors such as smoking, diet and alcohol intake. The increasing incidence of prostate cancer is likely to be due to an increase in the uptake of PSA testing rather than a true increase in life-threatening disease.

Cancer survival is lower in more deprived populations hence there is a particular need to focus on reducing the inequalities gap.

What we don't know

We do not yet know if we have improved population awareness of cancer. However the 2010 survey provides baseline data for future comparisons.

Whilst programme budgeting data is available, no specific work has been done recently to understand spend against performance locally.

We do not sufficiently understand inequalities by specific groups due to lack of data.

We need a better understanding of where outcomes could be improved for cancers other than the main four.

Key evidence and policy

Improving Outcomes: A Strategy for Cancer sets out how the new health and care system plans to improve outcomes focusing on: public health service delivery in prevention, raising awareness of cancer symptoms and achieving earlier diagnosis; resources available to the NHS Commissioning Board to drive quality improvements; ways in which best practice approaches to cancer commissioning might be disseminated through the transition and beyond. The aim is to save an additional 5,000 lives every year by 2014/15, whilst narrowing the inequalities gap.

Sussex Cancer Network developed a three year service delivery plan (2012-15) and an annual workplan (2012-13) which identify the key initiatives for implementing the national strategy.

Priorities for improving survival are:

- Increase population awareness of cancer
- Increase screening uptake
- Increase GP use of two week wait referrals
- Improve cancer waiting times in the acute sector
- Increase diagnostic capacity particularly endoscopy
- Increase access to radical treatments (surgery, chemotherapy and radiotherapy) instead of palliative treatments
- Improve access to laparoscopic surgery and enhanced recovery
- Improve access to radiotherapy, including new technologies which can target treatment more precisely and improve outcomes

There is much NICE public health guidance relating to prevention of cancer risk factors. In addition NICE produces many tumour-specific clinical guidelines that identify best practice in cancer care and treatment and also cancer service guidance (Improving Outcomes Guidance) that guides the planning, commissioning and organisation of cancer services.

Recommended future local priorities

Cancer and access to cancer screening is one of the five priorities of the Health and Wellbeing Board. The strategy includes three areas for focus to make a difference

1. Continue to invest in reducing the avoidable causes of cancer and support cancer survivors to lead a healthy lifestyle.
2. Continue to invest in raising awareness of cancer signs and symptoms and providing support to primary care to encourage earlier presentation and referral, particularly in the more deprived areas of the city.
3. Maintain continued implementation of former Sussex Cancer Network's delivery plans.

Key links to other sections

- Smoking
- Healthy weight
- Alcohol

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- Physical activity and sport
- Sexual health
- Access to cancer screening

Further information

National Cancer Intelligence Network. Cancer eAtlas

http://www.ncin.org.uk/cancer_information_tools/eatlas/

Cancer Research UK Local Cancer Profiles: Brighton & Hove Clinical Commissioning Group

<http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics/?location-name-1=NHS%20Brighton%20%20Hove%20CCG&location-1=09D>

Cancer Inequalities in the South East Region: The Burden of Cancer

http://www.sepho.org.uk/Download/Public/10398/1/cancerIneq1_051006_FINAL.pdf

Last updated

August 2013

Why is this issue important?

Mental health problems are common:

- One in four people experiences a mental health problem in their lifetime.
- One in six adults has a mental health problem at any one time.
- One in ten new mothers experiences postnatal depression.
- One in 100 people has a severe mental health problem.¹

The cost of mental ill-health to the economy in England has been estimated at £105 billion.

Stress and other mental health problems are the leading cause of long-term absence (four weeks or longer) for both manual and non-manual workers.

Up to 25% of GP consultations concern mental health issues.

Poor physical health is a significant risk factor for poor mental health and poor mental health is associated with poor self-management of long term conditions and behaviour that may endanger physical health such as drug and alcohol abuse.

Social inequalities may both cause and be caused by mental ill-health. People with better mental health are more likely to stay in education for longer, to be in employment, to be in good physical health, to have longer life expectancy, and to feel more integrated into their communities.

A report published by the Northwest Public Health Observatory found that the prevalence rate for mental illness was 2.75 times higher for the most deprived quintile of the population in the Northwest region than that for the most affluent. Poor mental health increases rapidly between the third and fifth poorest quintiles of population.²

Key outcomes

- **People in contact with secondary mental health services who live in stable and appropriate accommodation (Public Health**

Outcomes Framework) / Proportion of adults in contact with secondary mental health services living independently, with or without support (Adult Social Care Outcomes Framework)

- **Employment for those with long-term conditions including adults with a learning disability/in contact with secondary mental health services (Public Health Outcomes Framework - Placeholder) / Proportion of adults in contact with secondary mental health services in paid employment (Adult Social Care Outcomes Framework) / Enhancing quality of life for people with mental illness, including employment (NHS Outcomes Framework)**
- **People in prison who have a mental illness (Public Health Outcomes Framework - Placeholder)**
- **Reducing premature death in people with serious mental illness (NHSOF/ Public Health Outcomes Framework)**
- **Improving outcomes from planned treatments (5) psychological therapies (NHS Outcomes Framework)**
- **Improving experience of healthcare (community mental health services) for people with mental illness (NHS Outcomes Framework)**

Impact in Brighton & Hove

Prevalence

Local prevalence of mental illness continues to be generally higher than England. This is true for both common problems and severe mental illness.

Severe mental illness: The City has a higher prevalence of people (1.1%) on a GP register for psychoses or severe mental illness than England (0.8%). In 2011-12, 3,335 people (all ages) were included on these registers.³

Common mental health problems: In 2011-12, 12.69% of people aged 18 years and older (31,044

¹ HM Government. No health without mental health, a cross-government mental health outcomes strategy for people of all ages. London: HM Government; 2011. [Online] Accessed 2013 May. Available at URL: <https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

² Mental health, self-harm and alcohol, North West Public Health Observatory, 2005.

³ Health and Social Care Information Centre. Indicator Portal: Compendium of Population Health Indicators [online]. Available at: <https://indicators.ic.nhs.uk/webview/> [Accessed 2013 May]

7.5.9 Mental health (adults)

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adults) were included on a GP register for depression; the figure for England was 11.68%.⁵

Treatment

The City has higher rates of treatment for mental illness than England; outcomes are mixed – some are better, some poorer.⁴

Allocated average NHS spend on mental health per head 2011-12 was £197 compared to the England figure of £183. However, the overall 'mental health programme spend' is nearer to similar areas, at an average of £271 per head in Brighton & Hove compared to £265 for our ONS cluster in 2011/12.⁵

Primary care

Of adults aged 18 or more on GP depression registers in 2011-12, 89% received an initial severity assessment compared with the England figure of 91%, 67% received a follow-up assessment, compared with 72% for England.⁴ Assessment is an important part of providing appropriate care.

Of patients included on GP Severe Mental Illness registers in 2011-12, 79% had a comprehensive care plan compared with 88% for England.⁴ It is important that the primary care team takes responsibility for discussing and documenting a care plan, especially in the event of a relapse, which includes the views of the individual and their family or carers as appropriate.

Secondary care

The detailed data below show that Brighton & Hove has higher rates of contact and admission for all aspects of secondary mental health care.⁶

Number using adult and elderly NHS secondary mental health services: the rate per 1000 population 2010-11 was 3.3 for Brighton & Hove compared to 2.5 for England.

Contacts with mental health services: rate per 1000 population 2010-11 was 375 for Brighton & Hove compared to 313 for England.

Contacts with community psychiatric nurses: rate per 1000 population 2010-11 was 230 for Brighton & Hove compared to 169 for England.

Number on a Care Programme Approach: rate per 1000 population 2010-11 was 7.7 for Brighton & Hove compared to 6.4 for England.

All hospital admissions for mental health: the directly standardised rate 2009-12 for Brighton & Hove was 328 compared to 243 for England.

Hospital admissions for unipolar depressive disorders: the directly standardised rate 2009-12 for Brighton & Hove was 42.8 compared to 32.1 for England.

Hospital admissions for schizophrenia, schizotypal and delusional disorders: the directly standardised rate 2009-12 for Brighton & Hove was 71 compared to 57 for England.

In year bed days for mental health: the rate per 1,000 population 2010-11 for Brighton & Hove was 240 compared to 193 for England.

Length of stay: the average number of days for hospital stays for adult secondary care mental health services in Brighton and Hove is higher than for England.⁷

Emergency hospital admissions for people aged 15 – 74 for schizophrenia are much higher than the England, at a local rate of 33 per 100,000 compared to 19 for England.⁴

Emergency hospital admissions for people aged 15 – 74 for neuroses are nearly twice the England rate, at 29.85 per 100,000 in Brighton & Hove compared to 16.4 for England.⁴

Outcomes

The recovery rate for users of IAPT services 2011-12 was worse in Brighton & Hove at 26.0 than the rate for England at 43.8.

However, the excess under 75 mortality rate in adults with serious mental illness 2010-11 was significantly better at 602 in Brighton & Hove compared to 921 in England.

Wider determinants

The Health Counts survey 2012 included questions that screened for depression. 38.5% of

⁴ Network of Public Health Observatories, Public Health England. Community Mental Health Profiles 2013: Brighton and Hove. Accessed 2013 May. Available at URL: <http://www.nepho.org.uk/cmhp/>

⁵ Public Health England. Spend and outcome factsheet 2010/11. http://yhpho.org.uk/quad/pcts1011/5LQ_PB1011%20Profile.pdf

⁶ Network of Public Health Observatories, Public Health England. Community Mental Health Profiles 2013: Brighton and Hove. Accessed 2013 May. Available at URL: <http://www.nepho.org.uk/cmhp/>

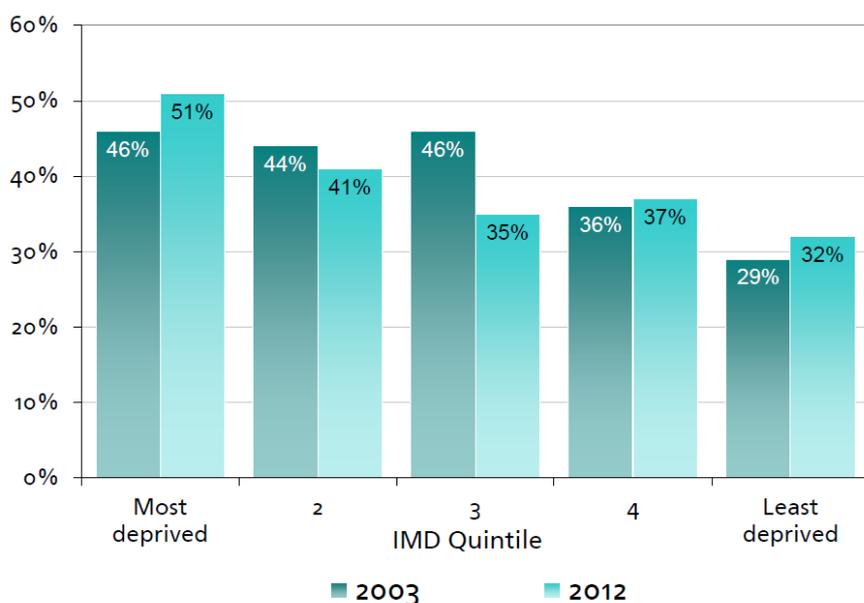
⁷ Local contract monitoring data.

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respondents were identified as at raised risk of depression, approximately consistent with previous surveys in 2003 and 1992. The risk of depression was significantly higher in people who: are single, divorced or separated; rent their home; or are out of work. In general, there are no significant differences between localities or wards within the city, though Queen's Park ward shows a significantly higher risk. The risk is significantly lower for people who own their home; live as a couple, in a civil partnership or are married; and are educated to degree level or above.⁸

The percentage of people at risk of depression is highest in the most socio-economically deprived.⁸

Figure 1: Percentage of responders at risk of major depression by deprivation quintile, 2003 and 2012.



Source: Health Counts survey 2012

Housing commissioning report that an increasing number of clients with complex social care and health needs (including dual diagnosis) are being referred to supported accommodation and presenting as homeless.

In Brighton & Hove 52% of working age adults claiming incapacity benefit were as a result of mental ill-health (2,360 of 4,520). This is considerably higher than both England (43%) and the South East (44%).⁹

⁸ NHS Brighton and Hove and Brighton & Hove City Council. Health Counts Survey. 2012. Available at: www.bhlis.org/surveys

⁹ Department for Work and Pensions. Proportion of working age people who are receiving Incapacity Benefit / Severe Disablement Allowance as a result

Provisional data for 2012/13 shows that in Brighton & Hove 5.9% of working age adults who are receiving secondary mental health services and who are on the Care Programme Approach were recorded as being employed (aged 18 to 69) – slightly lower than England (7.7%) and the South East (7.8%).¹⁰

The Public Health Outcomes Framework data tool now contains baseline data for the percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation, however the latest data it gives is for 2010/11. In this year 68% of adults in Brighton & Hove who were in contact with secondary mental health services lived in stable and appropriate accommodation, similar to England (67%).¹¹

Users of community mental health services at Sussex Partnership NHS Foundation Trust report average satisfaction with most aspects of their care, except for advice and follow-up about medication, which scores worse than average. This survey covers all of Sussex, and is not specific to Brighton & Hove.¹²

Where we are doing well

The proportion of people entering treatment from Improving Access to Psychological Therapies 2011-12 is better than the national figure at 77.5% in Brighton & Hove compared to 60.1% for England.¹³

of mental health conditions. From NOMIS Work and Pensions Longitudinal Study: benefit payments - incapacity benefit / severe disablement dataset. Available at:

<http://www.nomisweb.co.uk/query/select/getdatasetbytheme.asp?opt=3&heme=&subgrp=> [Accessed 19/08/2013]

¹⁰ Health and Social Care Information Centre. Measures from the Adult Social Care Outcomes Framework - England, 2012-13, Provisional. July 2013.

Available at: <http://www.hscic.gov.uk/searchcatalogue?productid=11918&q=%22Social+Care+and+Mental+Health+Indicators+from+the+National+Indicator+Set%22&topics=0%2fSocial+care&sort=Relevance&size=10&page=1#top> [Accessed 19/08/2013]

¹¹ Public Health England. Public Health Outcomes Framework Data Tool [Online]. Available at: <http://www.phoutcomes.info> [Accessed 19/08/2013]

¹² Care Quality Commission. Community mental health services survey 2012. Accessed May 2013 at: <http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/community-mental-health-survey-2012>

¹³ Network of Public Health Observatories, Public Health England. Community Mental Health Profiles 2013: Brighton and Hove. Accessed 2013 May. Available at URL: <http://www.nepho.org.uk/cmhp/>

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The Brighton and Hove Wellbeing Service, launched in the summer of 2012, is designed to assess and treat the needs of individuals presenting with mental health issues who can be treated safely in primary care and should help to reduce waiting times and make better use of resources. The proportion of patients moving to recovery has significantly increased and is now meeting the national target of 50%.¹⁴

A redesigned range of community and voluntary sector mental health services started operating in April 2013, to ensure that resources are used in the most effective way. These include: information and advice; psychosocial support; employment support and day services.

Strong local voluntary sector provision continues to offer a diverse range of services for communities of interest as well as geographic communities.

Housing

Brighton and Hove has similar proportion of adults in contact with secondary mental health service who live in stable and appropriate accommodation, at 68% compared to 67% for England in 2010-11, the baseline year for this indicator.¹⁵

In recognition of the 2011 JSNA, the city council and CCG have worked jointly to commission further supported accommodation services (to support an additional 100 people) specifically for people with mental health issues and complex needs. This should improve step down options and improve move-on to greater independence.

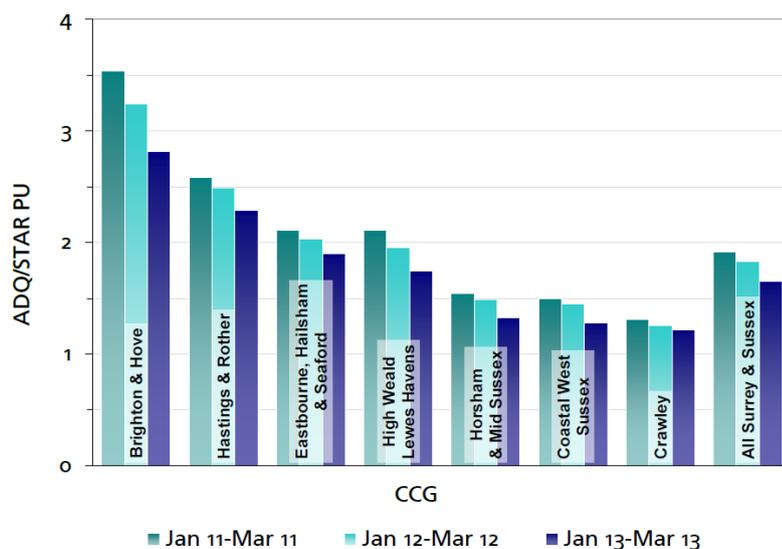
Benzodiazepines

In previous years, Brighton & Hove has had significantly higher rates of prescribing for benzodiazepines (a group of tranquillisers) than comparator Primary Care Trusts. Long term benzodiazepine use is associated with an increased risk of falls and fractures, road traffic accidents, memory loss, confusion, cognitive impairment, ataxia, low mood and insomnia. A programme of local initiatives to reduce prescribing was set up, and Figure 2 shows that the last two years have

resulted in an 11% year on year drop in benzodiazepine and Z drug prescribing across Brighton & Hove and, for October-December 2012 data, Brighton and Hove has:

- the 4th highest drop in prescribing in terms of ADQ per STAR PU (0.355); and
- 21st highest percentage drop in England.

Figure 2: Benzodiazepine Receptors ADQ/STAR PU (CCG prescribing compared, period on period, within Area Team)



Local inequalities

More men than women are admitted to the mental health trust overall for mental illness: 64% of people admitted are men.¹⁶ When comparing local admission rates to national rates, the picture is mixed. For women in Brighton & Hove, the 2010-11 rate of emergency hospital admissions for schizophrenia is nearly double the rate for England (26 per 100,000 locally compared with 14 for England), whereas the rate for men is only 60% higher. However, the emergency admissions for neuroses for the same year show the opposite pattern for gender: the city's rate for men is 30 per 100,000, more than double the rate for England at 14 per 100,000, whereas the rate for women is 61% higher (18 per 100,000 compared to 29 for England).

There are more men than women in housing commissioned to support mental health by the

¹⁴ Local contract monitoring data.

¹⁵ Public Health Outcomes Framework tool. Accessed 2013 May. Available at URL: <http://www.phoutcomes.info/public-health-outcomes-framework>

¹⁶ Sussex Foundation Partnership NHS Trust data for Brighton and Hove residents (2012-13).

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local authority, though there is one female-only house.

Across England, BME groups are more likely to be diagnosed with a mental illness than those who are White British, with new psychosis diagnoses up to seven times higher in Black Caribbean groups.¹⁷ It appears from recent local data from the mental health trust that admission rates for BME groups are no higher than for the total population.

Count Me in Too found that 79% of the city's lesbian, gay, bisexual and transgender (LGBT) population reported some form of mental health difficulties.

An older people's needs assessment (2008) found the mental health problems affecting the greatest number of older people in the city are dementia and depression. Applying national prevalence to the local population suggests that there are around 3,100 with depression and 1,000 with severe depression.

The number of people presenting as homeless has increased significantly, as has rough sleeping. Service providers report that a significant proportion of rough sleepers have mental health problems. Brighton & Hove has a significantly higher rate of statutory homeless households than England: 3.7 per 1000 households in 2010/11, compared to 2.0 per 1000 for England.

The 2012 Health Counts survey indicates that carers are at greater risk of major depression than all respondents.⁸

Predicted future need

2011 census data provides information about demographic groups at higher risk of mental illness in the city, which helps to predict future need. For example:

The proportion of young adults in the city is increasing, which may lead to a higher prevalence of mental illness. Nationally, the rate of common mental disorders (anxiety and depression) has been found to be highest for women among 45-54 year olds, with a quarter (25.1%) of this group meeting the criteria for at least one CMD. Among men the

rate was highest in 25-54 year olds (14.6% of 25-34 year olds, 15.0% of 35-44 year olds, 14.5% of 45-54 year olds). The overall prevalence of psychotic disorders for both men and women is highest in those aged 35 to 44 years.¹⁸

A smaller proportion of Brighton & Hove residents own their home (53%) than in England (63%): renting a home is associated with a higher risk of depression in the Health Counts survey.

The proportion of one person households in Brighton & Hove (36%) is higher than for England (30%). This proportion has been falling, except among those aged 65 and over. Social isolation is associated with higher risk of depression, especially in older people.¹⁹

Homelessness is strongly linked with mental ill-health; with changes to housing and other benefits we are likely to see an increase in levels of rough sleeping and difficulties with housing, with associated mental health problems.

The 2008 older people's needs assessment estimated that, by 2030, the number of people aged 65 years or more with depression will rise to 3,800 and with severe depression to 1,200.

What we don't know

The last comprehensive mental health needs assessment was carried out in 2007 and was based on data that was often several years old at that time: an update will be needed soon.

Some additional demographic details about service users would be useful for service planning and needs assessment: for example, reporting on parental status would improve our understanding about children and families at greater risk of poverty or disadvantage. Fuller understanding of the impact of mental ill health and use of services by different BME communities would also be useful.

Women are more likely to suffer from depression and from anxiety: prevalence rates have

¹⁷ Raleigh VS, Irons R, Hawe E, et al. Ethnic variations in the experience of mental health service users in England: results of a national patient survey programme. *Br J Psychiatry*. 2007;191:304-312.

¹⁸ McManus S et al. Adult psychiatric morbidity in England. Health & Social Care Information Centre, 2009.

¹⁹ Graham CC et al. Management of depression in older people. London: RCGP; 2011.

7.5.9 Mental health (adults)

consistently been found to be between 1.5 and 2.5 times higher in women than men for both.^{20,21}

Some groups within the population are identified nationally as having a higher risk of developing mental problems and/or not accessing primary care mental health services: LGB, transgender, homeless people, some BME communities, gypsies and travellers, victims of violence, offenders and those with alcohol or substance misuse problems.²²

Key evidence and policy

No health without mental health: a cross-government mental health outcomes strategy for people of all ages. HM Government, 2011.

No health without mental health: implementation framework. HM Government, 2012.

NICE have published extensive evidence on mental health and illness, including quality standards for depression and for service user experience in adult mental health, and pathways for antenatal and postnatal mental health, depression, generalised anxiety disorder, panic disorder, post traumatic stress disorder and self harm.

Recommended future local priorities

The Council and CCG have a commitment to a joint all-ages emotional wellbeing and mental health strategy, to be developed in 2013-2014. This will reflect the aspirations of *No health without mental health* and will identify local priorities for prevention and treatment, including:

Gaps identified in local delivery against the *No health without mental health* implementation framework;

Implementation of priorities identified in the CCG's Annual Operating Plan for 2013/14 including: improved waiting times for access to psychological services; integration of physical and mental health care within the pathways for diabetes, MSK,

digestive diseases, dementia and integrated primary care teams; increased investment in community and primary care services;

Smoothen transition between young people's and adult services;

Investment in emotional wellbeing and the wider determinants of positive mental health.

A dual diagnosis needs assessment was completed in 2012 and includes 14 recommendations; implementation is being monitored by a multi-agency steering group.

Key links to other sections

- Emotional health and wellbeing – children and young people
- Happiness and wellbeing
- Social connectedness
- Community resilience
- Rough sleeping
- Housing
- Substance misuse and alcohol
- Domestic or sexual violence
- Suicide prevention
- Dementia
- Dual diagnosis

Further information

Government policy is for mental health to be given equal weight to physical health.¹ Mental illness still carries considerable stigma: the 2011 national survey of attitudes to mental illness reported that 43% would feel uncomfortable talking to their employer about their mental health.²³

Last updated

August 2013

²⁰ National Institute for Health and Care Excellence (NICE). Depression: the treatment and management of depression in adults. 2009. Accessed 2013 May. Available at: <http://guidance.nice.org.uk/CG90>.

²¹ National Institute for Health and Care Excellence (NICE). Anxiety. 2011. Accessed 2013 May. Available at:

<http://guidance.nice.org.uk/CG113/Guidance>

²² Centre for Mental Health, Department of Health, Mind, NHS Confederation Mental Health Network, Rethink Mental Illness, Turning Point. No health without mental health: implementation framework. 2012. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216870/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf [Accessed 19/08/2013]

²³ Health and Social Care Information Centre. Attitudes to mental illness – 2011 survey report. 2011. [Online] Available at: <http://www.hscic.gov.uk/pubs/attitudestomi11> [Accessed 19/08/2013]

Why is this issue important?

Dual diagnosis describes the co-existence of mental health and substance misuse problems (both drugs and alcohol). It is a broad term with definitions which vary according to severity. The Department of Health defines dual diagnosis as “severe mental health problems and problematic substance misuse,” while some other definitions are broader and include lower level problems.

It is a very challenging condition and individuals with a dual diagnosis have complex needs which require input from a range of services.

Mental health and substance use often coincide, and the relationship between the two is very complex. Possible mechanisms include:

- A primary psychiatric illness precipitating or leading to substance misuse
- Substance misuse worsening or altering the course of a psychiatric illness
- Intoxication and/or substance dependence leading to psychological symptoms
- Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses¹

It is estimated nationally that a third of patients in mental health services have a substance misuse problem, and around half of patients in drug and alcohol services have a mental health problem, most often depression or personality disorder.²

Dual diagnosis is more prevalent among psychiatric inpatients and people in secure services,³ and it is also common among the prison population (up to 75% of prisoners).⁴

The term ‘dual diagnosis’ implies that mental health and substance misuse problems have been diagnosed. It is clear that this is not always the case and some people have mental health needs which

do not meet thresholds for a formal diagnosis or treatment for a mental health condition. Many of these people have co-existing substance misuse problems in addition to a wide range of other needs. The term ‘complex needs’ may therefore be more appropriate.

Compared with others in mental health or substance misuse treatment services, people with a dual diagnosis have worse physical health and poorer quality of life, higher levels of personality disorder and disability and greater risk profiles than those without.³ They are at increased risk of a range of poor health outcomes including long term physical health problems, self-harm and suicide. Other risks include homelessness and social isolation, disrupted family relationships, domestic violence, unemployment and imprisonment.

Key outcomes

The Public Health Outcomes Framework does not have specific indicators for dual diagnosis, but a number are relevant:

- ***Suicide***
- ***Excess under 75 mortality in adults with serious mental illness***
- ***People entering prison with substance misuse issues who are previously not known to community treatment***
- ***People in prison who have a mental illness or significant mental illness***
- ***Successful completion of drug treatment.***

Impact in Brighton & Hove

Brighton & Hove has high rates of substance misuse and mental health problems, which have a big impact on the city. The city also has high rates of suicides and drug related deaths. A local audit of the 26 suicides in Brighton & Hove during 2010 found that 38% had both mental health and substance misuse problems.

Determining the prevalence of dual diagnosis nationally is complicated and depends on the definition used. It is also difficult to ascertain the number of people with a dual diagnosis locally because there is not currently a shared database between mental health and substance misuse services.

¹ Department of Health. Dual Diagnosis Good Practice Guide. 2002 Available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationPolicyAndGuidance/DH_4009058 [Accessed 26/08/2012].

² Rethink. Dual Diagnosis Toolkit. Available at: <http://www.rethink.org/dualdiagnosis/pdfs/Toolkit.pdf> [Accessed 26/08/2012].

³ Strathdee G et al. Dual diagnosis in a primary care group – a step by step epidemiological needs assessment and design of a training and service response model. Department of Health/National Treatment Agency 2002.

⁴ Prison Reform Trust. Prison Fact File December 2011. Available at: <http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefing%20December%202011.pdf> [Accessed on 26/08/2012].

7.5.10 Dual diagnosis

Within mental health services in Brighton & Hove in early 2012, it was estimated that 10%-25% of the 1,369 recovery team clients and 46% of the 116 Assertive Outreach team clients had a dual diagnosis.

Within substance misuse treatment services, 208 clients were recorded as having a dual diagnosis during calendar year 2012, representing 13% of all those in treatment during this period.

Housing is a key issue for people with dual diagnosis, most of who are at risk of homelessness. Between April 2008 and December 2010, 43% of clients in hostel accommodation in the city reported a need to manage mental health and substance misuse problems (of any severity). However this does not mean that they have both a mental health and substance misuse diagnosis.

There is limited provision of specialist accommodation for those with dual diagnosis, and it is recognised that there is a significant gap in supported accommodation for this client group.

Dual diagnosis is consistently identified as a priority in consultation with substance misuse service users. In 2012 service users identified the need to improve access to treatment and services, and availability of support for all service users with substance misuse and mental health problems as key priorities.

Dual diagnosis is one of the priority pathways identified in the Adult Mental Health and Substance Misuse work plans for 2013/14.

Where we are doing well

Improving the dual diagnosis care pathway is a key priority for Brighton & Hove CCG and Brighton & Hove City Council. In 2012 a comprehensive needs assessment was undertaken to support this work programme. A multi-agency action plan for dual diagnosis in Brighton & Hove has been developed. There is representation from all relevant organisations at the steering group taking this work forward.

Service mapping work is underway to identify gaps in service and areas for improvement. A dual diagnosis screening tool has been developed which is being piloted with frontline workers, to assist them in identifying clients who may have complex

needs and would benefit from support from mental health and substance misuse services.

A shared care plan between mental health and substance misuse services has been developed, which is also being piloted. It is anticipated that this will improve the quality of care received.

Local inequalities

We don't have detailed local data for dual diagnosis to allow us to examine inequalities. However nationally we know that in comparison with drug misuse and treated mental illness, there is more widespread social and regional variation in dual diagnosis. Comorbidity is more common among patients from practices in deprived areas than those in affluent areas. However it has been suggested that the rate is increasing more rapidly in affluent areas.⁵

The following groups were identified at particular risk in the 2012 Dual Diagnosis needs assessment⁶:

The learning disabilities JSNA in 2011 identified mental health and substance misuse as significant additional needs among people with learning disabilities in the city. Of the 798 people in Brighton & Hove receiving adult social care funding from the Learning Disability budget in 2011/12, 15-20% had significant mental health needs, and at least 1.2% had substance misuse problems. This is lower than the national estimates, indicating that it is likely that there are a high number of adults with learning disabilities and mental health problems that are undiagnosed. The needs assessment suggested there is a need for specialist provision locally for people with learning disabilities and additional needs, including mental health or substance misuse problems, to improve support and reduce need for costly, out of area care placements.⁷

LGBT people surveyed by Supporting People in 2003/4 had high levels of need for support with mental health issues (39%) and complex substance

⁵ Frisher M et al. A national epidemiological study of comorbid substance abuse and psychiatric illness in primary care between 1993-1998 using the General Practice Research Database.

⁶ Brighton and Hove and Brighton & Hove City Council. Dual Diagnosis JSNA. 2012. Available at www.bhllis.org/needsassessments [Accessed 16/08/2013]

⁷ Brighton & Hove City Council and NHS Brighton and Hove. Learning disabilities JSNA (adults). 2011. Available at: www.bhllis.org/needsassessments [Accessed 16/08/2013]

misuse problems involving both drugs and alcohol (37%).⁸

The Count Me In Too research project investigated the experiences of LGBT people in Brighton & Hove during 2006, and included specific research relating to mental health, and drug and alcohol use. The research found that those who had used illegal drugs, or legal drugs without a prescription in the past five years were more likely to report mental health difficulties than those who had not (76% vs. 61%). LGBT people reporting mental health difficulties were more likely to have used illegal drugs or legal drugs without prescription/medical advice, and to be concerned about the amount they drink, than those without mental health difficulties. Serious thoughts of suicide were more frequently reported among LGBT people who had used drugs than those who hadn't (21% vs. 14%) as was attempted suicide.⁹

Predicted future need

National trends show that over the last 20 years there have been large increases in rates of drug dependency, including young people dependent on cannabis. This, coupled with the increasing prevalence of common mental health disorders such as anxiety and depression, suggests that dual diagnosis could be increasingly recognised.¹⁰

A study in primary care in England and Wales in 2004 estimated that the prevalence of comorbid psychiatric illness and substance misuse was increasing by 10% each year, and at a higher rate among younger patients.¹¹

What we don't know

We don't have information on the extent of undiagnosed mental health problems among people with substance misuse.

There is no shared database between mental health and substance misuse services so collecting information on the prevalence of dual diagnosis is difficult.

We don't have local evidence enabling us to look at dual diagnosis by ethnicity, religion, all disabilities, and marital status or for carers.

National evidence shows that among those with co-existing mental health and substance use needs, some minorities are over represented (e.g. African-Caribbean groups) while others are under-represented (e.g. Asian groups).¹²

Key evidence and policy

The Dual Diagnosis Good Practice guide¹³ recommends 'mainstreaming' as the key policy for delivering services for people with a dual diagnosis. This means recognising that substance misuse is usual rather than exceptional among people with severe mental illness. Care for the most severe presentations should be delivered within mental health services, with the support of substance misuse services.

Evidence shows that many people within substance misuse treatment have mild to moderate mental health problems, and it is recommended that this group is managed within specialist substance misuse services and/or primary care. There should be mutual support between both services. Patients should not be shunted between different services or put at risk of dropping out of care.¹³

The Government's drug strategy¹⁴ emphasises a recovery-led approach to tackle drug dependence, which can be particularly challenging in individuals with a dual diagnosis.

There are specific NICE guidelines relating to psychosis and substance misuse,¹⁵ and comorbid

⁸ Brighton & Hove City Council. Supporting People Strategy 2008-2011. Available at:

http://www.brighton-hove.gov.uk/downloads/bhcc/SP_strategy-Final.doc [Accessed 16/08/2013]

⁹ Browne K, McGlynn N, Lim J. Count Me In Too – drugs & alcohol additional findings report. 2009. University of Brighton & Spectrum. Available at: http://www.realadmin.co.uk/microdir/3700/File/CMIT_DrugAlcohol_AF_Rep_ort_August09.pdf

¹⁰ National Mental Health Development Unit. Briefing 189. Meeting the challenge of dual diagnosis. 2009. Available at: <http://www.nmhdu.org.uk/silo/files/seeing-double-meeting-the-challenge-of-dual-diagnosis.pdf> [Accessed on 26/08/2012].

¹¹ Frisher M et al. Prevalence of comorbid psychiatric illness and substance misuse in primary care in England and Wales. *J Epidemiol Community Health* 2004;58:1036-41.

¹² Turning Point. Dual Diagnosis: Good Practice Handbook. 2007

¹³ Department of Health. Dual Diagnosis Good Practice Guide. 2002. Available at:

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009058 [Accessed on 16/08/2013].

¹⁴ HM Government. Drug Strategy 2010. Reducing demand, restricting supply, building recovery: supporting people to live a drug free life. <http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010> [Accessed on 26/08/2012].

¹⁵ National Institute for Health and Care Excellence (NICE). Psychosis with Co-existing substance misuse. National Clinical guideline 120. <http://www.nice.org.uk/nicemedia/live/13414/53691/53691.pdf> [Accessed on 26/08/2012].

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depression and anxiety are considered within national alcohol guidance.¹⁶

Recommended future local priorities

1. Continued development of joint working between mental health and substance misuse services.
2. Improved data collection for dual diagnosis.
3. Continued development and improvement of clear dual diagnosis care pathways.
4. Learn from pilots being undertaken and apply learning to improve the experience of clients with complex needs.
5. Continued commitment to staff training in dealing with dual diagnosis.
6. Monitoring drug related deaths and suicides among people with a dual diagnosis.
7. Development of specialist accommodation provision for people with a dual diagnosis.

Key links to other sections

- Alcohol
- Emotional health and wellbeing
- Mental Health
- Young Offenders
- Rough sleeping
- Substance misuse and alcohol in young people
- Substance misuse
- Suicide prevention
- Housing

Further information

Sussex Partnership NHS Foundation Trust Dual Diagnosis Strategy 2011-2016

<http://www.sussexpartnership.nhs.uk/gps/dual>

Dual Diagnosis Good Practice Guide

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009058

Last updated

July 2013

¹⁶ National Institute for Health and Care Excellence (NICE). Alcohol use disorders. Diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE Clinical Guideline 115: February 2011. <http://www.nice.org.uk/nicemedia/live/13337/53191/53191.pdf> [Accessed on 26/08/2012].

7.5.11 Dementia

Why is this issue important?

Dementia presents a huge challenge to society, both now and increasingly in the future. There are approximately 651,997 people aged 65 and over in England with dementia.¹ Dementia costs the UK economy £23 billion a year and this will rise to over the £27 billion a year by 2018, the number of people with dementia in the UK doubles every 20 years and will rise to 1.7 million by 2050.²

Dementia is a syndrome which results in a progressive decline in multiple areas of function, including memory, reasoning, communication skills and the skills needed to carry out daily activities. Individuals may also develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering, which complicate care and can occur at any stage of the illness. There are different types of dementia caused by different diseases of the brain, including Alzheimer's disease and vascular dementia. These diseases affect the brain in different ways and produce different symptoms.

Carers of people with dementia are often old and frail themselves, with high levels of depression and physical illness, and a diminished quality of life. Dementia is a terminal condition but people can live with it for 7–12 years after diagnosis.²

The prevalence of both early onset and late onset dementia increases with age, doubling with every five-year increase across the entire age range from 30 onwards. Overall, 10% of deaths in men over 65 years, and 15% of deaths in women over 65 years are attributable to dementia.¹

There is evidence that people with dementia have worse clinical outcomes than people with the same conditions without dementia. This contributes towards longer length of stay in general hospitals. Nationally, it is estimated that two thirds of people in care homes have dementia and 40% of these people are not in specialist dementia care homes.³

Apart from family members or friends, who provide the vast bulk of care and support, home

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care is probably the single most important service involved in supporting people with dementia in their own homes. The Commission for Social Care Inspection (CSCI) has found that good-quality, flexible home care services contribute significantly to maintaining people's independence, reducing social isolation, preventing admissions to care homes and hospitals, and supporting carers.⁴

Historically, dementia has been under diagnosed, both locally and nationally. It is estimated that only a third of people with dementia receive a formal diagnosis or have contact with specialist services at any time in their illness. Also, such diagnosis and contact often occur late in the illness and/or in crisis when opportunities for harm prevention and maximisation of quality of life have passed.⁴

Contrary to social misconception, a great deal can be done to help people with dementia.⁵ Dementia should be diagnosed early and well so that people with dementia and their carers can receive treatment, care and support to enable them to live as well as possible with dementia.⁶

Key outcomes

- **Health related quality of life for older people (Public Health Outcomes Framework)**
- **Estimated diagnosis rate for people with dementia (Public Health and NHS Outcomes Framework)**
- **Improving experience of healthcare for people with mental illness: Patient experience of community mental health services (NHS Outcomes Framework)**
- **Dementia – estimated diagnosis rate for people with dementia (Public Health Outcomes Framework); a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life (Adult Social Care Outcomes Framework, Placeholder and NHS Outcomes Framework)**

¹ Institute for Public Care. Projecting Older People Population Information System (POPPI). Available at: www.poppi.org.uk (registration required) [Accessed 23rd May 2013]

² Alzheimer's Society. Facts on Dementia. Available at: http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=535&pageNumber=2 [Accessed 23/05/13]

³ Commission for Social Care Inspection (CSCI). See me, not just the dementia. 2008

⁴ Commission for Social Care Inspection (CSCI). Time to Care? London: TSO. 2006

⁵ NICE/SCIE. Dementia: Supporting people with dementia and their carers in health and social care. London: TSO. 2006

⁶ National Audit Office. Improving services and support for people with dementia. London: TSO. 2007

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Impact in Brighton & Hove

It is estimated that in 2013 there are 2,891 people aged 65 years or over with dementia in Brighton & Hove, based on applying national prevalence rates to the local population.¹ It is estimated that there are currently 60 people with early onset dementia in the city.⁷

Dementia has been included in the Quality and Outcomes Framework (QOF) measures for GP practices since 2006/07. Since that time the proportion of the GP registered population on local practice dementia registers has increased slightly from 0.32% to 0.4% in 2011/12 (reflecting an increase in actual numbers from 937 to 1,132).⁸ Brighton & Hove is ranked 159 out of 176 PCTs for the reported number of people with dementia on registers as a percentage of predicted prevalence (37% for Brighton compared with 40% for South East Coast SHA and 44% for England).⁹

Explanations put forward for under-diagnosis include the stigma associated with dementia which prevents people from going to their GP about memory loss, as well as dementia being considered by some people, including GPs, as a normal part of ageing.¹⁰ Lack of diagnosis is a key factor that prevents people seeking the treatment they need and gaining support during early stages.¹¹

According to the NHS Atlas of Variation 2011 (also see Variations in healthcare section),¹² Brighton & Hove PCT is in the lowest quintile for:

- Prescribing of anti-dementia drug items within primary care
- Rate of admissions to hospital for patients over 74 years with a secondary diagnosis of dementia.¹³

⁷ Institute for Public Care. Projecting Adult Needs and Service Information. Available at: www.pansi.org.uk (Registration required) [Accessed 23/05/2013]

⁸ Health and Social Care Information Centre . QOF prevalence data tables 2011/12 available at: <https://catalogue.ic.nhs.uk/publications/primary-care/qof/qual-outc-fram-11-12-pct/qual-outc-fram-11-12-pcts-prev.xls> [Accessed on 23/05/2012]

⁹ Mapping the Dementia Gap. Alzheimers Society. 2012

¹⁰ NHS Brighton and Hove and Brighton & Hove City Council. Annual Report of the Director of Public Health. Brighton & Hove. 2011

¹¹ Brighton & Hove Joint Dementia Plan. NHS Brighton & Hove, Brighton & Hove City Council. 2012

¹² Rightcare. NHS Atlas of Variation: Mental Health. 2011. Available at: http://www.rightcare.nhs.uk/atlas/downloads/MentalHealth_AoV_2011.pdf [Accessed on 26/08/2012]

¹³ Local data identifies 1,034 hospital admissions for Brighton & Hove residents with a diagnosis of dementia in 2010-11.

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These figures will be at least partly explained by the low level of diagnosed dementia in the local population.

Patients with dementia should be reviewed within primary care at least every 15 months. In 2011/12 local performance was 76% which was slightly lower performance than for England and the South East Coast Strategic Health Authority (79% and 78% respectively).¹⁴

In Brighton & Hove, dementia, Alzheimer's or "senility" is mentioned on 22% of death certificates, a higher proportion than the England average (17%).¹⁵ This includes deaths where these conditions are the underlying cause or a contributory cause. Some caution in interpreting this information is necessary because nationally it is thought that dementia is under-reported on death certificates.

As the cost of care for people with dementia is embedded across the whole of the health and social care system, including acute hospitals, mental health services, residential and nursing homes, it is difficult to determine the precise costs of dementia care.

Where we are doing well

The Health and Wellbeing Board have identified dementia as a priority for the city and the Joint Health and Wellbeing Strategy includes a section on dementia. There are plans to develop a Brighton & Hove Dementia Partnership Board.

A Care Home In-Reach service supports independent sector care homes and nursing homes to develop person-centred approaches to dementia, in particular identifying alternatives to anti-psychotic medication. An 80 bed care home has recently been built in the city, a 100 bed one is due to open soon and a third one is under construction. All these homes should have capacity for dementia patients, reducing the need to place people outside the city.

A dementia champion and specialist dementia nurse posts have been funded at Royal Sussex

¹⁴ Health and Social Care Information Centre. Quality and Outcomes Framework (QOF). 2011/12. <http://www.hscic.gov.uk/qof> [Accessed on 23/05/13]

¹⁵ Public Health England. End of Life care PCT Profile. Available at: http://www.endoflifecare-intelligence.org.uk/end_of_life_care_profiles/la_2012_pdfs [Accessed 23/05/13]

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County Hospital. A dementia pathway has been developed in the hospital to provide a memory screen to 90% of patients over 75 who have been admitted for more than 72 hours. The hospital has also adopted the Butterfly scheme to promote education and a common care approach to patients with dementia.

The Older People's Mental Health Liaison service at the Royal Sussex County Hospital is being reviewed for its effectiveness in reducing length of stay.

A new memory assessment service (MAS) will commence in June 2013, provided from GP surgeries in Portslade, Patcham and Saltdean. This will form part of a care pathway into specialist dementia services for those with complex needs. The MAS has a Carers Needs Assessment Worker to carry out assessments for the carers of patients referred to the service.

Further investment has been made into the Community Rapid Response Service to offer crisis and short term community support, to enable more people with dementia to be supported at home and avoid hospital admission.

Specialist resources are being developed to improve the End of Life Care for people with dementia.

A review of a day service for people with early onset dementia has been completed and support is being given with the move to new premises and identifying funding to improve the support available.

Design plans for a new building at the Royal Sussex County Hospital (RSCH) have considered the orientation needs of people with dementia.

A Dementia Friendly environment capital bid has reached the second round and aims to improve the care environment in primary, secondary, community and residential care.

National Dementia Challenge Fund money has been agreed for a community development worker for one year to support community and voluntary groups in making the city more dementia friendly.

Local inequalities

Dementia affects men and women in all social and ethnic groups. There is limited local evidence available on whether dementia has a differential

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impact on equality groups. Nationally, dementia is more common in women and two thirds of people with dementia are women.³ Research suggests early onset dementia is more common in men.⁹

Nationally, it is known that people with Downs syndrome are at greatly increased risk of developing dementia with a lower age of onset than the general population. This is of increasing importance as the life expectancy of people with Downs syndrome is increasing. Rates of dementia are also higher in people with learning disabilities other than Downs syndrome.¹⁶

Based on national research it is likely that at least 71% of people with dementia have a carer. In Brighton & Hove this equates to over 2,300 carers or 10% of all carers in the city.¹⁷

Research findings indicate that abusive behaviour by family carers towards people with dementia is common, with a third reporting important levels of abuse and half some abusive behaviour.¹⁸

A YouGov survey commissioned in 2008 found that 19% of carers of people with Alzheimer's sometimes or often feel threatened by the person they care for.¹⁹

Brighton & Hove is included in the Pan Sussex Integrated End of Life Dementia Pathway. This aims to improve the end of life care for people with dementia, and enable more to die in their preferred place of death; increase advance care planning for people with dementia; and increase practitioners knowledge and skills about end of life dementia care.

Predicted future need

By 2030, it is projected that the number of people aged 65 years or over with dementia will increase by 26% to 3,858¹ (Table 1).

The number of people with early onset dementia is projected to increase by 21% (to 68) by 2020.⁷

¹⁶

http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=103

¹⁷ Brighton & Hove Multi-Agency Commissioning and Development Strategy for Carers Refresh 2012-2013

¹⁸ Cooper C et al. Abuse of people with dementia by family carers: representative cross sectional survey. *BMJ* 2009;338:b155

¹⁹ YouGov. YouGov / Channel Four Survey Results. 2008.

<http://iis.yougov.co.uk/extranets/yougov/content/pdf/C4%20results%20alzheimers.pdf> [Accessed on 26/08/2012]

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However, these figures do not take into account the current under-diagnosis of dementia. If levels of diagnosis improve, the proportional increases could be much greater.

Table 1: Number of people aged 65 or over predicted to have dementia by age, 2013 and 2020 projection

	2013	2020
65-69 years	138	126
70-74 years	213	269
75-79 years	392	415
80-84 years	650	657
85-89 years	750	761
90 plus	748	982
Total 65 +	2,891	3,211

Source: Institute for Public Care. Projecting Older People Population Information System.
www.poppi.org.uk

What we don't know

There is a lack of local needs data on dementia. Much of our local information is based on estimates or national data.

Key evidence and policy

The Prime Minister's Challenge on Dementia was published in 2012. This made key commitments for driving improvements in health and care; developing dementia friendly communities that understand how to help and better research.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/146773/dh_133176.pdf

A National Dementia Strategy was published in 2009 and updated in September 2010. It identified four priority areas to improve the quality and outcomes of care for people with dementia and their carers:

- Good quality early diagnosis and intervention for all
- Improved quality of care in general hospitals

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- Living well with dementia in care homes
- Reduced use of antipsychotic medication
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/168220/dh_094051.pdf

Other key documents include:

The NICE-SCIE guideline on supporting people with dementia and their carers in health and social care. National Collaborating Centre for Mental Health. 2006

<http://www.scie.org.uk/publications/misc/dementia/>

A report into prevalence. Dementia UK. 2007
<http://www.alzheimers.org.uk/site/scripts/download.php?fileID=2>

Quality outcomes for people with dementia: Building on the work of the National Dementia Strategy. Department of Health. 2010
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135771/dh_119828.pdf.pdf

Living well with dementia: A national dementia strategy - good practice compendium. DH. 2011
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147541/dh_123475.pdf.pdf

Joint Dementia Plan. NHS Brighton & Hove and Brighton & Hove City Council. 2012
<http://www.brightonandhove.nhs.uk/about/improving/documents/LocalDementiaPlan2012FINAL.doc>

Recommended future local priorities

Local priorities as outlined in the Brighton & Hove Joint Dementia Plan which will go some way to addressing the issues outlined above include:

- improving dementia diagnosis rates and 15 month review rates through implementation of dementia DES in 2013/14
- memory assessment and ongoing community support (including carers)
- improving quality of care in general hospitals
- crisis home support
- living well with dementia in care homes
- supporting practices and provider services to reduce inappropriate prescribing of

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antipsychotic medication and promote alternative strategies for managing the behavioural and psychological symptoms of dementia.

- develop a clear picture of research evidence and needs
- development of structured peer support and learning networks, including an informed and effective workforce
- improved end of life care for people with dementia
- improved dementia services for people with specific needs including young onset, learning disability, dual diagnosis and Korsakoffs.
- develop a dementia friendly environment as part of an Age Friendly City.

Key links to other sections

- Ageing well
- Older people - Social Care
- Mental health
- Adults with learning disabilities

Further information

NHS Brighton & Hove, Brighton & Hove City Council. Brighton & Hove Joint Dementia Plan.

Last updated

May 2013

Why is this issue important?

HIV remains one of the most important communicable diseases in the UK. It is associated with serious morbidity, significant mortality and a potentially shortened lifespan.

At the end of 2011 there were an estimated 96,000 people living with HIV in the UK, with around 22,600 (24%) unaware of their infection. In 2011, 6,280 new diagnoses were made of which 47% were diagnosed late and 26% very late.^{1,2}

Individuals diagnosed late have higher rates of morbidity and mortality. Mortality within a year of HIV diagnosis is nine times higher for heterosexuals diagnosed late and more than one in twenty die within a year of diagnosis.³ A quarter of deaths among HIV positive individuals in the UK are of those diagnosed too late for effective treatment: individuals diagnosed late starting antiretroviral therapy have a significantly increased risk of contracting opportunistic diseases.

The introduction of effective antiretroviral therapy has transformed HIV from a fatal illness to a chronic manageable condition. However costs of providing HIV specialist treatment and care are substantial and increasing. The cost of HIV treatment in England is 49% of annual spending on infectious diseases, equating to £890 million in 2010/11.⁴ The average annual expenditure per patient is £13,900.

There are significantly higher care costs for people diagnosed late. Direct medical costs in the first year after diagnosis are twice as high for those diagnosed late, largely due to increased inpatient hospital care costs which are

15 times higher for those diagnosed late. The costs of HIV care remain 50% higher in the years following diagnosis due to increased rates of hospital admission and increased costs of antiretroviral therapy.⁵

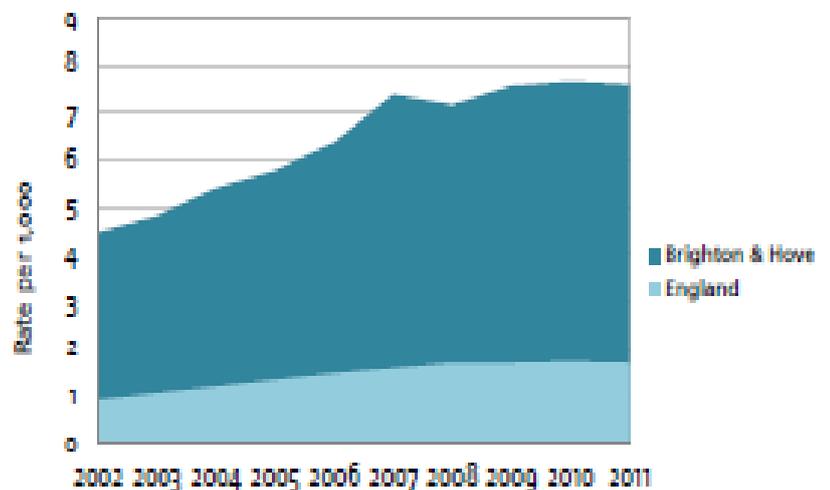
Key outcomes

- **People presenting with HIV at a late stage of infection (Public Health Outcomes Framework)**

Impact in Brighton & Hove

In 2011 Brighton & Hove had the ninth highest HIV prevalence in England at 7.6 per 1,000 population (aged 15-59 years) compared with 1.7 in England and the highest prevalence outside of London. In 2011 1,528 residents of the city accessed NHS HIV treatment services. The total figure for both sexes has been increasing rapidly; in 2005 it was 942 people; in 2002 it was 717 people.⁶ From 2003 to 2007, there were between 130 and 260 new diagnoses in Brighton & Hove residents each year.

Figure 1: Prevalence of HIV per 1,000 population aged 15-59 years in Brighton & Hove and England, 2002 to 2011



Source: Health Protection Agency

Of individuals accessing services at Sussex Beacon (a clinical care centre for men and women living with HIV/Aids) between January 2010 and March 2013, many had additional support needs. The main additional support needs are for issues of

¹ The percentage of diagnosed HIV-infected adults (aged 15 years or more) who have a CD4 count of less than 350 cells per mm³ and 200 cells per mm³ respectively within 91 days of HIV diagnosis. This indicator directly measures late diagnoses, and over time it will show whether there is a trend towards earlier diagnosis. This indicator, as a measure of the time between infection and diagnosis, also indirectly informs our understanding of the proportion of HIV infections undiagnosed.

² Health Protection Agency, Evidence and resources to commission expanded HIV testing in priority medical services in high prevalence areas, April 2012. <http://www.hpa.org.uk/Publications/InfectiousDiseases/HIVAndSTIs/1204ExpandedHIVtestinginhighprevalenceareasApril2012/> [Accessed on 26/08/2012]

³ Chadborn, T.R., Delpech, V.C., Sabin, C.A., Sinka, K., et al. 2006. The late diagnosis and consequent short-term mortality of HIV-infected heterosexuals. *Aids*, **20**(18), pp.2371-2379.

⁴ Department of Health Programme Budget data. http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743 [Accessed on 26/08/2012]

⁵ Krentz, H.B. & Gill, M.J. 2011. The Direct Medical Costs of Late Presentation (<350/mm³) of HIV Infection over a 15-Year Period. AIDS Research and Treatment.

⁶ Health Protection Agency. HIV prevalence by Local Authority in England. 2010. Available at: http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1228207184991 [Accessed on 26/08/2012]

anxiety/depression, followed by alcohol or drugs issues. Other issues included psychiatric /psychological support needs, self-harm and suicidal ideation.⁷

Where we are doing well

In 2011 in England just under half of those diagnosed with HIV were classed as a late diagnosis and 28% very late. This is considerably lower in Brighton & Hove at 38% and 16%. Just over half of diagnosed HIV patients locally are asymptomatic, and a quarter are symptomatic and pre-AIDS. Less than one in five have progressed to AIDS and less than 1% died in 2010 (latest available data).

The Sussex Beacon record confidence ratings for their day service clients. As at May 2013, the majority of clients were mostly-always confident with making appointments (75%) and contacting health care providers (83%), with taking medication (82%) and voicing opinions to healthcare providers (75%). However, when it came to discussing sexual needs/wants with either the sexual health clinic (54%) or partner(s) (40%) confidence was lower.⁷

Local inequalities

Around 90% of the HIV infected population of the city are male and around 10% are female. Prevalence of HIV infection in women giving birth within the region is highest in Brighton & Hove.

Rates of HIV infection per 10,000 population are highest in the 45-54 year age group and lowest in those under 25 years of age. This is reflected in those receiving care at Sussex Beacon, with 43% of those accessing services between January 2010 and March 2013 being aged 45-54 years.⁷

HIV-infected women locally are younger than HIV-infected men.

More than 90% of HIV infected males living in the City are White and around 57% of HIV-infected females living in Brighton & Hove are Black African.

In 2011, in 83% of patients in the city, the probable route of transmission was sex between men. The rise in infections acquired through heterosexual sex between 2006 and 2007 was twice the increase through sex between men, but the rate of increase

was similar for 2004-2008. It is estimated that one in four gay men with HIV are unaware of their infection⁸ which is important from a prevention perspective and to ensure correct monitoring to allow treatment to begin as soon as required.

Around 40% of those infected live in the most deprived quintile in the city, concentrated particularly in East Brighton.

Predicted future need

Given the trend in increased prevalence of HIV since 2002, it is expected that this will continue to increase with resulting increases in costs.

What we don't know

There is a lack of information about all groups living with HIV locally in terms of their marital status, religious beliefs and whether or not individuals are carers. This issue may be most pertinent to women and particularly African women.

It can be difficult to evaluate the effectiveness of HIV prevention and sexual health promotion as survey data often provide a conflicting picture of resources, needs and behaviours of at-risk groups.

The Gay Men's Sex Survey (2010) reports that of 289 respondents living in the city, 19% had never taken an HIV test, 21% last tested negative more than a year ago and of those who had ever tested, 25% tested positive. Of respondents who were not diagnosed HIV positive 87% were very confident they could get a test if required. Over half (53%) of respondents' last anal sex with a male partner (in the last 6 months) was without a condom. Over a third (37%) reported seeing/hearing about HIV/STI prevention specifically for men who have sex with men in the last week and 60% in the last four weeks.⁹

Key evidence and policy

National HIV testing guidelines issued in 2008 by the British HIV Association and the British Association for Sexual Health and HIV recommend HIV testing in specific medical services, for

⁷ The Sussex Beacon, January 2010 to March 2013. Figures provided May 2013

⁸ Health Protection Agency, Sexually Transmitted Infections in Men who have Sex with Men in the UK, 2011 report. http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1317131680627 [Accessed on 26/08/2012]

⁹ Sigma Research, Gay Men's Sex Survey, 2010. Available at <http://www.sigmaresearch.org.uk/gmss/> [Accessed on 26/08/2012]

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individuals at-risk of acquiring an HIV infection and for clinical indicator diseases. They also recommend the routine offer of an HIV test to all general medical admissions and all adults registering in general practice in areas where local diagnosed HIV prevalence is greater than two per 1,000 among 15-59 year olds.¹⁰

The National Institute for Health and Care Excellence (2011) guidance for increasing the uptake of HIV testing in Black African and MSM (men who have sex with men) communities recommends wide-scale testing for these groups in primary, secondary and emergency care settings and called for the development of local strategies to overcome barriers to more widespread testing.^{11,12}

Each HIV infection prevented is estimated to save between £280,000 and £360,000 in lifetime treatment costs. If the 3,640 UK-acquired HIV diagnoses made in 2010 had been prevented between £1 billion and £1.3 billion lifetime treatment and clinical care costs would have been saved.¹³

Recommended future local priorities

Prevalence locally warrants the continued implementation of published HIV testing guidelines, including:

1. Development of a local strategy for HIV prevention and to increase the uptake of HIV testing among MSM and Black Africans.
2. Continued roll out of the routine offer of HIV testing at registration with primary care or substance misuse services, during medical admission, and at termination of pregnancy.

3. Increasing opportunities for HIV testing in community settings.

Key links to other sections

- Sexual health (adults and older people)

Further information

Brighton & Hove Sexual Health Needs Assessment 2010 www.bhlis.org/needsassessments

Last updated

September 2013

¹⁰ BHIVA. 2008. UK national guidelines for HIV testing.

<http://www.bhiva.org/documents/Guidelines/Testing/GlinesHIVTest08.pdf> [Accessed on 26/08/2012]

¹¹ National Institute for Health and Care Excellence. 2011. Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among black African communities living in England.

<http://guidance.nice.org.uk/PH33> [Accessed on 26/08/2012]

¹² National Institute for Health and Care Excellence. 2011. Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among men who have sex with men

<http://guidance.nice.org.uk/PH34> [Accessed on 26/08/2012]

¹³ Health Protection Agency, Evidence and resources to commission expanded HIV testing in priority medical services in high prevalence areas, April 2012.

<http://www.hpa.org.uk/Publications/InfectiousDiseases/HIVAndSTIs/1204ExpandedHIVtestinginhighprevalenceareasApril2012/> [Accessed on 26/08/2012]

Why is this issue important?

The term 'musculoskeletal conditions' encompasses a range of common conditions, including back pain, shoulder pain, elbow pain, hand pain, and hip and knee pain. Musculoskeletal conditions can also limit mobility in older people and make them vulnerable to falls.

In England over 9.6 million adults and around 12,000 children have a musculoskeletal condition. Problems can be non-specific with no simple solution.¹ Recurrence is the norm for most musculoskeletal conditions.

An estimated 11.2 million working days a year are lost through these conditions. It is the second most common reason for receipt of incapacity benefit.²

Key outcomes

- *Enhancing quality of life for people with long-term conditions. (NHS Outcomes Framework)*
- *Helping people to recover from episodes of ill health or following injury (NHS Outcomes Framework)*
- *Enhancing quality of life for people with care and support needs. (Adult Social Care Outcomes Framework)*

Impact in Brighton & Hove

Based upon national evidence:

Back pain: in each year 38% of the adult population have low back pain. In Brighton & Hove, this would mean 79,900 people will have back pain in one year.³

Upper extremity disorder: One year prevalence ranges from 2.3% to 41%.²

Shoulder pain: 16% of adults experience shoulder pain. In Brighton & Hove this would mean 33,600 adults have shoulder pain in one year.⁴

Elbow pain: One year prevalence ranges from 1% to 3%. In Brighton & Hove this would mean 2,600 - 7,800 people had elbow pain in one year.⁵

Hand pain: 12 to 21% of people have hand pain, but in a year most do not consult their GP.⁶

Hip: 5% of the population are estimated to have symptoms of hip disease. In Brighton & Hove this would mean 10,500 people with hip pain in a year.²

Knee: 49.5% of over 50s had knee pain in one year, with 60% of over 65s having severe knee pain. In Brighton & Hove this would mean 36,900 people have knee pain in a year of which 18,500 is severe.⁷

Hip and knee replacement surgery is very successful, but there is substantial variation in the kind of hip replacement undertaken (cemented or uncemented) and in other knee surgery i.e. anterior cruciate ligament reconstruction.

Treatment: As described in Section 8.4 of the JSNA Summary (Variations in Healthcare) we have a high rate of therapeutic knee arthroscopy. We also have a low rate of health gain from knee procedures, and from hip replacement,⁸ implying that patients are being treated with lesser degree of disability in Brighton & Hove than elsewhere.

In contrast to other South East Coast PCTs and England, the length of stay for hip replacements has increased in Brighton & Hove from seven to 10 days between 2005/06 to 2009/10, and in 2009/10 we had the highest average (median) length of stay for hip replacements in the country.² Emergency admissions for hip replacements are usually the result of fractures of the hip joint, often related to falls in the elderly.

In 2009/10 there were approximately 4,200 non-emergency inpatient admissions for musculoskeletal conditions in Brighton & Hove, similar to the England and South East Coast SHA rates.²

¹ Kammerling M. Pickin M. Gilchrist K. MSK Needs Assessment. NHS Sussex. October 2011.

² Gilchrist K. Musculoskeletal conditions – Sussex rapid needs assessment working draft v4. August 2011.

³ Kammerling M. Pickin M. Gilchrist K. MSK Needs Assessment. NHS Sussex. October 2011. Appendix 1.

⁴ Urwin M, Symmons D, Allison T, Brammah T, Busby H, Roxby M, Simmons A, Williams G. Estimating the burden of musculoskeletal disorders in the community: the comparative prevalence of symptoms at different anatomical sites, and the relation to social deprivation. *Ann Rheum Dis*; 1998; 57: 649-655.

⁵ Allander E. Prevalence, incidence and remission rates of some common rheumatic diseases and syndromes. *Scand J Rheumatol* 1974; 3:145–153.

⁶ Myers H, Nicholls E, Handy J, Peat G, Thomas E, Duncan R, Wood L, Marshall M, Tyson C, Hay E and Dziedzic K. The Clinical Assessment Study of the Hand (CAS-HA): a prospective study of musculoskeletal hand problems in the general population. *BMC Musculoskeletal Disorders* 2007. 8:85doi:10.1186/1471-2474-8-85

⁷ Jinks C; Ong Bie Nio; Richardson J. A mixed methods study to investigate needs assessment for knee pain and disability: [population and individual perspectives. *BioMed Central Musculoskeletal Disorders* 2007; 8:59.

Non-emergency hospital admission rates for musculoskeletal conditions per 1,000 by GP practice population for 2012/13 in Brighton & Hove varied from 4.6 to 35.2, with a mean of 14 per 1,000.

Spend per weighted head of population on musculoskeletal conditions is significantly higher in Brighton & Hove compared with England, and is one of the highest nationally.⁸ 96% of this spend is on secondary care. Disease specific expenditure does not include expenditure on prevention, or GP expenditure, but does include prescribing expenditure.

Where we are doing well

Analysis in 2008 indicated there were no inequalities for access to hip and knee replacements within the city.

Local inequalities

The prevalence of musculoskeletal pain rises significantly with increasing social deprivation at all ages, associated with a significant increase in global disability at ages 45-64.²

Poor housing and type of employment can influence the site of the musculoskeletal condition. Stress, depression and obesity are also associated with musculoskeletal conditions.⁴

National population studies have shown that many people who would benefit from treatment (e.g. knee and hip replacement surgery) do not always get it and that the most deprived are more likely to miss out even though they are more likely to have musculoskeletal symptoms.⁹ Locally, age standardised rates per 100,000 for hip and knees arthroplasty and revisions for 2008/09 and 2010/11 show that the most deprived quintiles have a higher rate of intervention procedures than the less deprived quintile.¹⁰

Nationally people who are aged 60-84 years receive greater provision for hip and knee

replacements relative to need, than those aged 50-59 years or 85 years and over.⁸

Research conducted in Manchester indicated that disability prevalence due to musculoskeletal pain was higher for Indian and Bangladeshi people than white people.¹¹

Judge et al (2010) found that in England men received 31% more knee replacements relative to need than women and 8% more hip replacements.¹²

Predicted future need

Increasing longevity, obesity and lack of weight bearing exercise will increase the number of patients with musculoskeletal conditions.¹³ Rates of elective joint replacement surgery are predicted to rise by 4.2% annually.¹³ Osteoarthritis is impacted by obesity and is projected to increase in the future.¹⁴

It was estimated in 1999 that demographic changes are likely to increase the national demand for knee replacement by 40% over the next 40 years.¹⁵

The increase in the older population in Brighton & Hove will increase at a slower rate than the national trend and it is not projected to see a great increase in the next 10 years, so a large rise in the number of older people with musculoskeletal conditions is not predicted.

What we don't know

We do not have any local patient voice on this topic.

We do not know what actions are being taken to promote awareness of the importance of nutrition and physical activity to improve bone health.

⁸ Spend and Outcome factsheet: Yorkshire Public Health Observatory. Available at: <http://www.yhpho.org.uk/default.aspx?RID=49488> [Accessed on 26/08/2013].

⁹ Jinks C; Ong Bie Nio; Richardson J. A mixed methods study to investigate needs assessment for knee pain and disability: [population and individual perspectives. *BioMed Central Musculoskeletal Disorders* 2007; 8:59.

¹⁰ Dorling C. Copy of standardization hipsknees quintiles. 2008

¹¹ Allison T et al. Musculoskeletal pain is more generalised among people from ethnic minorities than among white people in Greater Manchester. *Ann Rheum Dis* 2002;61:151-156. doi:10.1136/ard.61.2.151 [Accessed September 2009]

¹² Judge A. and Welton NJ, et al. Equity in access to total joint replacement of the hip and knee in England. *British medical Journal* 2010; 341:c4092 doi:10.1136/bmj.c4092

¹³ Department of Health. *The Musculoskeletal Services Framework – A joint responsibility: doing it differently*. London: Crown Copyright. 2006. Available http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationPolicyAndGuidance/DH_4138413 [Accessed on 26/08/2012].

¹⁴ Foresight. *Tackling obesity: future choices – Modeling future trends in obesity and the impact on health*. 2nd edition. Government office for science, 2007 [on line] <http://www.bis.gov.uk/assets/foresight/docs/obesity/14.pdf>

¹⁵ Fear J and Hillman M et al. Prevalence of hip problems in the population aged 55 years and over: access to specialist care and future demand for hip arthroplasty. *Br J Rheumatology* (in press)

There is no other data available in relation to protected characteristic groups apart from gender and ethnicity.

Key evidence and policy

NICE has published the following clinical guidance relating to musculoskeletal conditions:

Falls (August 2005 and update 2011)

Osteoporosis (February 2008)

Osteoarthritis (2008)

Rheumatoid arthritis (2009)

Lower back pain (2009)

Hip fractures (2011)

Recommended future local priorities

1. Ensure care pathways maximise the benefits of non-surgical interventions in musculoskeletal conditions, including physiotherapy,
2. Review the criteria for access to surgery to ensure equity of access across the area.
3. Depending on overall financial pressures, consider establishing access criteria which ensure a pre-operative health/disability score more similar to the national average.
4. Review access by areas of deprivation to ensure a similar level of service for similar need.
5. Identify and address reasons for differential use of cemented and uncemented joint replacements.
6. Review evidence base and cost effectiveness of anterior cruciate ligament reconstruction to move to a consistent evidence-based care pathway, consistent with local financial pressures.
7. Review falls prevention activity to ensure maximum benefit from current resources.
8. Review community services and discharge arrangements for hip replacement in Brighton & Hove, to reduce lengths of stay.
9. Ensure the proposed service model changes the ratio of spend in musculoskeletal conditions from secondary to primary care. Review the reasons for high spend in Brighton & Hove.

10. Ensure NICE guidance is utilised to guide service developments.

Key links to other sections

- Healthy weight (adults and older people)
- Disability
- Carers
- Care of the elderly
- Variations in healthcare

Further information

MSK Needs Assessment. NHS Sussex. October 2011. Kammerling M. Pickin M. Gilchrist K.

Last updated

September 2013

Why is this issue important?

Primary care¹ is a focal point for prevention of ill-health, treatment and support of illness in all its forms for the people of Brighton & Hove. Every General Practice can save lives and reduce morbidity by identifying patients with risk and managing them effectively on disease registers. Finding patients who already have, or who are at risk of developing, disease and successfully managing their condition/s are crucial to efforts to reduce premature mortality, morbidity and inequalities in health.

Key outcomes

NHS Outcome Framework

- **Preventing people from dying prematurely (Domain 1)**
- **Enhancing quality of life for people with long term conditions (Domain 2)**
- **Ensuring that people have a positive experience of care (NHS Outcomes framework 2013-14, Domain 4) including: patient experience of primary care; GP services; GP Out of Hours services; NHS Dental Services; and friends and family test.**

Public Health Outcomes Framework

- **Increased healthy life expectancy**
- **Reduced differences in life expectancy and healthy life expectancy between communities**
- **Healthcare public health and preventing premature mortality specifically aiming to reduce numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.**

The Quality and Outcomes Framework (QOF) is a part of the GP contractual arrangements introduced in April 2004 and rewards GP practices for how well they care for patients rather than simply how many they treat, based on performance against indicators. Each indicator is worth a maximum number of points and GP practices are rewarded financially depending on

how many points they achieve. Up to 31st March 2013 the QOF focused on a number of domains covering:

- Clinical indicators relating to key disease areas and their treatment
- Patient experience indicators
- Organisational/management indicators
- Additional services and treatment indicators

Practices can identify a number of patients as “exceptions”, who are then not counted towards QOF scores. Reasons for citing a patient as an exception include specific clinical reasons, as well as, for example, patients not responding to several requests for a clinical review in the practice.

As part of the 2013/14 GMS contract changes, the Department of Health (DH) have implemented a number of changes to the QOF effective from 1 April 2013. The key changes include: implementation of NICE recommended replacements, new indicators and retirements; introduction of a new public health domain; removal of the organisational domain indicators not retained in the quality and productivity domain or moved into the public health domain; and an increase in thresholds for all existing indicators, in line with the 75th centile of achievement phased in over two years.

A review by the King’s Fund² finds that the QOF has been successful in incentivising a more organised approach to chronic disease management and secondary prevention. QOF has also encouraged practices with more deprived populations and those that were more disorganised or lacked resources to adopt a more systematic approach.

However, there is a lack of evidence that QOF has directly improved health or reduced inequalities. QOF has not provided an incentive for primary prevention or case-finding and practices with more deprived patients are failing to identify all cases of disease within their practice populations. QOF is also not working well for particularly vulnerable groups with great public health needs, such as the homeless and travellers. The QOF may encourage a clinical and mechanised approach to managing

¹ In this JSNA ‘Primary Care’ primarily focuses on general medical practice. Oral health, sight and pharmacy are addressed in separate JSNAs.

² Dixon A. et al. Impact of Quality and Outcomes Framework on health inequalities. King’s Fund. 2011.

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chronic disease that does not support holistic care or promote self-care and management.

The QOF was not developed as a measure of population health improvement. However, the new QOF will be a lever to raise the bar in achievement, improving patient outcomes through improvements in quality in primary care.

The new thresholds for maximising attainment at 75% (an increase of 5% from re April 2013 QOF) of all possible patients on a given disease register, means that even when a practice achieves maximum points there may be up to 25% of patients whose condition is not being optimally managed within prescribed levels. There are also concerns that the difficulty in achieving the new stretched thresholds may result in an increase in exception reporting.

Impact in Brighton & Hove

In Brighton & Hove, like elsewhere in England and Wales, there is a substantial gap between numbers of people on disease registers in general practice and the modelled prevalence for those conditions in the local population.

Brighton & Hove has the 7th worst level of exception reporting for patients in England. Many of these patients are likely to be some of the most vulnerable people in the city, some of whom live challenging and chaotic lives. Enabling these patients to access care and support is critical to reducing health inequalities within the city.

There remains a wide variation in achievement of quality outcomes for patients in general practice in the city. In 2011/12, out of a total of 1,000 points, QOF scores at an individual practice level varied ranged from 783 – 998 points. The Morley Street homeless practice made the biggest improvement from a low of 370 points in 2009/10 to 915 in 2011/12. In 2010/11, excluding the homeless practice, scores ranged from 655 to 1,000.

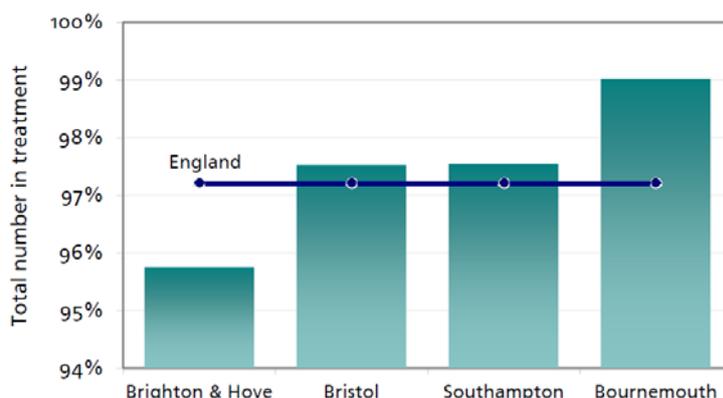
On average local QOF scores are lower than the national average. The average number of QOF points scored by practices in Brighton & Hove in 2011/2012 was 952 out of 1,000 points available compared with the England average of 969. In 2010/2011 the average for Brighton & Hove was

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934 (excluding the Homeless practice for that year) and the national average was 947.

Figure 1 demonstrates that other areas with comparable populations to Brighton & Hove are achieving above the England average for total QOF points. Brighton & Hove performs below the national average for total points.

Figure 1: Total QOF points achieved as a QOF points for Brighton & Hove with ONS comparators and England average, 2011/12.

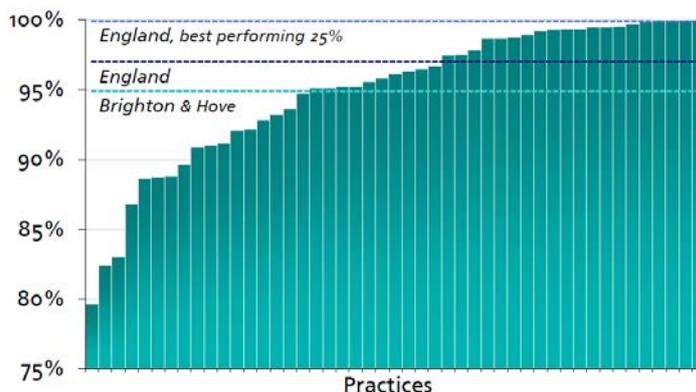


Source: Quality and Outcomes Framework (QOF)

<http://www.hscic.gov.uk/qof>

Figure 2 demonstrates that there is variability in the achievement of QOF clinical points across the city, indicating that there is scope for many practices across Brighton & Hove to improve the quality of care for patients.

Figure 2: Analysis of QOF clinical points earned by GP practice, Brighton & Hove, 2011/12



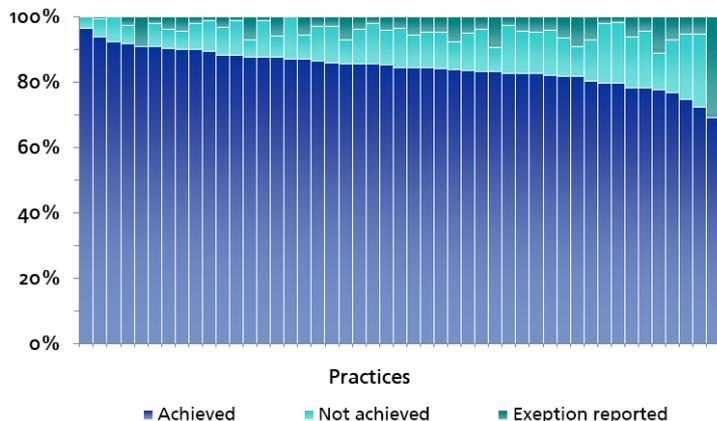
Source: Quality and Outcomes Framework (QOF)

<http://www.hscic.gov.uk/qof>

The variation in clinical QOF achievement among the city's practices is repeated across a range of clinical indicators, characterised by high levels of exception reporting and variance in levels of achievement (see example in Figure 3 for management of coronary heart disease).

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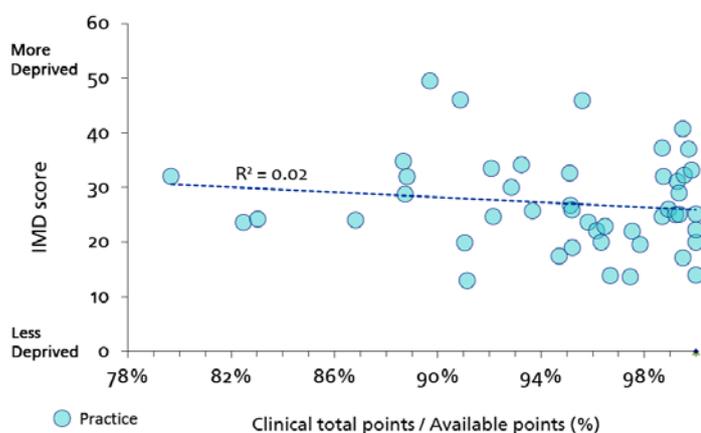
Figure 3: Percentage of patients with coronary heart disease whose last blood pressure reading was less than or equal to 150/90 (measured in the last 15 months) (CHD06) by GP practice, Brighton & Hove, 2011/12



Source: Quality and Outcomes Framework (QOF) <http://www.hscic.gov.uk/>

Figure 4 shows that there is no association between the level of deprivation for the area from which a Practice draws its patients and clinical points achieved. This means that some Practices based in the most deprived areas achieve higher clinical points like their peers in more affluent areas and some in more affluent areas score lower clinical points.

Figure 4: Clinical domain QOF scores per practice, 2011/12 against IMD by Practice

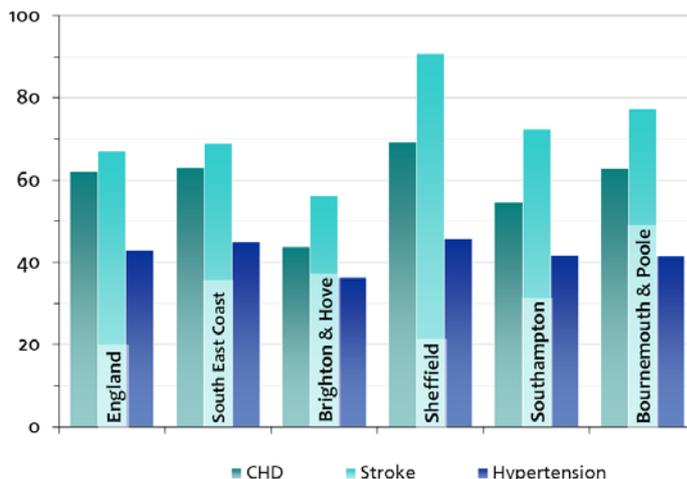


Source: Quality and Outcomes Framework (QOF) <http://www.hscic.gov.uk/>

In Brighton & Hove there is a substantial gap between the numbers of people on disease registers in general practice and the expected number of people with those conditions in the local population (known as modelled prevalence).

Figure 5 shows the proportion of expected cases identified for coronary heart disease (CHD), stroke and hypertension in Brighton & Hove and across the South East. Brighton & Hove has the lowest proportion in the South East and is significantly below the England average.

Figure 5: Proportion of expected cases of specific conditions identified on GP registers



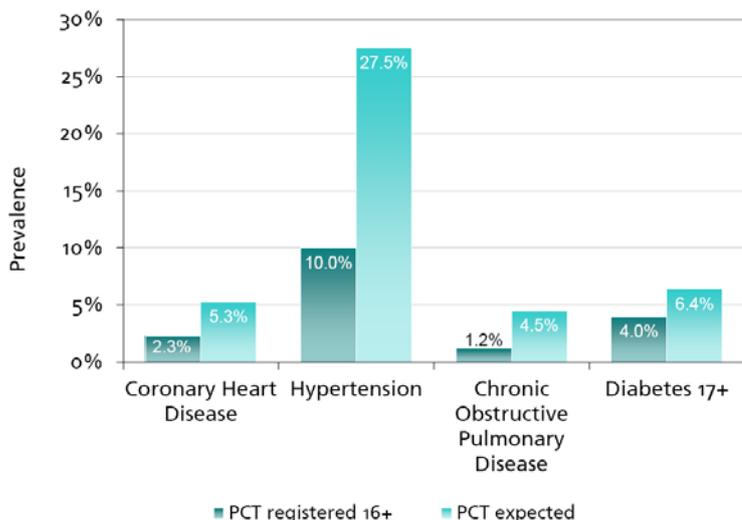
Source: Quality and Outcomes Framework (QOF) <http://www.qof.ic.nhs.uk/> and Association of Public Health Observatories

Figure 6 shows that prevalence of CHD, diabetes, Chronic Obstructive Pulmonary Disease (COPD) and hypertension as measured by the QOF registers are lower than expected for our population.

Approximately half of patients with CHD, well over half of patients with hypertension, just over one third of patients with stroke and three-quarters of patients with COPD are not detected by general practices. This indicates large-scale undiagnosed conditions in our population and the potential to save lives, reduce the burden of ill-health and improve patient outcomes through risk identification, placing people with identified risk on disease registers and delivering high quality care for these patients in primary care. This is a commissioning challenge and a provider challenge.

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Figure 6: Expected versus registered prevalence of major QOF conditions, Brighton & Hove, 2011/12

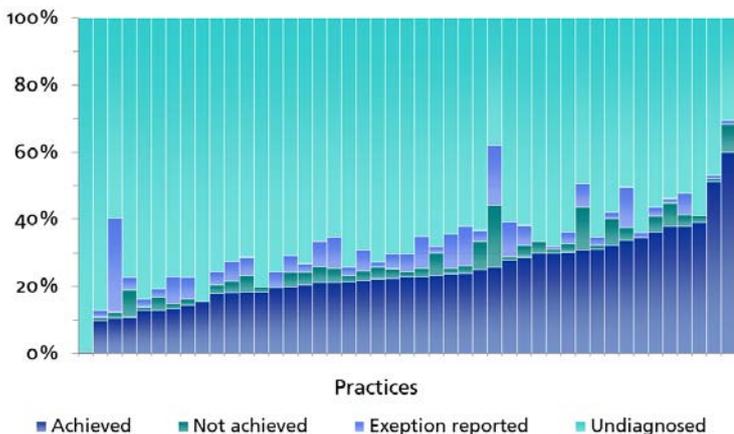


Source: Quality and Outcomes Framework (QOF) <http://www.qof.ic.nhs.uk/> and Association of Public Health Observatories

Figure 7 shows the proportion of people with COPD who would be expected to be found based on modelled prevalence not yet on registers, added to those already on the COPD register. Those patients for whom COPD is not controlled, or are either exception reported or not yet on the register, are at risk of progressive disease and premature death. This pattern is repeated across many disease registers across Practices in the city. In population health terms the challenge is to reach as many of these people as possible and provide high quality care for them.

Figure 7: Percentage of patients with COPD with a record of FeV1 in the previous 15 months, 2011/12

Source: Quality and Outcomes Framework (QOF)

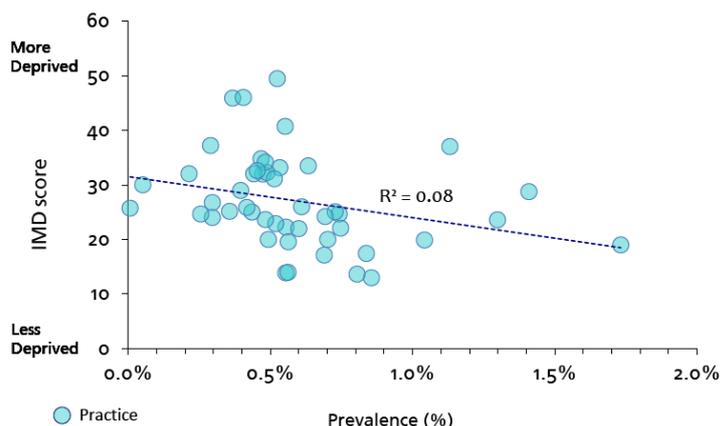


<http://www.qof.ic.nhs.uk/>

Local inequalities

Most recently available data indicate that Practices in more deprived areas have lower prevalence for atrial fibrillation (AF), stroke, hypertension, Chronic Kidney Disease (CKD), dementia and significantly lower for Heart Failure (HF), smoking, cancer, hypothyroidism and dementia. Practices in more deprived areas have higher prevalence for COPD and significantly higher for mental health (MH), depression and epilepsy. There is no or very little association between prevalence and deprivation for coronary heart disease, diabetes and asthma. Figure 8 shows that heart failure prevalence is significantly lower the greater the deprivation score for general practices.

Figure 8: Heart failure (HF) prevalence by IMD score, General Practices, Brighton & Hove 2011/12



Source: Quality and Outcomes Framework (QOF) <http://www.qof.ic.nhs.uk/> and Index of Multiple Deprivation

As for achievement across the QOF clinical domains, there was slightly better achievement for practices in more deprived areas for CHD, AF, HF, stroke, hypertension, diabetes, CKD and dementia. Practices in more deprived areas achieved slightly lower scores for smoking, asthma, hypothyroidism and epilepsy compared with practices in less deprived areas of the city. There were similar levels of achievement between general practices working in more deprived and less deprived areas for COPD, cancer, MH and depression.

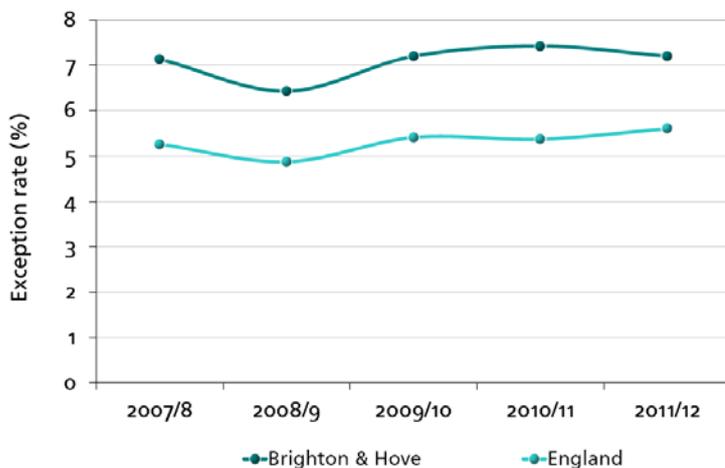
Exception reporting

Figure 9 shows that exception reporting in Brighton and Hove has been persistently above the England average for several years. For 2011/12, Brighton & Hove's exception reporting was 7.2%, higher than the national average exception

8.1 Primary care

reporting of 5.6%. Brighton & Hove’s position was seventh in national ranking for exception reporting. This represents 31,287 exceptions, slightly down from 31,724 exceptions reported in the previous year (6.43% in 2010/11). 70% of practices, 33 out of 47, have an exception rate higher than the national average with rates varying from 3.4% to 14.2% (excluding Morley Street homeless practice – 31.6% and Brighton Station - 16.7%).

Figure 9: QOF exception rates 2007/8 to 2011/12 for Brighton & Hove and England.



Source: Quality and Outcomes Framework (QOF) <http://www.qof.ic.nhs.uk/>

A high level of exception reporting due to patients not attending their practice could indicate that more wide-ranging approaches to attracting patients to attend may be needed, for example via text messages and phone calls rather than letters. It is often the most vulnerable people in society and those with chaotic lives who are not able to engage with routinely offered services. This requires creative and persistent approaches to optimise their engagement. This is a commissioning and provider challenge.

Analysis of QOF data together with practice-level deprivation scores,³ reveals that adding exception-reported patients into the analysis, reduces overall scores and weakens or reverses the relationship between deprivation and QOF achievement for a large number of indicators. This suggests that deprived practices in Brighton & Hove exclude more patients from QOF reporting and raises the possibility that poorer QOF achievement in

deprived practices is masked by exception reporting. Strategies to reduce health inequalities in the city will need to acknowledge that high levels of exception reporting, particularly in practices with deprived populations, may be disguising unmet need in those populations.

Voice

Patient satisfaction surveys

In the most recent City Tracker Survey, satisfaction with public services was highest for pharmacy, medical and hospital services, with four-fifths or more indicating they are very or fairly satisfied with their experience of these services in the city. 93% of all respondents were satisfied with their local chemist and 96% for those who had used a chemist locally. Overall 86% of survey respondents were satisfied with their local GP and 89% who had used their local GP were satisfied, with satisfaction highest for those living within the BN41 postcode district at 95%, compared to those living within BN2 and BN3, at 88% and 86%, respectively. Overall satisfaction was lower for NHS dentists at 61% of all respondents, and 79% for those who had used dentist.⁴

Figure 8 shows relatively stable levels of satisfaction with these primary care services over the past year in which three waves of the survey have been conducted.

Table 1: City Tracker Survey. Summary comparison of tracker questions: User satisfaction (Very/ fairly satisfied) – Waves 1, 2 and 3

	Wave 1	Wave 2	Direction of travel Wave 2&3	Wave 3	Direction of travel Wave 2&3
Your local chemist	96%	95%	↓ -1	96%	↑ +1
Your local GP (family doctor)	90%	91%	↑ +1	89%	↓ -2
Your local dentist	79%	79%	↔	79%	↔

³ Based on Index of Multiple Deprivation

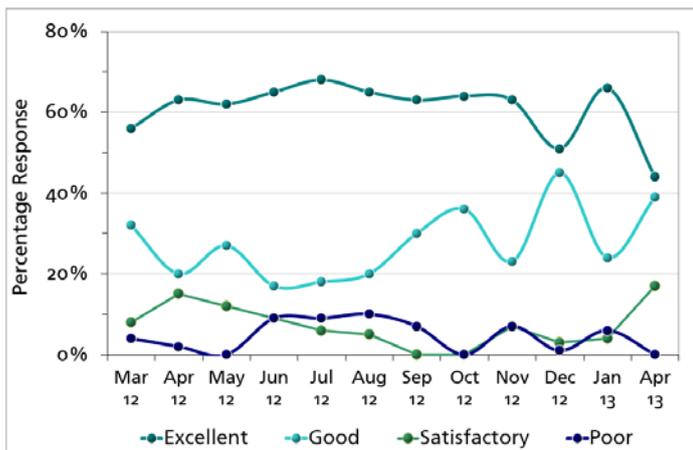
⁴ Brighton & Hove Strategic Partnership City Tracker, Third Wave January-February 2013 www.bhlis.org/surveys [Accessed on 10.05.2013].

8.1 Primary care

South East Health Limited manages GP out of hours services for Brighton & Hove. It receives feedback on its service by sending out monthly Patient Satisfaction Questionnaires (PSQ) to a random sample of patients. Figure 11 shows patient feedback for March 2012 to February 2013. Over this period, 88.5% of patients rated South East Health's service as excellent or good and 4.5% rated the service as poor. The overall response rate for this period was 22%.

The 2011/12 GP Patients Survey for Brighton & Hove shows that 93% of patients thought that reception staff were helpful; 96% were satisfied with their doctor and 98% with their nurse. Overall 90% of patients were satisfied with the level of care they received in General Practice and 84% would recommend their Practice to others. These results closely matched those nationally.

Figure 11: Patient feedback for out of hours GP service in Brighton & Hove, March 2012 to February 2013



Source: South East Health Limited

Voice: qualitative research

Research carried out by Right Here Volunteers aged 16 – 25 of 172 of their young peers in Brighton & Hove during October and December 2011⁵ aimed to assess young people's experiences of visiting their GP, identify responses they would like in relation to their mental and emotional health, and to identify improvements required to enable them to have an improved experience.

⁵ <http://right-here-brightonandhove.org.uk/wp-content/uploads/Summary-of-GP-report-April-2012.pdf>

Key messages were:

- opening hours are not always compatible with the school and college timetable. More drop-ins or lunchtime appointments are needed;
- young people want the choice to request to see the same doctor or request a doctor of a specific gender;
- posters and information for young people should be set aside from other medical issues so they are clear and noticeable. They should be kept up to date with clear numbers and information about places young people can go to support their mental and emotional health;
- making health questionnaires / quizzes / puzzles available in the waiting room can increase awareness about mental health issues and act as prompts for conversations in consultations;
- young people want to be active, well informed participants in the decisions made about their health. Being involved in decision making helps young people feel more in control and have a sense of independence, and often assists in their recovery;
- young people want to be offered additional support and help with treatment options. They want their GP's to promote well being resources / leaflets and websites and signpost them to local support services;
- only 50% of respondents said they would feel comfortable talking to their GP about emotional or mental health issues. Many young people said they would like to see a GP who specialises in working with young peoples mental health issues;
- young people would like confidentiality outlined clearly with verbal and visual reminders. 41% of respondents did not know what is confidential when they visit their GP which can prevent them from seeking help.

The Fed Centre for Independent Living conducted a study in 2011 which consisted of focus groups and in-depth interviews with 84 adults with a range of

8.1 Primary care

physical impairments, mental health conditions and learning disabilities.⁶

One of the main themes explored in the research was the experience of NHS healthcare. While some respondents were positive about the NHS overall, several reported mixed experiences of the care they received in primary care. Issues highlighted included:

- access to GPs
- the care and time taken by doctors
- willingness to proactively treat problems
- the extent to which doctors involved them in treatment decisions

Continuity of care was a very important factor in determining their view of healthcare. Those who were able to build up a personal relationship with their GP were more satisfied than those who saw many different GPs.

Some of the participants in the research had long-term, unusual conditions which were less commonly encountered by GPs. These disabled people typically had less positive experiences of their GPs who they felt did not understand their condition and lacked the expertise to treat them effectively. Patients reported that they felt like they had to research their own conditions to improve their treatment outcomes, due to the lack of knowledge of their GP.

There is little data regarding the experience of members of black and minority ethnic communities' experience of primary care in Brighton and Hove. A recent report⁷ of the perspective of service users with spoken language support needs highlighted the need for easy access to trained community interpreters. Additionally, it noted issues which are common to the needs of other groups:

- difficulties in getting urgent appointments even for children;
- being asked to wait a number of days for appointments;

- feeling rushed by the GP;
- frustration that GP's could only deal with one issue, necessitating a repeat visit. The presence of an interpreter may help to improve communication and reduce repeat attendances.

Predicted future need

Finding patients who already have, or who are at risk of developing, disease and successful management of their condition/s are crucial to efforts to reduce premature mortality, morbidity and inequalities in health. The challenge is to ensure that chronic disease registers are comprehensive, by addressing the barriers that prevent patients from coming forward.

Closing the gap between modelled prevalence and numbers of people on disease registers requires systematic and scaled up approaches to identify those with risk, place them on Practice registers and manage them effectively e.g. through increasing availability and uptake of NHS health checks.

As a result of changes in risk factors (in particular overweight and obesity) and the population age structure the number of people with diabetes (diagnosed and undiagnosed) in Brighton & Hove is predicted to increase to 17,842 in 2030 (compared with 9,936 registered patients in 2011/12).⁸

Age is a key factor in cardiovascular disease. The prevalence of cardiovascular disease increases significantly after the age of 40 years.⁹ The greatest projected increase in our population relevant to this age group is the 50-59 year olds.¹⁰

Whilst cancer is predominantly a disease of old age, the population of Brighton & Hove is generally younger than average and projections suggest that this pattern will remain. The incidence of some cancers is increasing, such as lung cancer and upper gastrointestinal cancer in females. This is

⁶ Fed Centre for Independent Living. Count Ability. 2012. Available at <http://www.bhfederation.org.uk/federation-services/count-ability.html> [Accessed 09/08/2012]

⁷ Health Services in Brighton and Hove – Perspective of service users with spoken language support needs. Sussex Interpreting Services & Black and Minority Ethnic Communities Partnership. 2013.

⁸ SEPHO. New APHO Diabetes Population Prevalence Model, July 2010. <http://www.sepho.org.uk/viewResource.aspx?id=13675> [Accessed 30 April 2012]

⁹ SEPHO. Cardiovascular disease PCT health profile. Brighton and Hove City. http://www.sepho.org.uk/NationalCVD/docs/5LQ_CVD%20Profile.pdf [Accessed 30 April 2010]

¹⁰ Brighton & Hove City Council and Brighton and Hove City PCT. Health and wellbeing Joint Strategic Needs Assessment Summary 2011.

8.1 Primary care

likely to be related to lifestyle behaviours such as smoking and alcohol consumption.

The 2012 Health Counts Survey found that 14% of people in Brighton & Hove smoke every day and a further 9% smoke occasionally. There has been a large fall since 2003 when 20% of city residents were daily smokers and 8% were occasional smokers. The 2012 Safe and Well at School Survey found that 84.6% of students aged 11-14, and 49.6% of students aged 14-16 years had never tried a cigarette. Over the last three years there has been an encouraging trend of increasing percentages of children in years 7, 8 and 9 never having tried a cigarette.

What we don't know

We have relatively low stroke mortality in Brighton & Hove but a high level of modelled hypertension. We cannot explain this at this point in time.

We do not know what impact the city's level of ghost¹¹ patients has on modelling of prevalence for specific conditions.¹² The modelling uses standard national tools based on PCT practice register populations rather than ONS numbers based on census data.

There is little evidence to inform insight to members of black and minority ethnic communities' experience of primary care in Brighton & Hove.

Key evidence and policy

Blair-Stevens T. Closing the Gap: finding the missing thousands. Department of Health. 2010.

Dixon A. et al. Impact of Quality and Outcomes Framework on health inequalities. King's Fund. 2011.

South East Public Health Observatory. Inequalities in primary care: what can analysis of QOF data reveal? Summary report for Brighton & Hove PCT. SEPHO. 2011.

Quality and Outcomes Framework Data Tables 2011-2012. The Health and Social Care Information Centre, 2013.

2011- 2012 GP Patient Survey, Brighton & Hove.

Recommended future local priorities

1. Support Primary Care development to close the gap between modelled prevalence and numbers on registers.
2. Agree a systematic approach across practices to detect people with risk.
3. Monitor outcomes for people once on register.
4. Undertake a retrospective mortality audit in general practice to inform strategy and action which will optimise care and reduce deaths which are amenable to prevention.
5. Develop an exceptions reporting strategy.

Further information

Leaman J. Systematic approaches to 'raising the bar' in primary care: what has been done to increase quality overall and specifically in those underperforming. Department of Health. 2010.

Vital: Brighton & Hove Annual Report of the Director of Public Health 2011
<http://www.bhlis.org/PHAR2011>

Last updated

August 2013

¹¹ 'Ghost' patients are patient who have moved away from the area in which they registered with a General Practice, but the Practice was either not informed or the patient was not removed from the register.

¹² NHS Brighton and Hove / Brighton & Hove City Council. Vital: Annual Report of the Director of Public Health. 2011

8.2 Urgent care

Why is this issue important?

The Department of Health's vision for urgent and emergency care is of universal, continuous access to high quality services. In practice this will mean that whatever our urgent or emergency care need, whatever our location, we get the best care from the best person, in the best place and at the best time.

Emergency admissions cost the health economy £43 million a year, and attendances at Accident and Emergency services are rising slowly.¹

Key outcomes

- ***Emergency admissions for acute conditions that should not usually require hospital admission (NHS Outcomes Framework)***
- ***Emergency readmission within 28 days of discharge from hospital (NHS Outcomes Framework)***
- ***Urgent care also impacts on a number of improvement areas in both the NHS and the Public Health Outcomes Framework - deaths from heart disease and respiratory disease, recovery from trauma, stroke and fragility fractures***

Key drivers for change

Based on national information:

- Urgent care services are currently fragmented and generate confusion amongst patients on how and where to access care.
- There is poor sharing of information as patients move between different providers of care in an emergency.
- There is variable quality of out of hours care, particularly in terms of continuity of care.
- Walk in centres do not appear to have led to shorter waits in general practice or lower admissions rates.
- Mental health problems are strongly associated with acute admissions; self harm is one of the top five reasons for medical admission.

Based on local intelligence:

- There are high levels of use of Accident and Emergency (A&E) services by non UK born residents, who may not be aware of the alternatives; recent internal migrants who may not be registered for primary care services; and people living in our most deprived areas.
- People are too likely to be admitted to hospital in last few days of life.
- The role of nursing homes in improving the support offered to people with long-term conditions or at risk of acute harm, and in the acute situation, could be enhanced.
- There are high levels of transport to hospital once ambulances are called.

Impact in Brighton & Hove

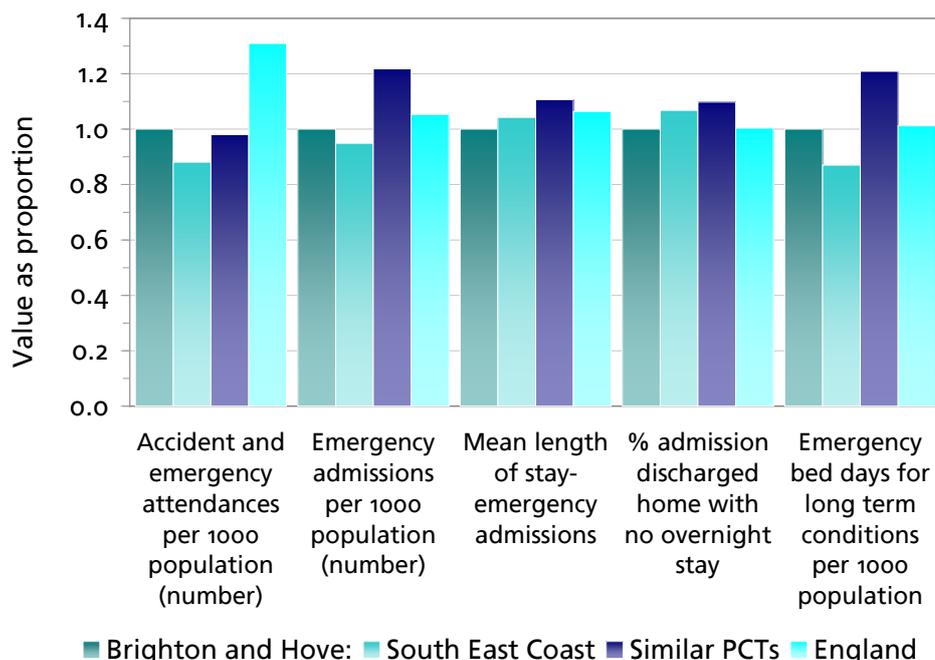
- About 81,000 local people attended A&E Departments in 2012/13. This represents about a overall 40% increase since 2006/7, but is actually a slight reduction of around 4% since 2010/11
- There are around 24,000 emergency admissions each year. This represents a modest decrease of 6% since 2008/9, and is remaining fairly stable.
- The attendance rate at A&E for local residents by age group is reasonably consistent across all age bands, except for high rates in the under 5s and increasing rates in the over 75's, with the highest attendance rate being for the over 85s.
- Appropriate management of emergency admissions contributes substantially to a reduction in deaths and long term disability from heart disease, trauma, and strokes.
- People who attend A&E are much more likely to require subsequent hospital admission the older they are.
- About 34% of emergency admissions are assessed, managed and discharged without the need for an overnight stay. This is an increase on 2010/11, where the comparable figure was 26%. It is unclear whether this represents increased hospital efficiency, or an increase in more minor cases being admitted.

¹ Ham et al 2010

8.2 Urgent care

Figure 1 shows how we compare on these measures both with the South East Coast area, and with other PCTs* with similar population characteristics. Unfortunately, some of the national systems used to make this data available have not been updated recently, and this data reflects the 2010 calendar year.

Figure 1: Urgent care - comparison of indicators



Source: NHS Comparators

Note: Brighton and Hove value = 1. 1.2 = 20% higher than Brighton and Hove, 0.8 = 20% lower than Brighton and Hove.

*ONS comparators: Bristol, Southampton, Leeds, Plymouth, Sheffield, Portsmouth, Newcastle, Salford and Liverpool.

Ambulatory care sensitive conditions (ACSCs) are conditions for which effective management and treatment should prevent admission to hospital. They can be classified as: chronic conditions, where effective care can prevent flare-ups; acute conditions, where early intervention can prevent more serious progression; and preventable conditions, where immunisation and other interventions can prevent illness.¹

In 2011/12, Brighton had an admission rate for these conditions very similar to the national average, but higher than other PCTs in the South East.

The highest admission rates for ASCSs (based on 2010 data) are:

- Convulsions and epilepsy

- COPD
- Influenza and pneumonia
- Diabetes complications
- Congestive heart failure
- Asthma

For all of these, bar influenza and pneumonia, Brighton & Hove has higher admissions compared with the national average and the South East Coast area.

Predicted future need

Although the local population is set to grow by about 5% over the next decade, the growth will be largest in young and middle-aged adults, and the number of older adults is set to fall slightly.

Whilst this might have some impact on the case mix, the pressure on A&E and acute admissions is likely to rise in parallel with population growth.

Increased life expectancy may mean that people live a longer time suffering from long-term conditions. In addition, there is likely to be an increase in people suffering from long-term illnesses, particularly those associated with obesity, such as diabetes.

What we don't know

Areas we do not know are:

- What changes in health care knowledge and technology will have a significant impact.
- How successful our efforts to improve our health (through preventing obesity, improving diet and exercise and stopping smoking) will be.
- How successful our efforts to maximise the role of ambulance staff in ensuring appropriate care for patients seen urgently will be.

8.2 Urgent care

Key evidence and policy

The Department of Health has issued new quality indicators for Accident and Emergency departments and ambulance services, intended to support local efforts to improve the quality of care.

A Kings Fund report offered the following guidance:

- GPs should play an active role in commissioning primary care out-of-hours services
- Develop a clinical dashboard for GPs
- Establish better and more integrated triage systems
- Provide effective signposting and access to urgent care services for patients
- Build systems to improve co-ordination of care between different providers
- Investigate patient flows to support the development of a local revised 'whole system' model of care

Recommended future local priorities

1. Continue to improve acute care for people with heart attacks, stroke and trauma, in line with national guidance.
2. Improve support to nursing homes to maximise their ability to manage long-term conditions, acute exacerbations, and end of life care.
3. Improve awareness of routes to urgent care.
4. Ensure high quality community support and routes to access help during exacerbations for people with chronic conditions, especially targeting those long-term conditions where admissions are relatively high - convulsions and epilepsy, COPD, diabetes complications and congestive heart failure.
5. Maximise uptake of flu vaccination in the over 75s.
6. Ensure appropriate management of mental health problems associated with acute admissions.

Key links to other sections

Because urgent care covers a wide range of needs for different conditions, many other sections in this JSNA relate to the need for urgent care:

- Diabetes
- Coronary heart disease
- Stroke
- Respiratory disease
- Cancer
- Mental health
- Dual diagnosis
- Dementia
- Musculoskeletal conditions
- Primary care services
- Variation in effective healthcare

Further information

NHS Comparators: Information Centre for Health and Social Care: www.ic.nhs.uk/nhscomparators

Emergency Hospital Admissions for ambulatory care-sensitive conditions; identifying the potential for reductions: Kings Fund; April 2012

Guidance for commissioning integrated urgent and emergency care: A 'whole system' approach; Dr Agnelo Fernandes: RCGP Centre for Commissioning; August 2011

Last updated

August 2013

8.3 Maternity care

Why is this issue important?

Maternity care provides a unique opportunity for health care professionals to meet & support women, partners & their families who might otherwise never or rarely access health services.

Standard 11 of the *National Service Framework for Children, Young People & Maternity Services* focuses on maternity services, encompassing the whole pathway of care from preconception to post birth. The overarching standard is that women have easy access to supportive, high quality maternity services, designed around their individual needs & those of their babies.¹

The vision is one of flexible services, which normalise pregnancy & birth, & good outcomes for mother & baby including being prepared for parenthood. There is a particular emphasis on the needs of vulnerable & disadvantaged women & the importance of engaging them early in pregnancy.

Building on this, *Maternity Matters*² sets out four national choice guarantees which should be available to all women (from the end of 2009):

1. Choice of how to access maternity care
2. Choice of type of antenatal care
3. Choice of place of birth with birth supported by
 - A midwife at home
 - A midwife in a local midwifery facility such as a designated local midwifery unit or birth centre
 - A maternity team in a hospital
4. Choice of postnatal care – at home or in a community setting

The Healthy Child Programme includes pregnancy, recognising its importance on the future health of the child. It focuses on the promotion of health & wellbeing & preparation for parenthood.

Key outcomes

- ***Improving the safety of maternity services (NHS Outcomes Framework)***

¹ Department of Health 2004. Standard 11. The National Service Framework for Children, Young People and Maternity Services. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationPolicyAndGuidance/Browsable/DH_4966996 [Accessed on 2.6.12]

² Department of Health 2007. *Maternity Matters: Choice, access and continuity of care in a safe service*. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationPolicyAndGuidance/DH_073312 [Accessed on 24.6.12]

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- ***Improving women & their families' experience of maternity services (NHS Outcomes Framework)***

In addition a number of key standards are monitored:

- ***Percentage of women with an assessment of health & social care need, risks & choices, by 12 completed weeks of pregnancy***
- ***Percentage of women receiving one-to-one midwifery care throughout labour & delivery***
- ***The midwife: birth ratio***
- ***Consultant presence on labour ward***
- ***Percentage of caesarean sections***

Impact in Brighton & Hove

Performance is monitored at Brighton & Sussex University Hospital's Trust level & hospital site (the Trust covers the Royal Sussex County Hospital in Brighton & the Princess Royal Hospital in Haywards Heath). At Royal Sussex County Hospital:

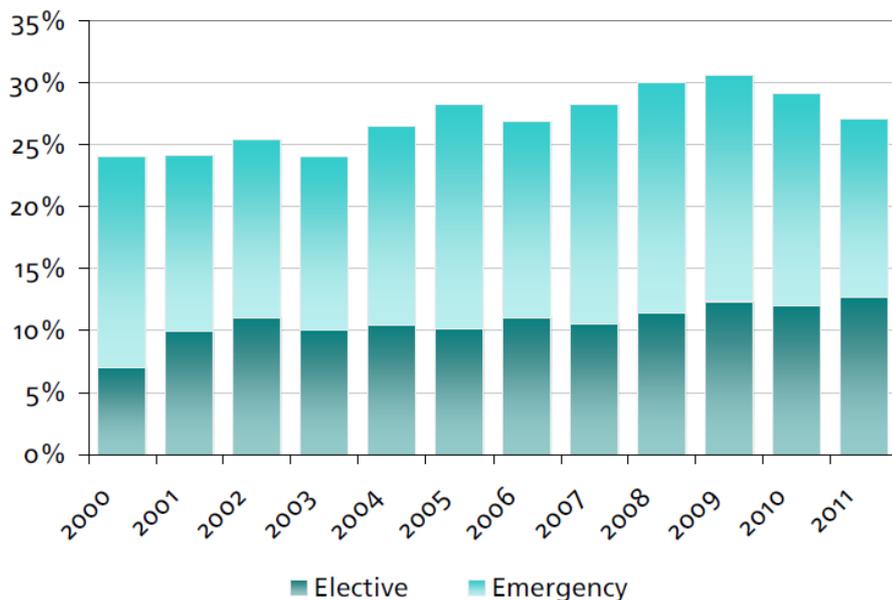
- Booking by 12 weeks of pregnancy was achieved for 86.4% women in 2011/12 (standard 90%).
- One-to-one midwife care during established labour was achieved 78% of the time during 2011/12 (the Royal College of Obstetricians & Gynaecologists (RCOG) standard is 100%).
- Midwife ratio to births is currently at 1:34 compared with the RCOG standard of 1:30.
- Consultant presence at RSCH is 60 hours per week in line with RCOG standards³ for the number of deliveries.
- The caesarean section rate was 26% in 2011/12 compared with an England average of 23%. (Figure 1 illustrates the trend at RSCH from 2004-2011.)

³ Royal College of Obstetricians and Gynaecologists. *The Future Workforce in Obstetrics and Gynaecology*. 2009. Available from <http://www.rcog.org.uk/news/future-workforce-obstetrics-and-gynaecology> [Accessed 31.7.12]

8.3 Maternity care

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Figure 1: Caesarean section rates at Royal Sussex County Hospital, 2004-2011



Source: Brighton and Sussex University Hospitals Trust

Patient voice

In 2008 the PCT commissioned a review of user experiences of pregnancy, birth & maternity service provision⁴. A number of specific developments were highlighted as priorities:

- A Midwife-Led Unit close to RSCH
- Continuity of care & carer
- Higher midwife: woman ratios
- More specialised midwives for under 25s
- Improved antenatal preparation
- Better involvement & support for fathers
- More flexible visiting policy for partners
- Trauma counselling on postnatal ward

Subsequently the PCT commissioned further work to improve user engagement with the Maternity Service Liaison Committee (MSLC); & now fund the lay chair to ensure this is maintained.

Where we are doing well

The city has an active Maternity Service Liaison Committee (MSLC) with good user involvement.

The caesarean section rate is reducing.

The teenage pregnancy service is considered an example of best practice nationally.

Local inequalities

There is a lack of information about inequalities in access to, or provision of maternity care. (Inequalities relating to lifestyle & outcomes can be found in the Maternal & Infant Health section.)

Access to perinatal mental health provision is limited in comparison with East & West Sussex.

Currently women do not have the choice of giving birth in a local midwife-led unit, & home birth rates are declining.

Predicted future need

The birth rate is not predicted to increase significantly. However the percentage of births to women aged over 40 years is increasing which will impact on service provision during pregnancy & birth.

The number of births to women born outside the UK is increasing (See Maternal & Infant Health section) so there is a need to ensure services continue to meet local need.

Obesity prevalence in pregnancy continues to increase impacting on maternity care & pregnancy outcomes.

Maternity service provision in Sussex is currently under review in the context of Sussex Together⁵.

What we don't know

There is a lack of information about maternity service usage & outcomes related to inequalities.

Key evidence & policy

There are several NICE guidelines⁶ relating to maternity care: Antenatal care; Diabetes in pregnancy; Pregnancy & complex social factors; Antenatal & postnatal mental health; Intrapartum

⁴ Nicholson U. Developing Community Maternity Services: "What do parents want from maternity services?", 2008.

⁵ Sussex Together is the programme by which local doctors, nurses and therapists are leading the changes that will ensure services are high quality, safe, and designed to meet the needs of the local population for years to come. Maternity and paediatrics is one of the workstreams.

⁶ NICE guidance Available from:

<http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7252>
[Accessed on 25.6.12]

8.3 Maternity care

care; Induction of labour; Multiple pregnancy; Caesarean section; Maternal & child nutrition; Quitting smoking in pregnancy & following childbirth; Weight management before, during & after pregnancy; Hypertension in pregnancy.

The Royal Colleges have agreed standards for maternity care covering the whole pathway from pre-pregnancy through to the transition to parenthood,⁷ recommending the RCOG Maternity Dashboard: Clinical Performance & Governance Score Card, to monitor local services.

In 2012 the Government pledged: to provide more support for women with postnatal depression & those experiencing miscarriage, stillbirth or death of a baby; to improve maternity care by ensuring all women have a named midwife to oversee care during pregnancy & birth; to have one-to-one midwife care during labour & birth; & for parents-to-be to get the best choice of where & how they give birth.

In 2013/14 Payment by Results (PbR) maternity services pathway funding will replace the current episodic system where hospitals are paid for each clinical intervention. It should enable providers to deliver care how they & women think best.⁸

Recent research has shown that planned birth in a midwifery-led unit results in significantly fewer interventions & more normal births than in an obstetric unit.⁹

Recommended future local priorities

1. Engage women & families from more deprived areas & groups through the MSLC & ensure all equalities groups are represented.
2. Improve data collection on service usage by protected characteristics.
3. Undertake a comprehensive needs assessment for perinatal mental health to inform future commissioning arrangements so as to ensure women in Brighton & Hove have access to a comprehensive perinatal mental health service.

Brighton & Hove JSNA Summary 2012

4. Improve continuity of care & one-to-one midwifery care during labour.
5. Improve choice of place of delivery by developing a midwife-led unit.
6. Implement the Sussex Together work programme.

Key links to other sections

- Pregnancy & maternity;
- Antenatal & newborn screening;
- Maternal & infant health;
- Healthy weight;
- Alcohol;
- Substance misuse;
- Smoking;
- Teenage conceptions

Last updated

September 2012

⁷ Royal College of Obstetricians and Gynaecologists. Standards for maternity care, report of a working party. June 2008. Available from: <http://www.rcog.org.uk/womens-health/clinical-guidance/standards-maternity-care> [Accessed on 31.6.12]

⁸ Department of Health. Maternity Services Pathway Payment System: A Simple Guide 2012/13. Gateway Reference: 17184

⁹ NPEU. The Birthplace Cohort Study: Key Findings. Available from: <https://www.npeu.ox.ac.uk/birthplace/results> [Accessed 1/7/12]

Why is this issue important?

Different areas of healthcare will have different needs for services and treatments. As many conditions are age-related, much variation relates to the age structure of the population, as well as other factors such as socio-economic deprivation or ethnicity, all of which impact on the likelihood of certain illnesses.

However, some variations are unwarranted, in that they cannot be explained by variation in patient illness or preferences. Such variations may have an impact on quality and outcome - for example indicating certain cancer treatments which people are less likely to receive if they live in one place rather than another or showing that different service models in different places may be more likely to achieve high uptake for screening than others.

High levels of activity which reflect unwarranted variation suggest that an area is investing more in this condition than elsewhere, and therefore investing proportionally less in other clinical areas, leading to potential waste, a failure to maximise value and developing health inequalities across geographical areas.

Key outcomes

- ***The key aim of examining variation is to reduce unwarranted variation in quality, safety and outcome, and in activity and cost***
- ***Targeting variation in his way will enable commissioners to maximise the value of the resources available, and in turn, to concentrate efforts on delivering the NHS Outcomes Framework and ensures the NHS achieves health outcomes that are amongst the best in the world***

Impact in Brighton & Hove

The local picture is derived from the NHS Atlas of Variations 2011,¹ published by the Department of Health. Although not covering every possible healthcare activity, it represents a broad view of the kind of variations where exploration is likely to be fruitful, based on discussion with national

clinical directors and clinical leads, as well as a wide range of other NHS organisations, public health and quality observatories, clinical networks, academics and some third sector organisations.

The key findings below are those areas where Brighton & Hove is either at the top or the bottom end of the national distribution, or where a series of indicators, taken together, give a broad impression. We indicate whether the overall picture is indicative of a positive picture or a possible area of concern.

However, it must be noted that the figures provided refer mainly to the 10/11 financial year, and there may have been some change since then.

Cancers and tumours (possible area of concern)

We have a low rate of lung cancer cases receiving surgery. Surgical treatment is considered to be related to survival.

We have a high rate of GP referrals for suspected cancer, which implies that work could be done on improving care pathways and specifically early detection in the community

Diabetes (possible area of concern)

There a number of indicators relating to diabetes which, taken together, suggest there may well be a high degree of unwarranted variation in the care of people with diabetes with an impact on the quality and cost of care locally. We have:

- high rates of lower limb amputation
- relatively high rates for excess length of stay in hospital for people with diabetes
- low rates for patients in the community receiving the full range of diabetes care processes
- high costs of insulin in the community
- poor uptake of diabetic retinopathy screening
- a relatively high rate of visual impairment as a result of diabetes

This implies that there may be very substantial scope for improvement in local diabetes care, and it is possible that resources in this clinical area are not being used as effectively as they might be.

¹ RightCare. The NHS Atlas of variation in Healthcare. November 2011. Available at: www.rightcare.nhs.uk [Accessed 27/08/2012]

Mental disorders (possible area of concern - but alternative hypotheses also likely)

These indicators give a confusing picture. We have

- a low number of patients identified with dementia, when compared with our expected prevalence
- low expenditure on dementia drugs
- low rates of hospital admissions in patients with dementia
- high rates of hospital admission for children with mental health disorders

These findings imply either a surprisingly low incidence of dementia locally or a system where identification and treatment of dementia is in need of significant improvement.

There may also be scope for a review of care pathways for children with mental health issues.

Problems of hearing (positive picture)

A high rate of audiology assessments and a low waiting time for assessment in newborns are positive measures for these services.

Problems of circulation (mixed picture)

These indicators give a mixed picture. The area has a high proportion of residents regularly involved in sports or physical recreation, but it must be noted that, even so, only a minority of adults are achieving desirable levels of exercise.

We seem to be less good at identifying people at risk of heart disease and stroke in primary care, as we are amongst the worst in the country.

Our use of implantable devices to support people with heart problems shows a mixed picture, with high rates for the use of pacing devices, but low rates for using implantable cardioverter-defibrillator devices.

We have high rates for elective angioplasty, and this could imply a reliance on this form of treatment over optimal medical management.

Dental problems (positive picture)

Although a few years old, the data suggests that children in Brighton & Hove seemed to have healthy teeth, and well over 90% of people can gain access to NHS dentistry.

Problems of the gastro-intestinal system (mixed picture)

These indicators suggest that we have a cautious approach to offering gall bladder removal locally, but we are amongst the highest for offering this as day case laparoscopic treatment. We have a low rate of gastroscopies and this needs to be considered in relation to our wider services for the investigation of the upper GI tract, including cancer care pathways.

Problems of the musculoskeletal system (possible areas of concern)

Two indicators stand out here. We have a high rate of knee treatments given using a small telescope inserted into the knee cavity, but the implication of this is unclear. However, the low rate of health gain from knee procedures implies that patients are being treated with a lesser degree of disability in Brighton than elsewhere, and suggests that a closer review of care pathways might be of benefit.

Problems of the genito-urinary system (possible areas of concern)

These two indicators suggest a review could be of value. We have a low rate of specialist investigation of people with urinary problems, and a high rate and acute kidney injury (acute renal failure) in emergency hospital admissions.

Reproductive health, maternity and neonatal care (positive picture)

We have a low rate of emergency admissions of home births, and readmissions to hospital of babies up to 14 days old. The low rate implies a successful outcome.

Emergency Care (possible areas of concern)

These indicators, taken together, suggest areas of potential concern. We have a high rate of Accident and Emergency (A&E) attendances, along with a low conversion rate to emergency admission - suggesting that a substantial proportion of attendances have conditions which are relatively mild. We also have a high rate of admission for cases that could potentially be managed outside hospital, suggesting that the links between hospital and community services need to be reviewed, along with the care management systems for chronic conditions.

End of life care (positive picture)

Taken together, these indicators give a positive impression. We have amongst the highest number of people dying at home (although at only 43%, there is still substantial scope for further improvement). We have amongst the lowest number of deaths of children that occur in hospital-very positive, due to the desire of children and their families for death to take place at home.

Imaging services (possible areas of concern)

DEXA scanning is used to measure bone density, which is in itself related to the risk of fracture, especially in older people. We have a low rate of DEXA scanning, which suggests we might need to review services in relation to fracture prevention.

Prescribing (area of concern)

Hypnotics are medications that encourage sleep for people with insomnia, but they are recommended for short-term treatment (up to 4 weeks) only. They include drugs such as benzodiazepines. We have the highest rate of hypnotic prescribing in primary care in the country, by a significant margin.

However, there has been recent work to support healthcare practitioners reduce the level of benzodiazepine prescribing, and this has resulted in a substantial reduction - the greatest in the South East. However, we remain an area with one of the highest prescribing rates both in the South East and the country as a whole, but the size of the difference between Brighton & Hove and the rest of the country has narrowed.

What we don't know

Evidence of variations does not identify good, bad or variant practice, but merely flags up areas where further investigation is needed.

Recommended future local priorities

Recommendations relate to those areas where we are an obvious outlier, or where a range of indicators suggest a system-wide review is needed.

1. Continue to tackle the exceptionally high rate of hypnotic prescribing in primary care.
2. Review diabetic care pathways.
3. Review management of people with dementia, specifically focusing on early identification

4. Review why people attend A&E services with conditions that don't need hospital care
5. Review management of urinary problems.

Other areas which are flagged by this set of measures as being in possible need of review are:

6. Use of surgery in lung cancer.
7. Identification of people with cardiovascular disease in primary care.
8. Optimal medical management for people with cardiovascular disease.
9. Care pathways for knee surgery.
10. Services for fracture prevention.
11. The management of upper GI conditions

Key links to other sections

- Emotional health and wellbeing
- Mental health
- Ageing well
- Dementia
- Diabetes
- Urgent care

Further information

RightCare. The NHS Atlas of variation in Healthcare: November 2011. www.rightcare.nhs.uk

Last updated

May 2013

9. End of life care

Why is this issue important?

End of life care services support those with advanced, progressive, incurable illness to live as well as possible until they die. They also enable people to choose their preferred place of death. The provision of end of life care services has become increasingly complex as people are living longer with multiple conditions.

Surveys of the public have shown that the first preference for most people in the UK (56-74 %) would be to die at home, although as people become sicker and approach death this proportion may decline, as they want access to more extensive support, such as hospice care.¹

The Department of Health End of Life Care strategy (2008) seeks to enable people to die at the place of their choice; raise the profile of end of life care in the NHS and local authority; and enable discussions about preferred place of death to take place between families and friends.

Key outcomes

- **Improving the experience of care for people at the end of their lives (NHS Outcomes Framework)**

The National Dementia Strategy 2009 has a related objective of improving end of life care for people with dementia. (See Dementia section)

Impact in Brighton & Hove

Between 2008 and 2010 there were 2,159 deaths from causes which would have fulfilled the criteria for end of life care (cancer, respiratory, cardiovascular disease & other main cause of death). This is based on a crude death rate for persons as a percentage of the average annual number. This represented a crude death rate of 0.8%, lower than the England average of 0.9%.³ suggesting a lower per capita demand for end of life services. This would reflect the younger age profile of the city.

During this period, 48% of total deaths in Brighton and Hove occurred in hospital, whilst 41% occurred in the usual place of residence (including care homes). Whilst Brighton & Hove are performing slightly better than the England average (54% of

deaths fulfilling the criteria for end of life care occurring in hospital and 38% in the usual place of residence), England performance is poor. The England target is for 70% of all deaths to occur at the usual place of residence.

Table 1: Place of death for deaths fulfilling the criteria for end of life care, 2008 to 2010

	No of deaths in Brighton & Hove	Brighton & Hove %	England %
Hospital	1,034	48%	54%
Own residence	466	22%	20%
Care home	412	19%	18%
Hospice	153	7%	5%
Total	2,159		

Source: Office for National Statistics. Mortality data 2008 to 2010

There is no local data on preferred place of death for end of life patients apart from the 200 patients on the Palliative Care Local Enhanced Services Register in 2011/12. Of these 175 (87.5%) had their preferred place of death recorded and 81% died in their preferred place.

The financial spend per year on existing end of life care services is £3,792,843.² In 2010/11 total spend on hospice services per death was £731 and end of life care per death was £1,234.³

Where we are doing well

The End of Life Care Profile for Brighton & Hove (Table 1) shows a higher proportion of people are dying in their own residence (22%) than in the South East (19%) or England (20%). A lower proportion of people are dying in hospital in Brighton & Hove (48% for 2008 to 2010) compared with the South East (51%) and England (54%).⁴

² Flint A. End of life community services review. Power point presentation. NHS Brighton and Hove. 2012.

³ National end of life care Intelligence Network. National End of Life Care Profiles for Primary Care Trusts. Brighton & Hove. May 2012.

⁴ National end of life care Intelligence Network. National End of Life Care Profiles for Local Authorities. Brighton & Hove. May 2012
http://www.endoflifecare-intelligence.org.uk/end_of_life_care_profiles/la_2012_pdfs

¹ Department of Health. End of life care strategy. 2nd annual report. 2010.

9. End of life care

A new Palliative Care Partnership (PCP) service model has been introduced in 2013, between Sussex Community NHS Trust Community Palliative Care Team, and The Martlets Hospice at Home Team; to provide a seamless end of life care pathway for palliative and end of life care patients. This provides a more joined up service with a single point of access telephone hub, seven day a week visiting and 24 hours Consultant telephone advice.

A framework for assessing the quality of end of life care in care homes with nursing has been developed in partnership with the council.³

Following a survey of learning disability services, joint work has been progressing on reviewing the end of life care pathway for people with learning disabilities. Toolkits are being developed for learning disability social care providers and for specialist palliative care services.

A professional network for end of life care and learning disabilities launches in Brighton & Hove in September 2013.

Brighton & Hove is included in the Pan Sussex Integrated End of Life Dementia Pathway. This aims to improve the end of life care for people with dementia, and enable more to die in their preferred place of death; increase advance care planning for people with dementia; and increase practitioners knowledge and skills about end of life dementia care.

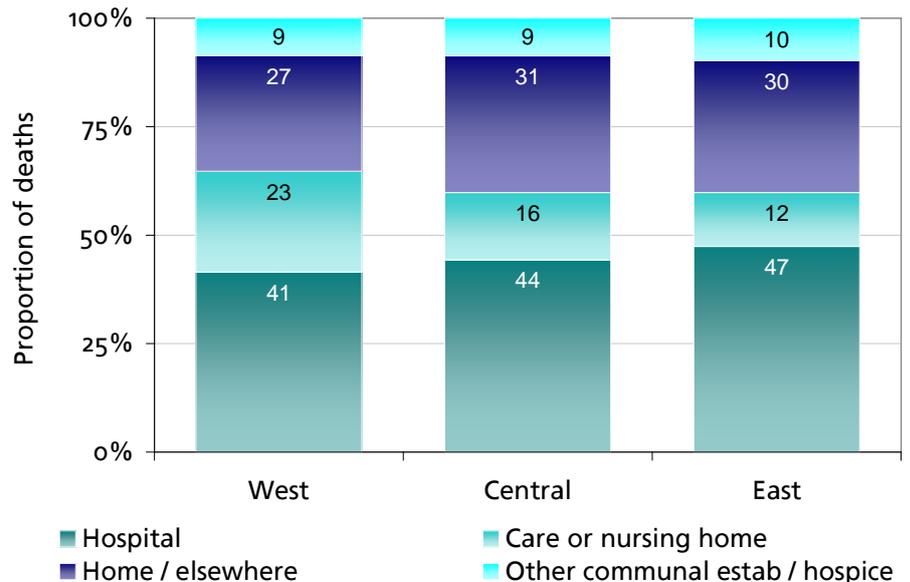
Local inequalities

Socio-economic deprivation is a major determinant of where, when and how people die. Nationally people living in the most deprived quintile (the poorest 20% of areas) are more likely to die in hospital (61%) than any other quintile (54-58%). People living in the most deprived quintile (11%) are less likely to die in care or nursing homes than any other quintile (16-20%).⁵

⁵ Deprivation and death: Variation in place and cause of death. National end of life care intelligence network. February 2012.

In Brighton & Hove, between 2008 and 2010, East locality had the highest proportion of deaths in hospital (47%), West had the highest proportion in care or nursing homes (23%), Central had the highest proportion of deaths at home (31%) and East had the highest proportion of deaths in other communal establishment or hospice (10%).

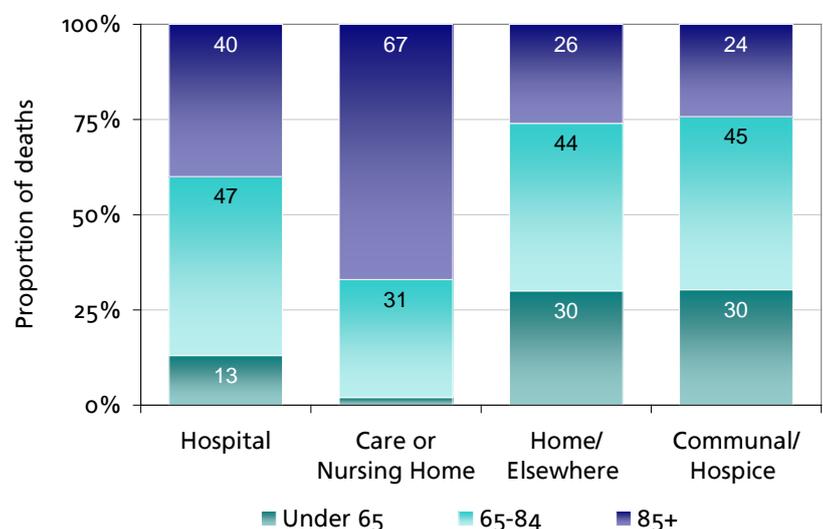
Figure 1: Place of death by Brighton & Hove Clinical Commissioning Group locality, 2008-2010



Source: Office for National Statistics. Mortality data 2008 to 2010

Nearly half of hospital deaths are of 65-84 year olds (47%) and the majority of people dying in care or nursing homes are aged 85 years or over (67%).

Figure 2: Place of death by age in Brighton & Hove Clinical Commissioning Groups, 2008-10



Source: Office for National Statistics. Mortality data 2008 to 2010

9. End of life care

A higher proportion of men die at home or elsewhere than women (35%) and slightly more men die in hospital (45%). A higher proportion of women die in a care or nursing home (24%) than men. This is likely to be a result of women living longer than men.

Between 2008 and 2010 a higher proportion of people with respiratory conditions died in hospital than with other conditions (Table 2). Cancer patients were more likely to die in a hospice.

Table 2: Place of death for deaths fulfilling the criteria for end of life care by cause of death, 2008-10

	Cancer	Cardio-vascular disease	Respiratory disease
Hospital	203 (34%)	312 (52%)	180 (64%)
Own residence	136 (23%)	149 (25%)	41 (15%)
Care home	93 (16%)	118 (20%)	50 (18%)
Hospice	141 (24%)	2 (0.3%)	2 (1%)
Total	593	602	279

Source: ONS mortality data 2008-10

Predicted future need

It is projected that the average number of deaths per year will have decreased very slightly by 2035, to an estimated average of 2,000.⁶ As more people live longer demands on end of life services are expected to increase.

What we don't know

We do not know what the preferred place of death is for Brighton & Hove residents.

There is no data available on sexual orientation, ethnicity, gender reassignment or other protected characteristic groups.

Key evidence and policy

Key evidence and policy can be found in the Department of Health national End of Life Care Strategy 2008.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_086345.pdf

Sixteen NICE Quality Statements set out the standard of care to be provided in end of life care. <http://www.nice.org.uk/media/EE7/57/EoLCFinalQS.pdf>

Recommended future local priorities

1. To continue the development of Electronic Palliative Care Coordination System for the sharing of electronic information on end of life care.
2. Work to increase the number of end of life care patients on GP registers.
3. Roll out of Bereavement Support
4. Review of the end of life care patient pathway.
5. Train SECAmb staff to treat people in the preferred place of care.

Key links to other sections

- Adults with physical disabilities or sensory impairments
- Adults with learning disabilities
- Carers
- Older people – Social care
- Coronary heart disease
- Respiratory disease
- Cancer
- Stroke
- Dementia

Further information

End of Life Care Network
<http://www.endoflifecare-intelligence.org.uk/home.aspx>

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⁶ Office for National Statistics (ONS). Public Health Mortality Files 2008 to 2010; ONS 2010-based Subnational Population Projections