Translation? Tick this box and take to any council office

ترجمة؟ ضع علامة في المربع وخذها إلى مكتب البلدية.	Arabic ❑
অনুবাদ? বক্সে টিক চিহ্ন দিয়ে কাউন্সিল অফিসে নিয়ে যান।	Bengali ❑
需要翻译？请在这方格内加刷，並送回任何市議會的辦事處。	Cantonese ❑
ترجمه؟ لطفا این مربع را علامتگذاری نموده و آن را به هر یک از دفاتر شهرداری ارائه نمائید.	Farsi ❑
Traduction? Veuillez cocher la case et apporter au council.	French ❑
需要翻译？请在这方格内划勾，并送回任何市议会的办事处。	Mandarin ❑
Tłumaczenie? Zaznacz to okienko i zwróć do któregokolwiek biura samorządu lokalnego (council office).	Polish ❑
Tradução? Coloque um visto na quadrícula e leve a uma qualquer repartição de poder local (council office).	Portuguese ❑
Tercümesi için kareyi işaretleyiniz ve bir semt belediye burosuna veriniz	Turkish ❑
	other (please state) ❑

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5513 produced by the communications team, Brighton & Hove City Council

Look inequality

Annual Report of the Director of Public Health Brighton & Hove 2014-15

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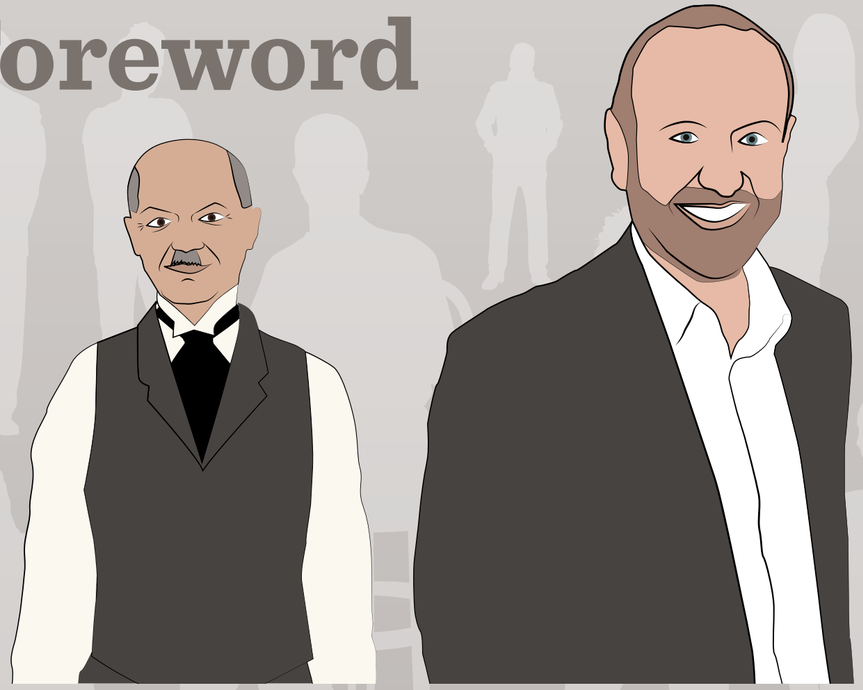

That's me on the right, the winged collar and Charlie Chaplin moustache are not quite my thing. My rather severe colleague is Dr Duncan Forbes, who back in 1912, as Medical Officer of Health for Brighton first reported on inequalities. You can read more about this inside. He measured infant mortality across five social class groups and found that infant death was 2.7 times more likely among the deprived than it was among the affluent. Today infant mortality rates have fallen dramatically - by over 1,200%, but the ratio between the most deprived and most affluent is still 2.1. We have made huge strides in infant health, but nullifying inequalities may take a bit longer.

Inequalities offend our sense of fairness and justice, our morality, and are bad for public health. Reducing inequalities brings benefits, not just to the 'least equal', but to society as a whole; benefits in health, social wellbeing and the economy. This report documents inequality in Brighton & Hove and it is very timely, for there is a perception that inequalities are wide and that they are set to widen further. The report shows that it is not quite that simple, and that the scale, distribution and direction of inequality in its many facets: education, housing, employment, income, health, crime and the environment, is quite variable.

It is a substantial report with a lot of evidence and technical information, but we have tried to make it as accessible and readable as possible. There is a separate supplementary report on the full impact of Welfare Reform, and a pull out section documenting the real lives of some of our 'less equal' residents. Data tells you so much, while the experience of people who 'live inequality' sheds light where no graph, table or carefully crafted prose can.

As ever, I am indebted to many colleagues across the city, all of whom have endured my relentless revisions of their contributions. The core team of Kate Gilchrist, Nicola Rosenberg, Peter Wilkinson, Alistair Hill, Chris Naylor and Sara McMillan have been most resilient, with excellent support from our Intelligence Team, imaginative flare from Creative Services team and a scrutinising proof reading eye from Ellie Katsourides. I am grateful to them all and one of these days, I will leave them alone (but not just yet).

The report includes examples of how to address inequalities, but any report on inequalities prompts some self-reflection, with questions about how we wish to live together, how much we value one another and our own place in society. This report doesn't pretend to provide answers to these difficult philosophical questions, but it does seek to encourage the debate, and I am confident it will.

Dr Tom Scanlon
Director of Public Health
Brighton & Hove City Council

Executive Summary

Tom Scanlon
Director of Public Health, Brighton & Hove city Council

This report explores inequality in Brighton & Hove. The dimensions of inequality examined are those identified in the Index of Multiple Deprivation: income, employment, health, education, housing, crime and the living environment. The measures of inequality used in the report are 'absolute' and 'relative inequalities', and the 'slope index of inequality'. The terminology used includes most deprived, and least deprived or most affluent; these refer to the sum of the dimensions of the Index of Multiple Deprivation and not just income. The report also uses cartograms - maps that are distorted in order to illustrate the size of an effect in a particular area.

Some groups are considered in more detail, in particular the young, the old and people from ethnic minorities. As the inequality data on certain protected groups is limited, the report also includes a series of case histories to shed light on what inequality means for different people. There are also examples of good practice in reducing inequalities in Brighton & Hove, and the report concludes with a section on recommendations.

Dr Becky Jarvis
(Happiness Champion)
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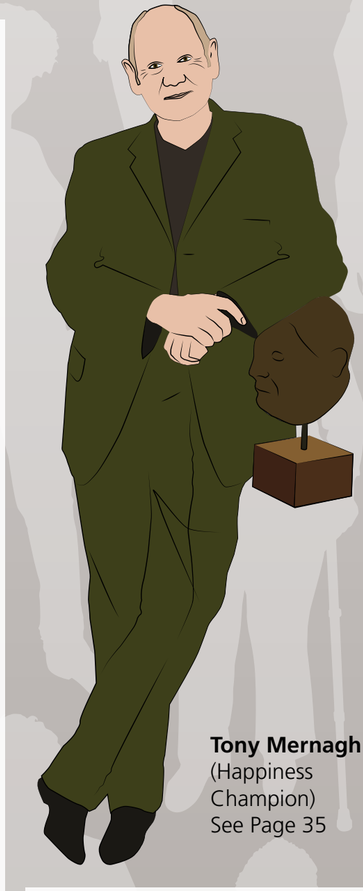
Overall deprivation

Overall deprivation levels as measured by the Index of Multiple Deprivation are higher than average in Brighton & Hove and the pattern of deprivation has changed little in the last decade; older people are less likely to live in more deprived areas and people from ethnic minority groups are more likely to live in deprived areas. Severe and multiple deprivation (homelessness, substance misuse and involvement in the criminal justice system), which is often accompanied by mental health symptoms has decreased over the last decade, and is now concentrated in the east of the city, particularly in Queen's Park. Tackling multiple deprivation requires coordination across a range of services, however initiatives like 'Stronger Families, Stronger Communities' can reap rewards.

Health

There has been some progress in reducing health inequalities over the recent years in Brighton &



Tony Mernagh
(Happiness Champion)
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Hove. Life expectancy is increasing and the gap between male and female life expectancy has fallen in recent years. However, each year in Brighton & Hove 500 extra people die due to deprivation, and 87 of them die before they are 75 years old. There is a strong association between mental ill health and deprivation, although this may be reducing. There is also a strong association between disability and deprivation, and this is becoming more marked. The relationship between lifestyles and deprivation is changing and there is no longer any association between drinking

above recommended limits, or being overweight and deprivation. There is however, a strong relationship between obesity and deprivation. In order to tackle the health inequalities that are due to deprivation, a life course approach is required. There is a good evidence base and the evidence is particularly strong for interventions in the early years through, for example, Children's Centres.

Younger people and older people

Child poverty affects 1 in 6 children in Brighton & Hove, although this is actually lower than in comparator cities or nationally. The highest rates are in the east of the city where 1 in 3 children live in poverty, and among certain groups like ethnic minority groups and gypsies and travellers. Levels of poverty among older people are lower and have fallen in recent years. The area with the highest proportion of older people (Rottingdean) actually has the lowest concentration of older people in poverty. Strategies to improve inequalities in children need to include initiatives to increase educational attainment, improve living conditions and support families into work. Strategies to address inequalities in older people need to include initiatives to tackle isolation, self-confidence, as well as practical issues like transport, carer support and financial inclusion.

Dave Padwick
(Happiness Champion)
See Page 69

Income

Income is the biggest driver of inequality, and in Brighton & Hove residents face the combined challenge of average wage levels and high housing costs. Recent rises in wages have not matched rises in inflation; this is particularly the case for those on the lowest wages. Part-time wages have fallen recently, accompanied by more people working part-time. The inequality between male and female wages has reduced but only in those women earning higher salaries, women earning low wages have seen no improvement in gender equality.

Welfare reform

Recent welfare reform has seen some residents already at one end of the inequality spectrum experience greater financial pressure. These effects are seen across the whole of the city, and while in deprived areas more people are affected, even within affluent areas some people have been severely affected. Reductions in benefits levels, which may be extended further, mean that in Brighton & Hove securing employment is the most realistic route for many people to address the fall in income. Support staff working with people challenged by this new reality, will have to develop skills in motivation and be able to steer more people into employment.

Food and hunger

Food poverty is growing and the number of food banks in Brighton & Hove continues to increase. As in many other areas of inequality, tackling food poverty requires a coordinated approach to increase employment, promote living wages and enhance financial inclusion, as well as specific initiatives to improve knowledge of nutrition, cooking and shopping skills.

Education

Education is a powerful factor in improving life chances and reducing inequalities. It has the strongest influence in early years, hence the importance of initiatives like Sure Start. Within schools, taking a whole school approach to address health, social skills, attitudes and behaviours as well as academic achievement, can help to reduce inequalities. Academic achievement is then a rather blunt tool to measure the full impact of schooling. In Brighton & Hove, there have been improvements in performance in pre-school readiness and within primary schools. The same cannot be said for secondary schools as measured by GCSE performance, where educational outcomes remain relatively poor. Adult education levels are very high but this may be at least in part the result of migration to the city, and university students staying on after graduation.

Employment

Like income, employment plays a dominant role in determining and resolving inequalities. Up to date employment figures are hard to obtain and proxies of benefit claimants are used. The number of people claiming Jobseekers Allowance claimants in the city is falling and the inequality gap between deprived and affluent residents is falling. The overall number of people claiming Employment Support Allowance or Sickness Benefit is also falling but there has been an increase in inequalities, most dramatic in the last year. People in receipt of Employment Support Allowance/ Incapacity Benefit are more deprived than they have been in previous years. In Brighton & Hove, nearly three times as many people (just under 13,000 people) are on Incapacity Benefit as are on Jobseekers Allowance (4,500 people). Worklessness (unemployed and actively, or not actively seeking a job) is higher in older people, women and some ethnic minority groups. In Brighton & Hove, because of competition from higher skilled and educated migrants to the city, low skilled residents, including many young people and single parents, face the biggest employment challenge.

Housing

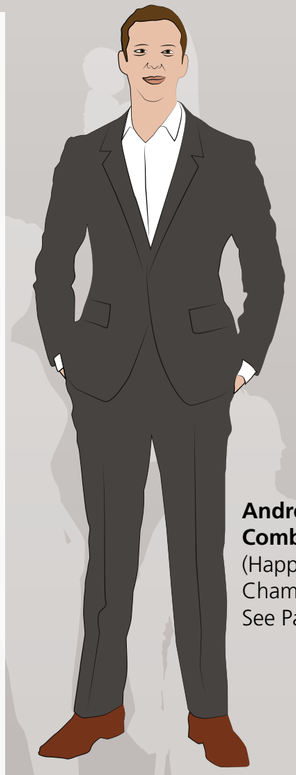
The last 20 years have seen increases in the inequalities in health and housing in the city. Residents renting from a housing association or the city council are increasingly more likely to be in poor health, have a long-term illness or disability and be at risk of major depression. Homelessness is the greatest manifestation of the effects of housing on health, and the average age of death of a homeless person is estimated at just 47 years. Homelessness, visible and invisible has been growing in the last 5 years and it is apparent that this represents one of the greatest inequality challenges to the city: one that will not be resolved overnight but like other inequalities in the city, will require the determined, resolute and coordinated efforts of many people.

Crime

The data on crime does not reflect the full extent of certain crimes such as assault with minor injury, criminal damage and theft, more than half of which are unreported. That said, just as there is nationally, in Brighton & Hove there appears to be a strong relationship between crime, anti-social behaviour and deprivation. The relationship is particularly strong regarding anti-social behaviour. Compared to the least deprived person, the most deprived person in the city is 5.1 times more likely to be a victim of anti-social behaviour and 1.6 times more likely to be a victim of acquisitive crime. As in other areas where inequalities apply, finding a solution to crime requires action across education, employment, health and social care as well as the criminal justice system.

Living environment

In Brighton & Hove, the geographical availability of green space does not reflect deprivation levels and some of the more deprived parts of the city have more green space, although there are some questions as to the quality of some of these spaces. Despite this potential availability, information on participation in the living environment shows that locally, deprived people are still less likely than affluent people to use open, green spaces. The reasons behind the relative inequality in the use of the living environment are not clear, however what is clear is the considerable potential to address inequalities by fostering a 'more equal' engagement in the living environment. Initiatives that promote the use of open spaces run the risk of increasing inequalities, as often the people who most take them up are those who are already using open spaces. Therefore, it is essential that planners work to involve local communities more in the design and operation of living environment initiatives if these inequalities are to be reduced.



Andrew Comben
(Happiness Champion)
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Conclusion

The picture of inequalities in Brighton & Hove is not straightforward and sometimes the findings are unexpected. There has been some improvement in some areas but in others, such as income, welfare reform, housing, secondary education and food poverty, the challenges remain substantial. There is one recurrent theme in this report: if we are to successfully tackle the inequalities that many people face, then a sustained, determined and coordinated approach across the city that engages people from the statutory, private and voluntary sectors as well as citizens themselves is required. This report aims to stimulate such a response.

Measuring inequality

Kate Gilchrist and Anjum Memon

1.1 Measuring multiple deprivation

Inequality has many dimensions and one of the main ways we measure the breadth of inequality is using the Index of Multiple Deprivation (IMD) 2010: an index based on seven dimensions or so-called domains. The IMD is updated periodically, and the 2015 IMD will be published later in the year. Therefore, this report uses the 2010 IMD, which also helps in looking at trends over time. The IMD data and related maps are published on the Brighton & Hove partnership intelligence website **http://brighton-hove.communityinsight.org/**, and later when available, information on the IMD 2015 will be published on the same site. The domains and weighting (percentage contribution from each domain) in the 2015 IMD update will be the same as the IMD 2010.

The Government measures multiple deprivation at lower super output areas (LSOAs – see box for definition) to provide information at a small area level. These LSOAs provide a (fairly) consistent geography to allow comparisons over time. The IMD 2010 combines 38 indicators from seven domains to arrive at overall deprivation scores for each LSOA, which are then ranked across England.

These domains are considered in more detail in relevant sections of the report. There are also two supplementary indices within the IMD: the Income Deprivation Affecting Children Index (IDACI), and the Income Deprivation Affecting Older People Index (IDAOPI). These are described later in the report.

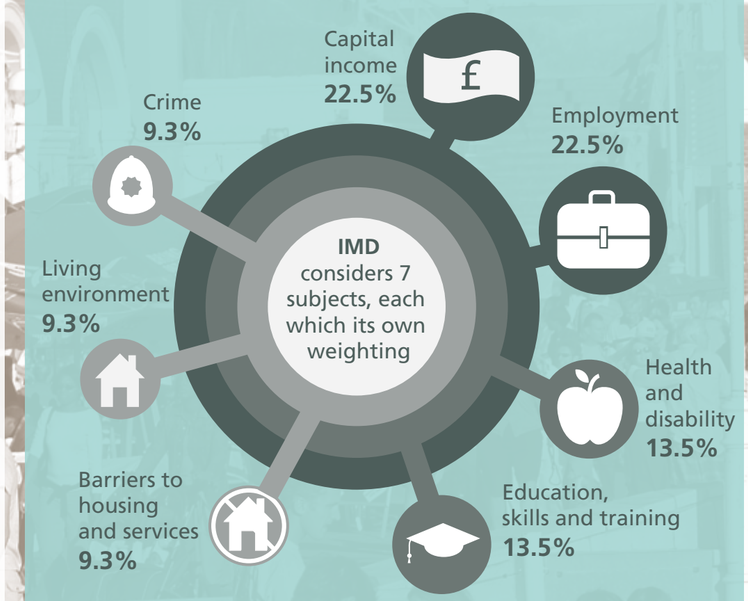
This report splits local LSOAs into quintiles (fifths) based upon their deprivation score and makes reference to the difference between the most deprived and the most affluent groups/people ('affluent' is used solely for ease of reading, the IMD measures deprivation rather than affluence). It is important to remember that the IMD deprivation index measures several domains, so these findings, and the terms 'deprivation' and 'affluence' used throughout the report do not simply relate to income, but rather to a composite of all the domains of the index.

While the domains of the Index of Multiple Deprivation (IMD) paint a wide picture of the dimensions of inequality, this is still not the full picture. For example, certain groups and communities experience inequality through discrimination. Therefore, this report also considers the experience of different individuals and communities in Brighton & Hove using other data, including case studies. It is not possible to show the experience of every population group but the scope of the report is considerable.

Lower Super Output Areas are used to report small area statistics in England and Wales. First introduced in 2004, each LSOA contains on average 1,500 people, with a minimum of 1,000 people. Prior to 2013, there were 32,482 LSOAs across England, and 164 in Brighton & Hove. The LSOA with a rank of 1 is the most deprived and the LSOA with the rank of 32,482 is the least deprived.

LSOAs can change however with population changes. Where populations have grown, LSOAs may be split into two or more areas; or where populations have shrunk, LSOAs may be merged.[1] In 2013, the number of LSOAs increased to 32,844 LSOAs in England and 165 in Brighton & Hove where one LSOA in the New England quarter split into two following an increase in the population associated with housing developments between the two Census periods.

The seven domains of the Index of Multiple Deprivation (IMD)



Note: the variables that make up each domain can be found at: http://brighton-hove.communityinsight.org/

1.2 Relative versus absolute inequality

Health inequalities are remarkably consistent across time and place. Some researchers such as Johan Mackenbach, Professor of Public Health at Erasmus University, have argued that what is most important to those living with the highest rates of ill health or mortality is the absolute improvement, rather than the relative rate of improvement compared to others.[2]

When considering inequalities in relative terms, a ratio of the most deprived to the most affluent is often shown. An alternate presentation is the absolute difference between the most and least deprived. Depending on the situation, one presentation may be more meaningful. The discussion on infant mortality over the last 100 years in Chapter 3 illustrates this dilemma well. The relative ratio between the most and least deprived has changed a bit, however the absolute difference has improved dramatically with huge reductions in infant mortality.

1.3 The Slope Index

Simply measuring inequality between the most deprived and most affluent groups is a little crude, as it does not explain the total extent of inequalities across the whole spectrum of the population. The size of the population affected in each deprivation quintile may make a difference, and the numbers of people in different groups changes over time.

This report also uses the "Slope Index of Inequality", which takes into account all population groups ranked by their IMD quintile and population distribution. The Slope Index of Inequality (SII) illustrates the relationship between a group's health status, its deprivation rank and the population living there. It can also demonstrate the absolute effect of moving up or down by one 'unit' of deprivation. Theoretically, the slope index shows both the absolute range and relative index of inequality between the most deprived and the most affluent individual (the hypothetical absolute). The relative index of inequality is the number of times more likely the most deprived individual is to experience the event than the most affluent individual. This is illustrated in Chapter 11 on Crime.

1.4 Population Attributable Risk (PAR)

Yet another measure: the Population Attributable Risk (PAR), is used to show how much of a feature, such as mortality, can be attributed to deprivation. This measure is calculated by applying the lowest rates seen in the most affluent group to the rest of the population. We can then calculate the reduction in mortality if deprivation was eliminated.

1.5 Ethical arguments

Determining whether inequalities are increasing or decreasing is not just a matter of science, it is also a matter of ethics. No matter what measure is used the context of inequality can often be better understood by talking to a person affected. Therefore, this report makes extensive use of the voice and experience of local people. Several local residents have been interviewed and their experiences help to paint a much more nuanced picture of what it feels like to be less equal in this city.

The shape of inequality in Brighton & Hove

Kate Gilchrist

2.1 Deprivation in Brighton & Hove

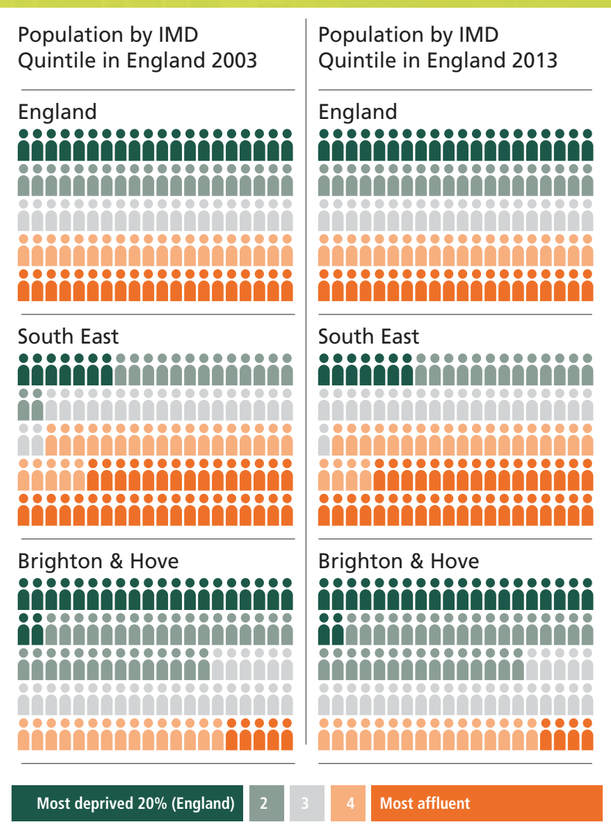
Deprivation is higher in Brighton & Hove than it is on average across England. In 2003, 54% of the city's population lived in wards included in the 40% most deprived areas in the country, and just 5% lived in wards considered to be in the 20% most affluent in the country. These figures have changed little in recent years. Today (figures from 2013), 56% of the city's residents live in areas included in the 40% most deprived in the country, and only 4% live in areas included in the 20% most affluent (Figure 2.1). Fourteen of the 21 wards in the city contain at least one LSOA in the 20% most deprived in the country; this has remained the same since 2004. Brighton & Hove is characterised by having a low proportion of people in the most affluent group and a high number of people in the second to most deprived group.

Figure 2.2 shows a map of the Index of Multiple Deprivation for 2010 by lower super output areas in each of the national deprivation deciles (10% of areas). As discussed above over 50% of the population live in LSOAs included in the 40% most deprived in the country.

Figure 2.3 shows the individual component dimensions of the IMD and what proportion of Brighton & Hove LSOAs are more, or less deprived in that context. Brighton & Hove fares poorest in the domains of Living environment, Health and disability, Barriers to housing and services, and Employment. Only in the Education domain do we see a "greener" "i360" picture.

A 'Reducing Inequality Review' was conducted for the city in 2007 and has been updated for this report. It shows the characteristics of those groups living in the most deprived areas of the city.[1] There has been very little movement in these indicators over the last decade.

Figure 2.1 Proportion of people living in each deprivation quintile in England, for England, the South East and Brighton & Hove, IMD 2010 and Mid Year Population Estimate 2013, compared with 2003 population



Source Communities and Local Government and Office of National Statistics mid year estimates

Summary changes in the deprivation profile of Brighton & Hove

- In 2006, 19% of all people resident lived in the 20% most deprived areas – this is similar in 2013 at 20%;
- The percentage of children and young people aged 0-15 years living in the 20% most deprived areas has changed little - from 20% in 2006 to 19% in 2013;
- Children in low income families are more likely to live in deprived areas with 41% living in the 20% most deprived areas of the city;
- Older people are less likely to live in deprived areas with 18% of people aged 65 or over living in the 20% most deprived areas in both 2006 and 2013. Whilst this difference may seem small, it is in fact statistically significantly different.
- In 2001, 22% of people in ethnic minority groups (non White UK/ British) lived in the 20% most deprived areas – in 2011, this rose to 23%. Again, whilst this difference may seem small, it is statistically significantly different.

People from BME groups, both in 2001 and currently, are significantly more likely to live in more deprived areas

Source Data sourced from Census 2001 and 2011, Office for National Statistics Mid-Year estimates and Communities and Local Government

Note Data is not available at this level for all groups including for trans and sexual orientation. Other population groups, such as disabled people, are looked at later in the report.

Figure 2.2 Indices of deprivation in Brighton & Hove by Lower Super Output Area – quintile in England 2010.

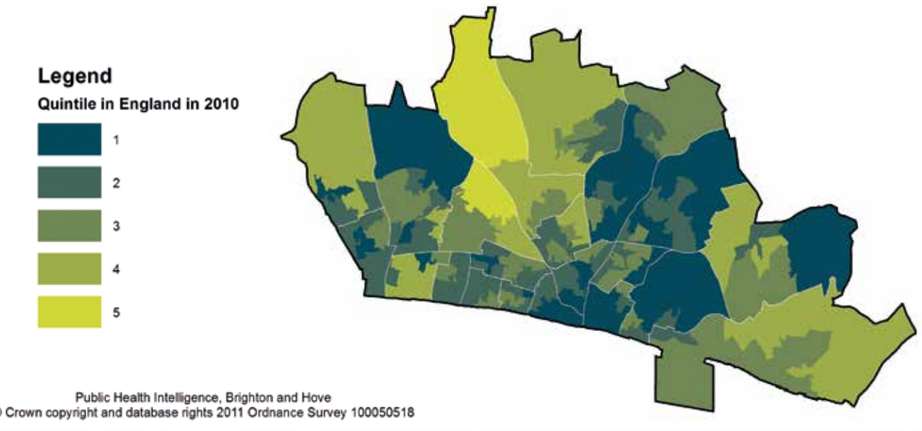
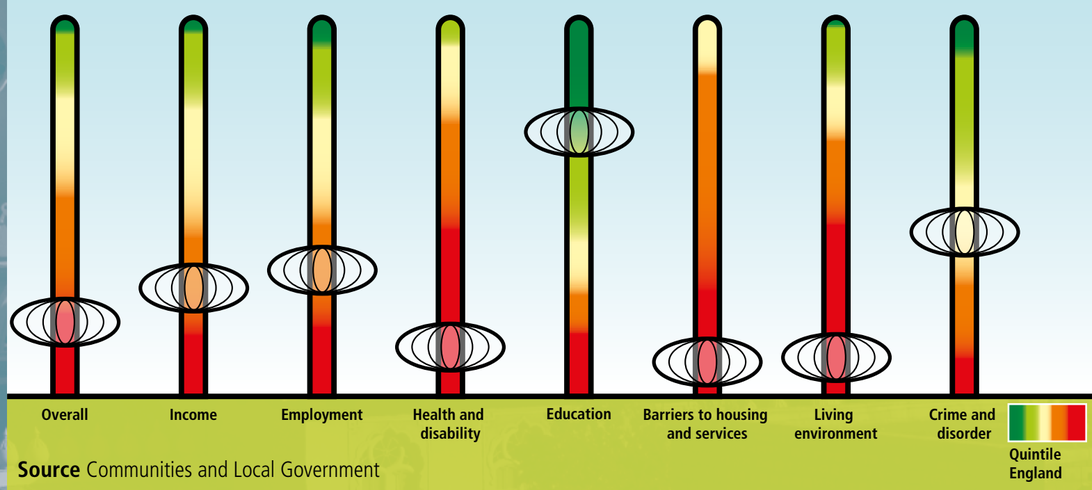


Figure 2.3 The Brighton & Hove "i360" deprivation by Index of Multiple Deprivation domains (2010); distribution of LSOAs by decile in England.



Source Communities and Local Government

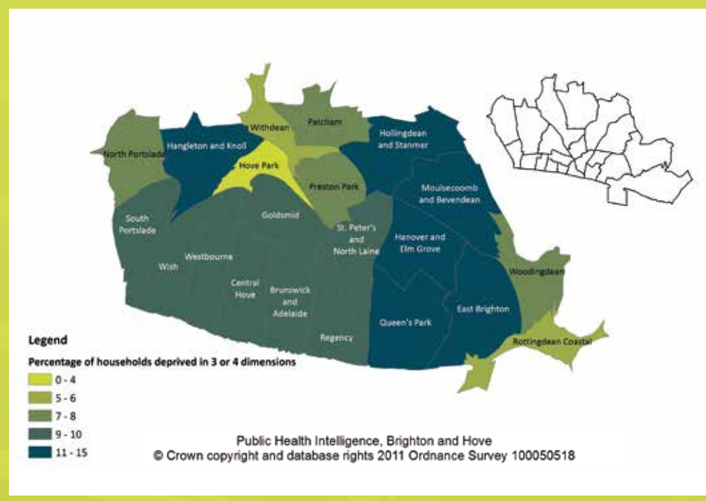
2.2 Multiple deprivation in Brighton & Hove

Using 2011 Census data the Office for National Statistics have produced figures for 'multiply deprived households' across four important dimensions: employment, education, health / disability, and housing. A household is deprived if they meet one or more of the following conditions:

- Employment: any member of a household not a full-time student, who is either unemployed or long-term sick;
- Education: no person in the household has at least level 2 education (e.g. GCSE A*-C/ NVQ Level 2/BTEC), and no person aged 16-18 is a full-time student;
- Health and disability: any person in the household has 'bad or very bad' general health or has a long-term health problem; and
- Housing: Household's accommodation is either overcrowded, with an occupancy rating -1 or less, or is in a shared dwelling, or has no central heating.

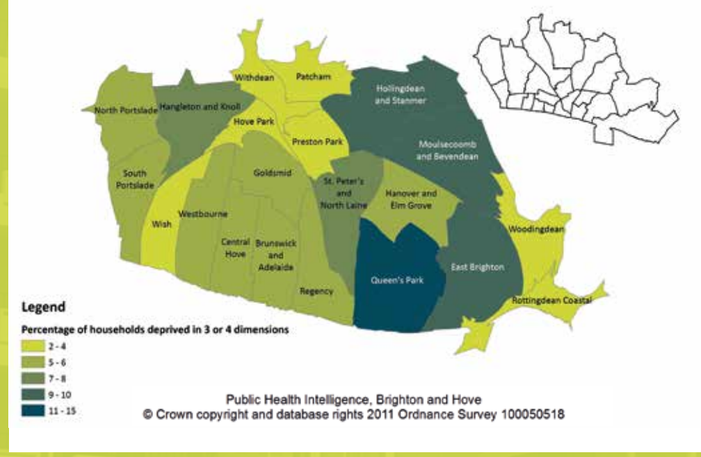
Within Brighton & Hove 1,050 households (0.9% of all households in the city) are deprived across all four dimensions, with an additional 6,700 (5.5% of households) deprived in three of the four dimensions. The percentage of households deprived across three or more dimensions (6.4%) is higher than England (5.7%) and considerably higher than the South East (4.0%).[2] The majority of households (76%) are deprived in one or none of these dimensions.

Figure 2.4 Multiply deprived households in Brighton & Hove by ward 2001



Source Census 2001 Table UV67Figure

Figure 2.5 Multiply deprived households in Brighton & Hove by ward 2011



Source Census 2011 Table QS119EW

Cartograms
Cartograms are distorted maps where a particular characteristic is applied to a given land area and that area adjusted accordingly to illustrate the size of that particular characteristic. In the case of this report, all cartograms have been created using the ward areas of Brighton & Hove. A colour scheme has been added to emphasise where the effect is greatest. So for example, when considering multiple deprivation, if this is particularly high in a ward, then the ward will be proportionally larger and a darker colour, whereas if multiple deprivation is low, then the ward will shrink in size and be light coloured.

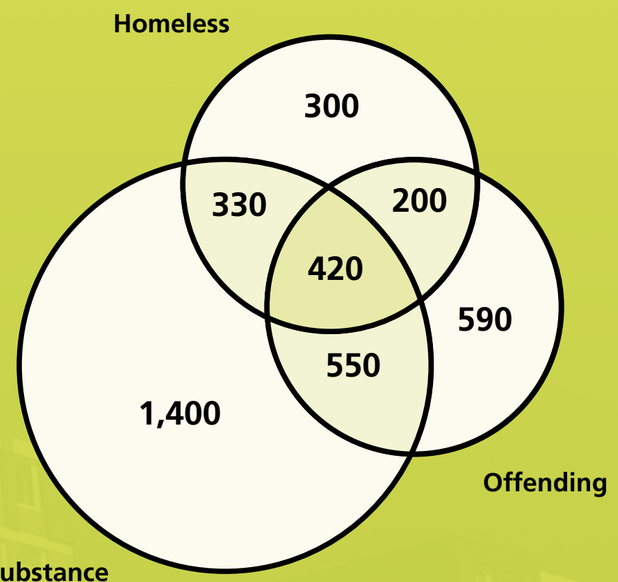
Ten years previously (2001 Census) 1,500 households were deprived in all four dimensions. There have been some minor changes to the definition of these dimensions, including the removal of the age restriction on employment. Nevertheless, there appears to have been a substantial reduction in numbers of households in Brighton & Hove between 2001 and 2011 that experience multiple deprivation across employment, education, health and housing. These findings are similar nationally. There is no data for this multiple deprivation post 2011, and so whether this trend has continued cannot be currently stated.

The reduction in numbers of multiply deprived households has seen them increasingly concentrated in the more deprived areas of the city. In 2001, around one-third were located in the most deprived 20% of areas; by 2011 this had increased to 41%. The largest concentration, as illustrated in the cartogram (Figures 2.4 and 2.5), is now in Queen's Park ward.

2.3 Severe and Multiple Disadvantage (SMD) in Brighton & Hove

Information on severe and multiple disadvantage comes from a recent report from the Lankelly Chase Foundation - "Hard Edges: Mapping severe and multiple disadvantage" profiled severe and multiple disadvantage (SMD) across England. [3] Severe and multiple disadvantage is a shorthand term used to signify the problems faced by adults involved in the homelessness, substance misuse and criminal justice systems in England, with poverty almost universal, and mental ill-health common.

Figure 2.6 Overlap of SMD disadvantage domains, Brighton & Hove, 2010/11



In Brighton & Hove, an estimated 20 per 1,000 working age adults receive services across at least one of the three domains. There is overlap but the estimates are that 14.2% of working age adults receives services for substance misuse, 9.2% for offending and 6.6% for homelessness. This gives a total figure of 3,790 affected (420 with all three, 1,080 with two and 2,290 with one). These findings are illustrated in Figure 2.6. Brighton & Hove ranks 61st highest (worst) of 151 local authorities in England.

The report also estimates the number of adults receiving support for at least one of these issues that also have mental health problems. In Brighton & Hove this estimate is 1,970 adults. The authors note however, that the incidence of mental health problems may be significantly greater than is recorded in the data used. Thus these figures may underestimate the overlap between mental health problems and severe and multiple disadvantage.

2.4 What does it all mean?

Deprivation is higher in Brighton & Hove compared to the national average. In addition, the proportion of people classed as the most affluent is particularly low compared to national figures. The pattern of overall deprivation has changed little in the city over the last decade. Deprivation is most marked in the areas of health and disability, living environment, housing and employment. Older people are less likely to live in deprived areas of the city. People from Black and Minority Ethnic (BME) groups are more likely to live in deprived areas. There is limited information on other population groups in this respect.

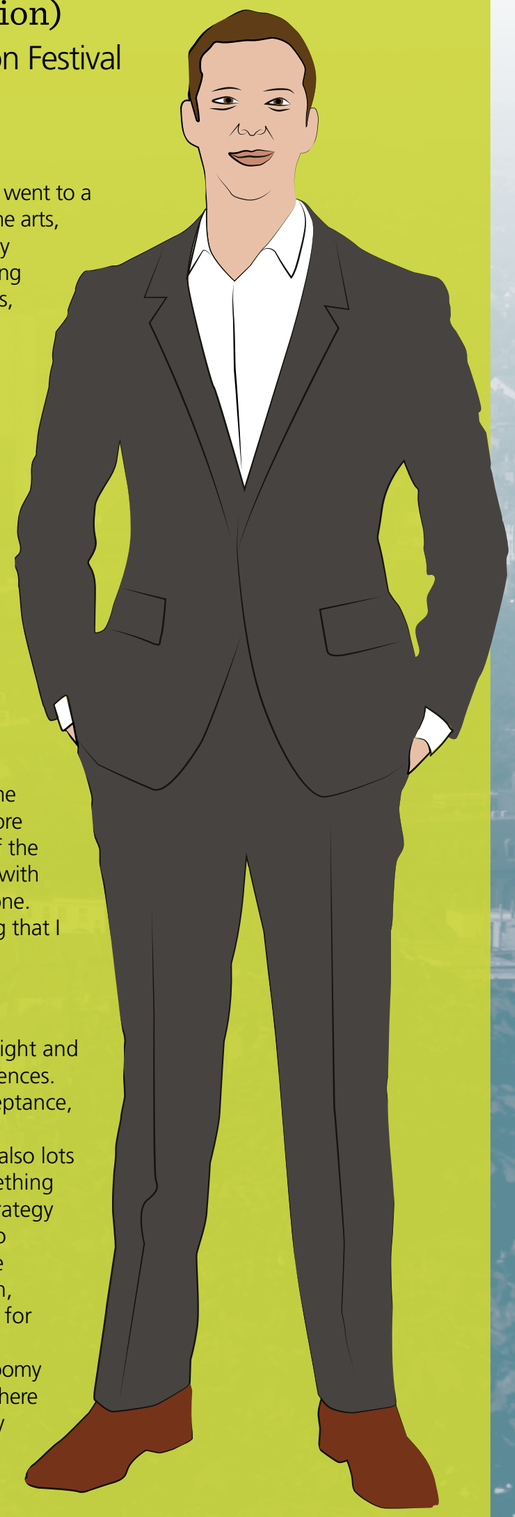
Multiple deprivation in the city decreased between 2001 and 2011 with the result that people with multiple deprivation are increasingly concentrated in the east of the city, with Queen's Park having the highest proportion of people living with multiple deprivation.

Tackling multiple deprivation requires coordination across a range of services and organisations. One of the approaches taken in recent years to supporting families affected by multiple deprivation has been through the Stronger Families, Stronger Communities team. The scope of support required to tackle multiple deprivation is considerable but there is evidence that it can work (see Chapter 4, Younger People/Older People).

Andrew Comben (Happiness Champion)

Chief Executive Brighton Dome and Brighton Festival

Interviewed by Tom Scanlon



Past

Some people are a little surprised to learn that I am Australian. I went to a Sydney state primary school that wasn't particularly strong on the arts, however one of the parents was a bass trombonist in the Sydney Symphony Orchestra and he ran the school band. I started playing French horn, and singing in the choir, encouraged by my parents, although neither are particularly musical, and I won a music scholarship in Melbourne. At 12 years of age I found myself touring as a chorister, regularly visiting the UK. I moved here permanently when I was 21 with the intention of a musical career. There is something about performing at an early age that gives you responsibility; you are treated as an equal to other, older performers. However, as I realised I might not make it as a musician I supplemented my income with other arts-related work. My big break – literally – came when a new computer system broke down at the Wigmore Hall and I cheekily told the office manager I could sort it. He said if I could there was a job for me. I fixed it and sure enough I found myself in employment.

Present

I became Chief Executive of Brighton Festival seven years ago having worked in many administrative arts roles across the country. Working in a role that supports artistic life, suits me perfectly. I don't perform but still get to be creative. I can explore ideas and watch them come to final fruition. My experience of the stresses and anxieties that all performers face helps in dealing with artists. The artists I most admire are those who do it for everyone. What helps define the Brighton Festival, and maybe something that I help bring as an Aussie, is that sense of egalitarianism.

Future

Brighton is the most Australian place in the UK, not just the light and the sky, but the people – embracing and open to new experiences. Of course there is inequality but I don't get any sense of acceptance, complacency or even absent-mindedness which you do see elsewhere. There is homelessness for example, but there are also lots of people, compassionate and determined, trying to do something about it. I think it's great that we have a mental wellbeing strategy that brings all sorts of people together in a collective effort to improve happiness. The arts play an important role. There are still people who think that the arts are for certain people; rich, comfortable, educated in a certain way – they're not, they're for everyone. That's what I try to instil in the festival - something unifying, aspirational, virtuoso but not elitist. I do feel a bit gloomy about the national picture, but I am more optimistic that here, there are enough people trying to do it differently and better. We may fall on our face, but in the arts, that's the risk we take, and if we do fall, we just get up again.

Unequal health - unequal life and death

Kate Gilchrist and Nicola Rosenberg

3.1 Infant mortality

Deaths in infancy have been recorded for centuries; so infant mortality has provided a good barometer of health as well as inequalities. Historically in the UK and across some parts of the globe today, infant mortality is a key marker of poverty. As Dr Duncan Forbes, Medical Officer for Brighton wrote in his 1924 Annual Report, "We know that general sanitation and standards of health and social conditions have improved greatly, and played a greater part in reducing infantile mortality than the intensive (health service) work."

Infant mortality decreased from 160 infant deaths per 1,000 live births in 1901, to 4 per 1,000 in 2013 with 11 deaths in this year across the whole of the city. Happily, with such low figures, analysis of annual infant mortality in Brighton & Hove is no longer a very useful means of monitoring health inequalities, although collating data from several years can be helpful.

In 1913 Dr Forbes, published a comparison of infant mortality for the period 1901 – 1912 across different social groups. We updated these rates in our 2009 Public Health Annual Report and we do so again in this report. In the first decade of the 20th century, for every thousand children born in Brighton to the most vulnerable group (then classified as illegitimate mothers) 188 died before their first birthday: that is nearly one in five infants. This compared to an infant mortality rate of 67 per 1,000 births in the so-called 'well-to do' families. Both rates are huge by today's standards, but there was still a clear gradient of inequality. The enormous reductions in infant mortality across all social groups are striking, although there remains a clear gradient of inequality. The population groups looked at then and now are not precisely comparable, but by using a slope index of inequality, we can compare relative and absolute inequalities in infant mortality over a century (figure 3.1).

Today, infant mortality rates in the least deprived are three deaths per thousand births, and in the most deprived six deaths per thousand. Relative inequality rates have reduced by approximately one fifth, from 2.7 times higher in 1901-1912 to 2.1 times higher between 2009-2013, but most striking has been the reduction in absolute inequality, which continues to fall in the 21st century.

We should celebrate this success, while understanding that every infant death is a personal family tragedy and recognising that inequalities persist for, if all groups had the lowest infant mortality rates in Brighton & Hove today, there would be on average three fewer infant deaths in the city each year.

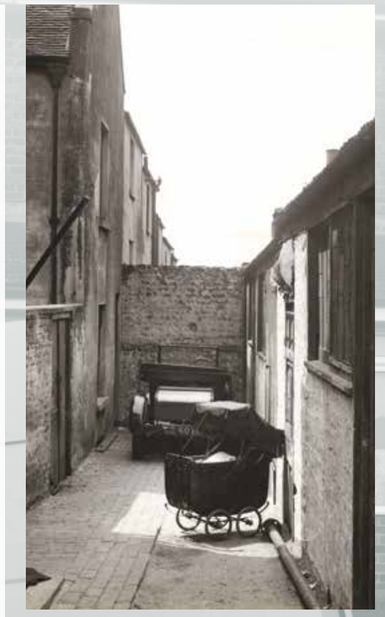
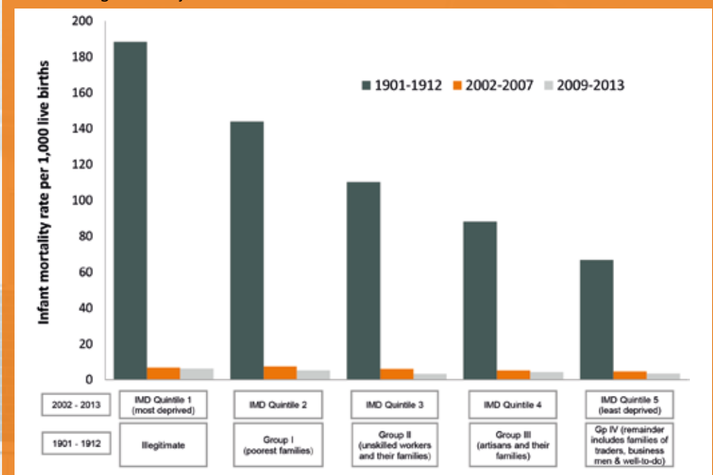
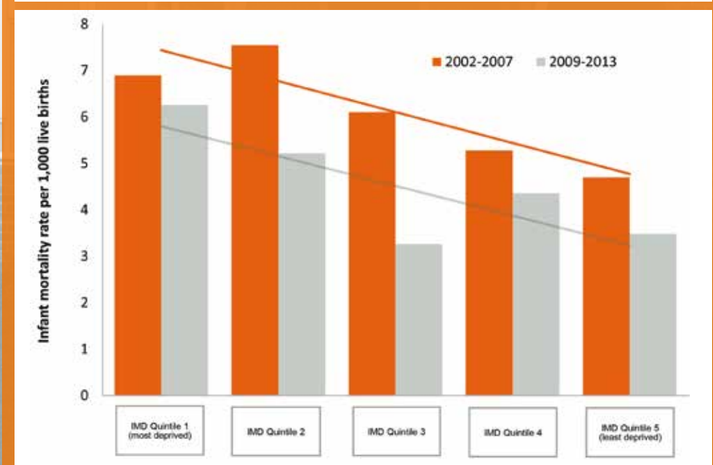
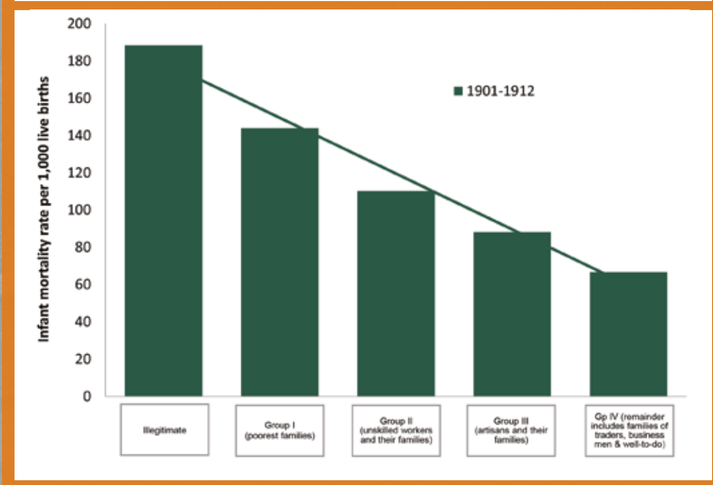


Figure 3.1 Infant mortality group by family status 1901-1912 and by Index of Multiple Deprivation quintile for 2002-2007 and 2009-2013, Brighton & Hove (1901-1912 is Brighton only)







Source Brighton & Hove City Council Public Health Directorate

3.2 Fertility, births, and low birth-weight

Fertility and births

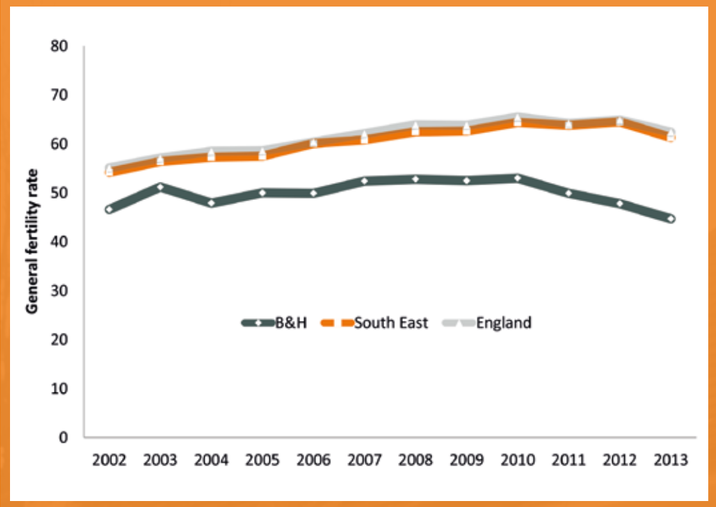
Birth rates in Brighton & Hove are falling. In 2013 in the city, there were 2,967 births to resident mothers – this was 200 fewer births than in 2012, and the lowest number seen in a decade. In 2013, in Brighton & Hove the general fertility rate (that is the number of live births for every one thousand females aged 15-44 years) was 45, much lower than both the South East (57) and England (62) (Figure 3.2). The city's general fertility rate has consistently been lower for decades, and this gap has increased in recent years. Most recently, Brighton & Hove has seen steady reductions since 2010, whereas across England the birth rate has been increasing since a low in 2001 (with the exception of 2012-13).[1]

When we consider births and birth rates by quintile of deprivation, the numbers of births are lowest in the two most affluent quintiles, and highest in the middle group. However, when we adjust for the numbers of women aged 15-44 living in each area, and look at birth rates we see a different pattern. In Brighton & Hove, women living in the most affluent areas have the highest birth rate, while those in the most deprived areas have a lower rate.

Low birthweight

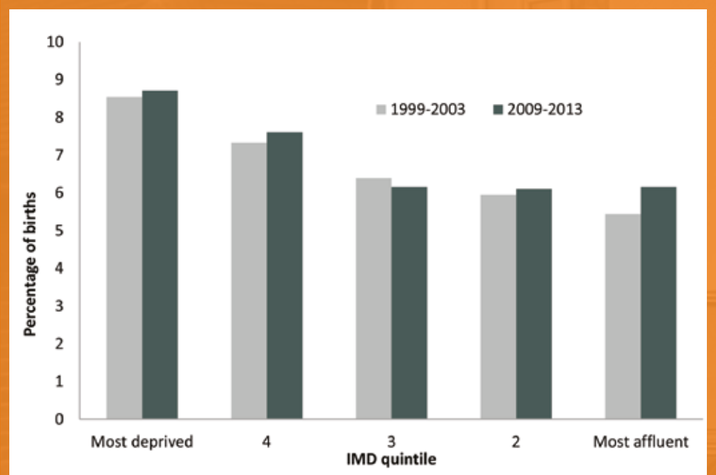
Babies born weighing less than 2,500 grams (5 lbs 8 oz) are defined as low birthweight. The main causes of a low birthweight are prematurity (being born before 36 weeks of gestation) or slow growth in the womb. Women who smoke during

Figure 3.2 General fertility rate: Number of live births per 1,000 females aged 15-44 years, Brighton & Hove, the South East and England, 2002-2013



Source Brighton & Hove City Council Public Health Directorate

Figure 3.3 Percentage of low birthweight births by IMD quintile in Brighton & Hove, 1999-2003 and 2009-2013



Source Brighton & Hove City Council Public Health Directorate

pregnancy are twice as likely as non-smokers to give birth to a low birthweight baby. Low income is also separately associated with low birthweight. [2,3]

Since the year 1999, in Brighton & Hove, 6 to 7% of babies have been born with a low birthweight. At the turn of the 21st century, (1999-2003) there was clear inequality, with 8.5% babies born to mothers living in the 20% most deprived areas of the city of low birthweight, compared to just 5.4% of babies born to mothers living in the 20% most affluent areas of the city. In relative terms the most deprived baby was 1.9 times more likely to be of low birthweight than the most affluent baby. By 2009-2013 this inequality had reduced and in relative terms the most deprived baby is now 1.5 times more likely to have a low birthweight compared to the least deprived baby. There is now an absolute difference of three babies in every hundred being born a low birthweight. As in the case of infant mortality, this is another example of reducing absolute and relative inequalities over time. Although examining low birthweight across deprivation quintiles (Figure 3.3), we see that only in the middle quintile has there been an actual reduction; so low birthweight is actually increasing, although the difference between different groups is falling.

This increase in low birthweight may reflect improved survival of babies born prematurely, higher incidence of multiple births and more births to mothers from BME groups. For example, low birth weight is more common in babies born to parents who are of Indian, Pakistani, Bangladeshi, African-Caribbean or black African origin, than babies who are born to white European parents.

Tackling inequalities – Gypsies and Travellers

The health of Gypsies and Travellers is much poorer than the general population,[4] with life expectancy 15-25 years less; an infant mortality rate three times higher; and parents 18 times more likely to experience the death of a child before they reach maturity, compared to other members of the population. Poor access to, and uptake of health services are factors in Gypsy and Traveller health. The 2012 needs assessment of the Gypsy and Traveller community in the city identified the following determinants of health:

Social stress; isolation; stigma; adaptability; gender roles; literacy;

Economic education and employment;

Environmental water and sanitation; waste disposal; warmth; transport;

Lifestyles smoking; poor diet; low breastfeeding rates and high sun-bed use.

Specific health priorities included obesity, oral health, mental health, and health care accessibility.[5] Friends, Families and Travellers (FFT) run a health improvement project with both housed and mobile gypsies and travellers in the city. A Health Promotion Outreach Worker - Emma, visits sites to provide support. Emma provides information on health topics, she supports women to stop smoking and takes a holistic approach on a number of issues including mental health. Over the last six months she has worked with 63 gypsies and travellers on issues such as maternal health, men's health, health care, debt, food, being active, alcohol and mental health. She organises well attended regular 'Zumba' sessions where a healthy lunch is also provided.

"We really enjoy Zumba. It's fun and you get fit. The biggest thing for me, is that me and my daughter get out and meet people. Emma helps us with other stuff like the forms for getting my little one into nursery. The teachers are a good laugh and let us choose songs, then we have some lunch and have a chat about health." (Miss M, who attends regularly)

Tackling inequalities – Breastfeeding

Breastfeeding rates in Brighton & Hove are amongst the highest in the country. The overall rate was 13th highest for the year 2013/14 for the percentage of mothers initiating breastfeeding (89%) compared with the England average of 74%. There is variation across the city, although even in areas with the lowest rates, they are above the national average. The community breastfeeding team supports mothers to breastfeed and seeks to reduce breastfeeding inequalities. Rates are relatively low in North Portslade and the team works with peer support volunteers and midwifery colleagues to increase breastfeeding. This year breastfeeding increased by 5% over the previous year and the number of mums attending the breastfeeding drop-in almost doubled.

The peer support worker contacts mums during their pregnancy, inviting them to the breastfeeding drop in, and then supports the family after birth by telephoning, visiting and attending the Children's Centre. This pro-active service, rather than waiting for mothers to ask, is proving effective in increasing breastfeeding rates. Peer support is a key way to encourage families and communities to see breastfeeding as the 'normal' way to feed a baby.

"I just wanted to say how grateful I was for the help and support. Breastfeeding was the hardest thing I have ever done and on many occasions I was ready to quit…but luckily with the support I persevered and now nearly a year later I am still breastfeeding. I wouldn't change it for the world. It was really nice to talk to other people at the Portslade support group and share stories and tips."

Afi Hoodless, new mum in Portslade.

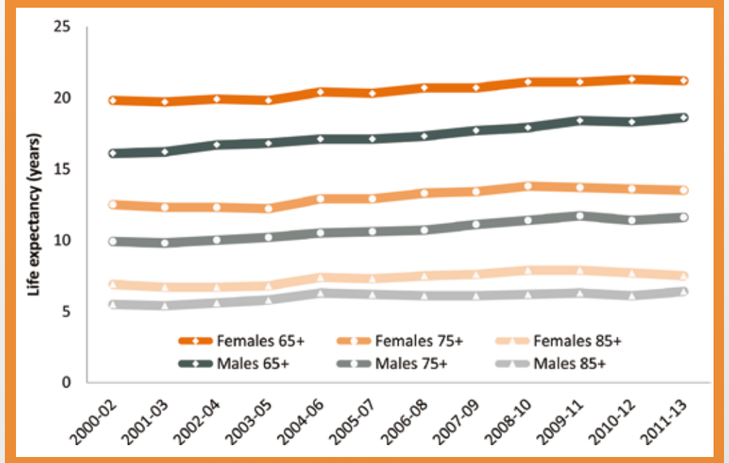
3.3 Life expectancy, healthy life expectancy and premature mortality

Life expectancy, healthy life expectancy

Life expectancy continues to rise. For females in the city it is the same as England (83.1 years): for males it is seven months less (78.8 years in Brighton & Hove compared with 79.4 years in England, in 2011 to 2013) (Table 3.1).[6] These increases in absolute life expectancy are seen at all ages. Even life expectancy for 85 year-olds, in both men and women, has increased by on average six weeks each year over the last decade (Figure 3.4).[7]

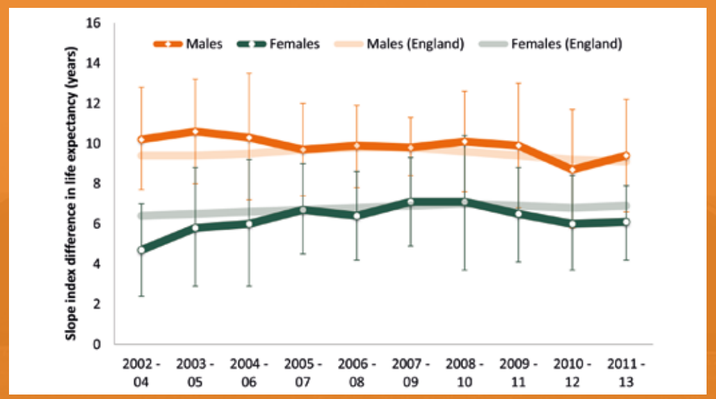
Healthy life expectancy is higher for females in Brighton & Hove compared to nationally, while for men it has varied against national figures. It is worth noting that the healthy life expectancy in men and women is below retirement age. (Table 3.1).

Figure 3.4 Life expectancy at age 65, 75 and 85 years by gender in Brighton & Hove, 2000-2002 to 2011-2013



Source Public Health England https://www.gov.uk/government/publications/life-expectancy-recent-trends-in-older-ages

Figure 3.5 Trend in Slope Index of Inequality in life expectancy in Brighton & Hove, Males and Females 2002-04 to 2011-13



Source Public Health England

Table 3.1 Life expectancy and healthy life expectancy at birth (in years) for males and females in Brighton & Hove and England, 2009-2011 to 2011-2013

Source: Office for National Statistics http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/healthy-life-expectancy-at-birth-for-upper-tier-local-authorities--england/index.html

Note: Healthy life expectancy is the average years a person would live in good/fairly good health if s/he experiences the local age-specific mortality and health rates throughout life.

	Males		Females	
	Brighton & Hove	England	Brighton & Hove	England
Life expectancy (years)				
2011-2013	78.8	79.4	83.1	83.1
2010-2012	78.7	79.2	83.0	83.0
2009-2011	78.5	78.9	82.6	82.9
Healthy life expectancy (years)				
2011-2013	62.8	63.3	64.4	63.9
2010-2012	63.6	63.4	66.5	64.1
2009-2011	63.0	63.2	64.0	64.2

Another way to look at this is the percentage of life spent in good health, for men this is 80% for the city and England, but for women it is lower at 78% in Brighton & Hove and 77% across England. Men have shorter lives, but a greater proportion is spent in good health.

More remarkable is the difference in life expectancy between the most and least deprived individuals in the city; 9.4 years for males and 6.1 years for females (2011-2013). This compares with a gap of 9.1 years for males and 6.9 years for females across England and is based upon the Slope Index of Inequality (Figure 3.5). In terms of progress against national equivalents there has been no significant change in the last 10 years.

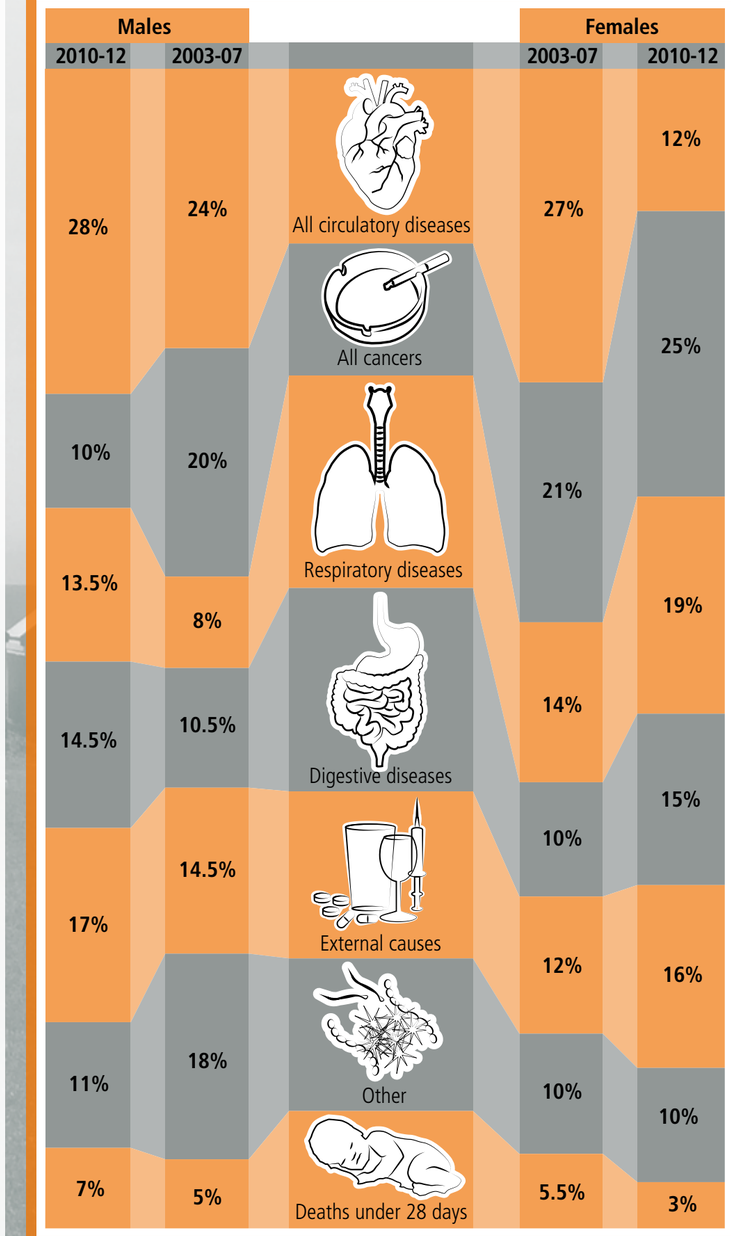
In females, cancer is now the cause contributing most to the gap in life expectancy between the top and bottom deprivation quintiles, increasing from 21% to 25% between 2003-07 and 2010-2012. The contribution of circulatory diseases has more than halved, from 27% in 2003-07 to 12% in 2010-12. As is the case for males, the contribution of respiratory diseases (14% to 19%), digestive diseases (10% to 15%) and external causes (12% to 16%) have all increased slightly.

For males, the greatest contributing cause in 2010-2012 remains circulatory conditions (28% compared with 24% in 2003-2007) but the contribution of cancer to the gap in life expectancy has halved from 20% to 10%. Respiratory conditions (8% to 13.5%) and digestive diseases (10.5% to 14.5%) which include alcohol-related conditions such as chronic liver disease and cirrhosis and external causes of death (includes injury, poisoning and suicide) (from 14.5% to 17%) have all increased slightly.

Causes of the gap in life expectancy

In the 2011 Public Health Annual Report we considered the contribution of different causes to the gap in life expectancy between the top and bottom quintiles in Brighton & Hove using data for 2003-2007. Public Health England have recently (January 2015) updated these analyses for each local authority in England for deaths in 2010-2012.[8]

Figure 3.6 Brighton & Hove Inequality gap, contribution of different diseases to inequalities in life expectancy



Source Public Health England

Premature mortality

These differences in life expectancy reflect differing mortality rates. Although the progress in reducing inequalities in life expectancy in Brighton & Hove is uncertain, there has been progress in improving mortality differences.

Over a five year period (2009-2013) a total of 2,534 deaths in Brighton & Hove of people of all ages can be attributed to the impact of deprivation. This is equivalent to over 500 deaths annually. On a positive note, this is an improvement on previous years, the same analysis for the years 1988-1992 shows that there were 873 deaths a year in the city attributable to deprivation (Figure 3.7). The improvements are much more marked in the 'all age' group as opposed to the 'under 75s' age group (Figure 3.8). Nevertheless, if all areas had the mortality rates of the least deprived 20% in the city, among those aged less than 75 years (2009-13 data), there would be on average 87 fewer deaths per year. During 1988-1992, there were on average 153 extra deprivation related deaths in those aged under 75 years.

Therefore, between the periods 1988-1992 and 2009-2013 when death rates fell in all quintiles of deprivation, there was a reduction in both absolute and relative inequalities in Brighton & Hove for all deaths at all ages.

Irrespective of these improvements, there is still some way to go with over 500 'inequality' or deprivation-related deaths in Brighton & Hove each year, 87 of people under the age of 75. The cartogram in Figure 3.9 shows the parts of the city affected most by this deprivation related premature mortality.

Figure 3.7 Directly age standardised all age all-cause mortality rate per 100,000 population by deprivation quintile, Brighton & Hove, 1988-92 to 2009-2013

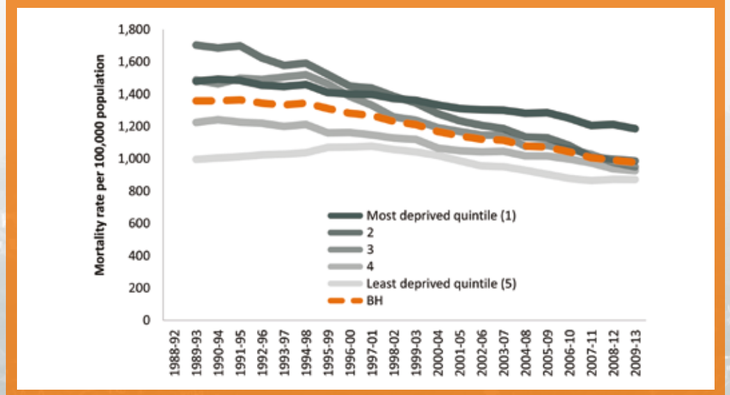


Figure 3.8 Directly age standardised under 75 all-cause mortality rate per 100,000 population by deprivation quintile, Brighton & Hove, 1988-92 to 2009-2013

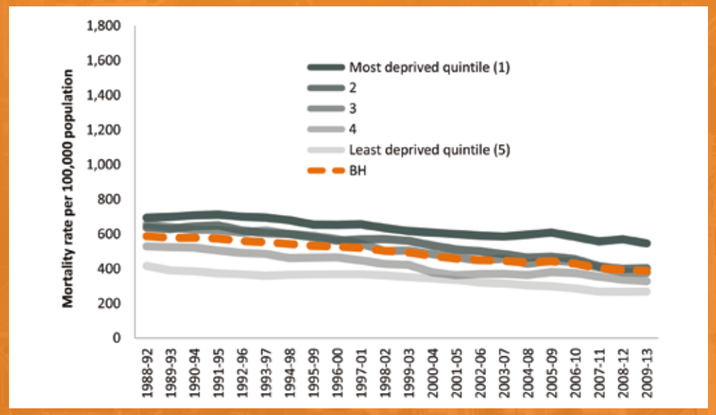
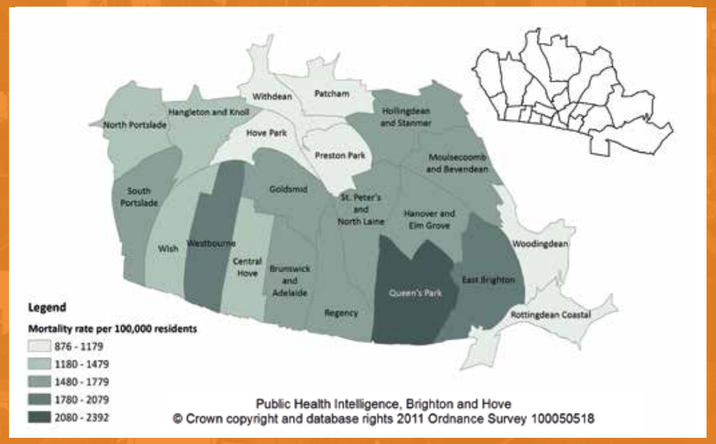


Figure 3.9 Cartogram of mortality rates (directly age standardised) in residents aged less than 75 years per 100,000 residents by ward, 2009-2013

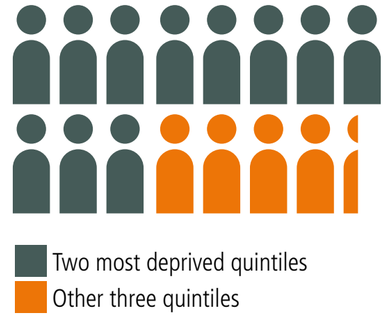


Source Brighton & Hove City Council Public Health Directorate. Based upon Office for National Statistics Primary Care Mortality Database and Office for National Statistics Mid-Year Population Estimates

Tackling Inequalities – Preventing premature mortality audit

The Public Health Annual Report of 2011 first drew attention to these inequalities in premature mortality. Following its publication, the City Council and Clinical Commissioning Group joined forces to undertake a Preventing Premature Mortality Audit in all GP practices led by the Public Health team. Three important chronic diseases contribute to this premature mortality: diabetes, cardiovascular disease and respiratory disease (in particular chronic obstructive pulmonary disease, COPD). Smoking, alcohol use, obesity, isolation and mental ill health issues were identified as contributory factors. As a result, a comprehensive programme of better identification and recording, improved lifestyle advice and referral, and better links with secondary care has been initiated. Part of this programme involves recruitment to health trainer posts to work alongside practices to improve lifestyles and early presentation in the event of symptoms. These health trainers have focused their work on more deprived areas of the city (Figure 3.10), men and those with chronic conditions (three of the key groups identified in the audit).

Figure 3.10 Brighton & Hove Health Trainers, 2013/14 clients completing personal health plans by deprivation quintile of 336 clients completing personal health plans



Tackling Inequalities George and alcohol

I found myself trapped in a cycle of binge drinking. I think it also fuelled an anxiety. I would call in sick at work, even days after a binge, as my body would still be recovering. My relationships suffered, I couldn't remember what I said, who I offended... I put on weight and my relationship with my partner was on a downward spiral.

The health trainer helped me to reflect on my drinking, and figure out ways of addressing what were destructive behaviours. As someone who is actively involved in the LGBT community, I recognise now that the way I got involved was fuelling my binges. I set out to "get wrecked" so as I could feel a sense of belonging, and the binges became a part of normal life.

I have figured out now that there is a lot more to the LGBT community. OK, bing drinking may be culturally ingrained in some sections, but not everywhere. Getting involved in doing other things means I still have a sense of inclusion. I won't kid you, I did struggle at times with having to change relationships and friendships, but you have to if you want to cut out destructive behaviours. It's painful and challenging, both emotionally and psychologically. But, I have now discovered a new network of LGBT friends, who don't binge and who have really helped me put things into perspective and still feel very much part of the community."

3.4 Disability and limiting long-term illness

'Disability' is an umbrella term used to describe impairments, activity limitations and participation restrictions. [9] It is the interaction between individuals with a certain health condition (e.g. cerebral palsy, Down's Syndrome and depression) and personal and environmental factors such as negative attitudes, inaccessible transportation and public buildings, and limited social supports. [10] There are there are 11.6 million disabled people in Great Britain, of whom 5.7 million are adults of working age, 5.1 million are over state pension age and 0.8 million are children.[11] Rates of people living with a disability are increasing due to population ageing and increases in chronic health conditions.

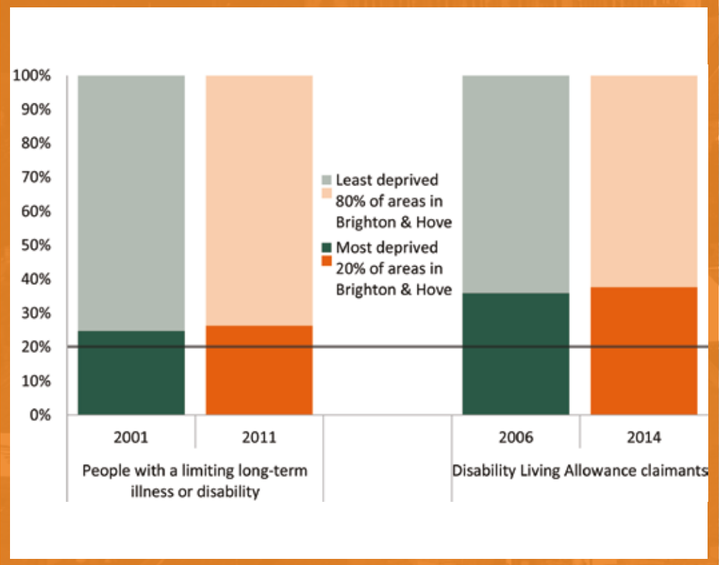
People with disabilities are particularly vulnerable to deficiencies in health care services and may be at greater risk of other health conditions associated with disability. They may experience age-related conditions prematurely and, associated with lower income, are more at risk of deprivation-related health risk behaviours such as smoking and poor diet.

In Brighton & Hove, there is a clear relationship between disability and deprivation. People with a limiting long-term illness and disability (Figure 3.11) are significantly more likely to live in more deprived areas and this trend may be increasing. In 2001, 25% of people living with limiting long-term illnesses or disabilities lived in the 20% most deprived areas of the city; by 2011 this had increased slightly to 26%.

This difference is more evident in terms of people claiming Disability Living Allowance, although as the Index of Multiple Deprivation uses benefit claimant figures in its calculation this might be expected. In 2014, 38% of people claiming Disability Living Allowance live in the 20% most deprived areas in the city. Again, this figure had increased slightly in recent years.

These differences matter. If we were able to eliminate them, we would see a considerable reduction in poor mental and physical health (Figure 3.12) https://infogr.am/llti-045459914502

Figure 3.11 Percentage of people with a limiting long-term illness or disability, or claiming disability living allowance who are living in the 20% most deprived areas within Brighton & Hove, various dates (see chart labels)



Source Census and Department for Work and Pensions

Figure 3.12 Impact of removing inequalities between the most affluent and most deprived in Brighton & Hove (2012 data)

If all groups in the city had the lower rates seen in the most affluent, there would be:

16,000 fewer people at risk of major depression

11,200 fewer people who had ever self-harmed

10,600 fewer people with a limiting long term illness

4,800 fewer people in 'poor' health

3.5 Mental health and wellbeing

Inequalities in mental health and wellbeing are stark, and it has long been established that mental ill health can result in deprivation (loss of employment, housing etc.) as well as result from deprivation (stress is associated with mental illness). The strap-line of the 2014 national mental health strategy - 'No health without mental health' - is apt. Evidence shows that mental wellbeing underpins behaviour change and national guidance highlights the need to understand psychological concepts, including well-being, to motivate and support behavioural change. [12,13]

There is reliable evidence for interventions across the life course for mental health and wellbeing and healthy behaviours. Improving the conditions of daily life from before birth, during early childhood, at school age, during family building and working ages, and at older ages provides opportunities both to improve mental health and to reduce the risk of mental health disorders. Comprehensive action across the life course is necessary, however there is considerable scientific consensus that giving every child the best possible start generates the greatest societal mental health benefits. [14]

Findings from local Health Counts surveys of adults show that in Brighton & Hove between 2003 and 2012, the absolute inequality gap for risk of major depression fell, with the ranges falling from 22% risk for the most affluent and 51% for the most deprived in 2003, to 21% and 49% respectively in 2012. Relative inequality also fell slightly, from the most deprived person being 1.8 times more likely to be at risk of major depression than the most affluent in 2003, to 1.7 times in 2003. These are modest changes, but at least they do not show a widening picture.

Within the survey, and confirmed in the recent trans needs assessment, groups identified as being at increased risk of major depression include Trans, Lesbian, Gay, Bisexual, Unsure (LGBU) or other, Black or Minority Ethnic Groups, single, separated and divorced people, and those renting either privately or from a local authority or housing association.

Tackling Inequalities – The Trans Community

Trans is an umbrella term to describe people whose gender identity differs from their assigned sex at birth. National and international evidence describes how trans people are subject to inequality and discrimination across many spheres of life including health, housing, education, crime, safety and family life.

In Brighton & Hove in 2012-13, a Trans Equality Scrutiny Panel considered the actions required to make life fairer for local trans people. The review was recognised with a national award for innovation, and an action plan to improve local services has followed. There has also been effective work in schools and with other young people, conducted in partnership with Allsorts.

Later in 2015, a needs assessment, jointly led with the trans community, will be published as part of the city's Joint Strategic Needs Assessment programme. This has analysed local data, national evidence, service provider views, and has included local community research involving 150 people.

One of the key findings of this work is evidence of high rates of stress, anxiety and depression among trans people. One in three trans respondents report that they have self-harmed (more than three times the rate in the general population). Trans people also report difficulty in accessing health services and highlight the vital role played by community groups in providing mental health support.

As part of the Brighton & Hove Happiness Strategy, peer support groups, provided by the Clare Project have been established for adults, and by Allsorts Youth for young people. These groups provide a safe space to discuss personal issues, and participants find out about other local sources of support.

Ryan Gingell of Allsorts says:

"We know that all of our trans young people have a tough time mentally and some of them even think about suicide. This 'safe space' which is for the under 26s, gives people somewhere to go where they can talk about their gender identity in a supportive environment. The number of trans children and young people accessing Allsorts doubled last year. So it's vital we carry on this work for young people, and the people who look after them."

3.6 Health behaviours

Health-related behaviour is influenced by environmental, social, economic and cultural factors, as well as by chronic diseases. Adverse health behaviours like smoking are more prevalent in socially and economically disadvantaged people.[15] To mitigate the impact of social disadvantage, we need to address wider factors as well as to provide support to individuals to change health behaviours.[16] There is good evidence that efforts solely focused on the behaviour change of individuals are ineffective. [17] Population approaches are required although action needs to be targeted at those who need support the most. [18]

Smoking

The key national priority areas for evidence based actions on reducing the prevalence of smoking are:[19]

- stopping the promotion of tobacco;
- making tobacco less affordable;
- effective regulation of tobacco products;
- helping tobacco users to quit;
- reducing exposure to second-hand smoke;
- effective communication on tobacco control.

School based smoking prevention programmes are cost effective with longer-term savings of £15 for every £1 spent.[20] Programmes to develop children's life skills such as problem-solving, building self-esteem and improving resilience to peer and media pressure, can reduce smoking initiation by 12%.[21] Tobacco control at a population level has the potential to benefit more disadvantaged groups and reduce health inequalities.[22]

Alcohol

There is considerable evidence to support population strategies in reducing inequalities resulting from alcohol consumption.
A ban on selling alcohol below the price of duty and VAT was introduced the spring of 2014 with the aim of reducing total annual consumption. Introducing a minimum unit price of alcohol of £0.45 would have the greatest effects for harmful drinkers on low incomes who buy more alcohol at less than the minimum unit price threshold compared with other groups.[23] Much alcohol attributable harm occurs in middle or older age groups as a result of years of drinking above the lower risk guidelines, therefore even a relatively small reduction of around 2% in the total annual consumption can have a significant impact upon long-term and chronic illnesses.[19] At the individual level there is good evidence that risk assessment/ screening, interventions and treatment programmes commissioned by local authorities and the NHS, and school based interventions can all reduce alcohol-related harm.

Diet, physical activity and obesity

Obesity is associated with deprivation, while being overweight is not. There is evidence that some interventions that aim to prevent, reduce or manage obesity reduce the social gradient in obesity. For children, interventions delivered at school and in the community, as well as those interventions that use community empowering mechanisms can be effective in reducing obesity in more deprived areas. For adults, tailored weight loss programmes in primary care and community based weight loss interventions are most effective, although only in the short term, and the effect is greatest for low-income women.[24]

Sexual health

Every £1 spent on contraception to prevent teen pregnancy saves £11 in fewer terminations and reduced antenatal and maternity care. [25] Schools are the most commonly reported source of information about sexual health and are where efforts are needed to inform people about healthy sexual activity.[26] In 2013 in Brighton & Hove, the chlamydia diagnosis rate in 15-24 year olds was 3,133 per 100,000 population. This is equivalent to 51% of 15-24 year olds tested. The positivity rate was 6.2%. Brighton & Hove ranks 22/326 Local Authorities (LAs) in England for chlamydia diagnosis rates (1st rank = highest rates). Screening is carried out in a range of settings across the city, however, irrespective of relatively high screening rates, in order to address the inequalities in chlamydia prevalence, it is important to assess who is being screened where.[27]

Health behaviours in Brighton & Hove

The information on health behaviours in Brighton & Hove, including associated inequalities, comes largely from local Health Counts surveys, conducted on three occasions over the last 20 years with data on lifestyles comparable between 2003 and 2012. The results show a mixed picture. Compared to the most affluent person, the most deprived individual in the city is:

- 1.7 times more likely to be obese, - an increase from 1.2 time in 2003 - with an absolute gap increase from 2 to 7 percentage points, equivalent to a rise from 2,000 to 5,000 people affected;
- 2.3 times more likely to smoke – a reduction from 2.5 times in 2003 – with an absolute reduction in the gap from 25 to 18 percentage points, equivalent to a fall from 23,800 extra smokers in 2003 to 16,900 extra smokers in 2012;
- 1.1 times more likely NOT to eat five a day of fruit and vegetables - a reduction from 1.2 in 2003 - with a reduction in the absolute gap from 11 to 5 percentage points, equivalent to a fall from 7,300 extra in 2003 to just 300 extra in 2012;
- more physically active - in both 2003 and 2012 there was an inverse relationship between deprivation and physical activity –the most affluent person was 4% less likely to be physically active at recommended levels than the most deprived in 2003, and 6% less likely in 2012.

There is no inequality in higher risk drinking nor was there any inequality in the prevalence of overweight (unlike obesity).

The differences in health behaviours attributable to inequalities

Figure 3.13 Impact of removing inequalities between the most affluent and most deprived in Brighton & Hove (2012 data

If all groups in the city had the lower rates seen in the most affluent there would be:

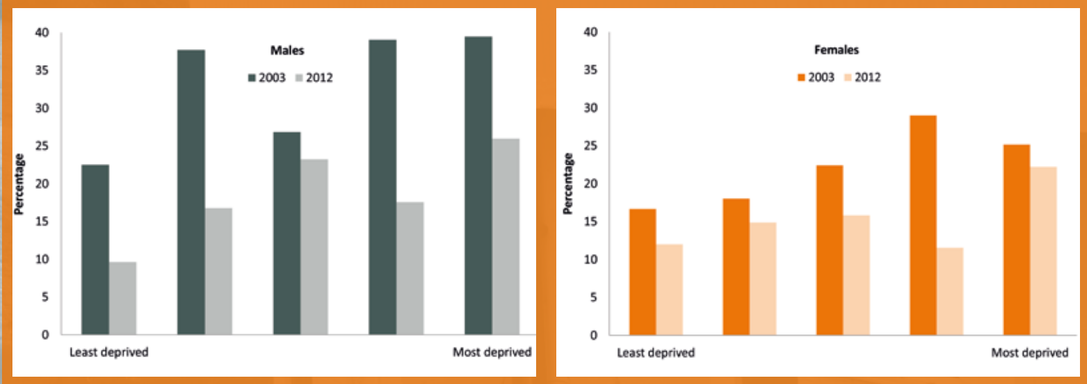
16,900 fewer smokers

8,000 fewer people drinking at increasing or high risk levels

9,300 fewer people who have ever been diagnosed with a sexually transmitted infection

5,000 fewer people who are obese

Figure 3.14 Adults engaging in three or four health risk behaviours, by gender and deprivation quintile, Brighton & Hove 2003 and 2012



Source Health Counts Surveys, Brighton & Hove Public Health Team

are shown in Figure 3.13.

Multiple health risk behaviours

Lifestyle behaviours rarely occur in isolation although there is evidence that the local population is becoming more health conscious. The Health Counts surveys show that the proportion of the population engaged in three or four of designated health risk behaviours (smoking, drinking above recommended levels, not keeping physically active and not eating five a day) declined from 26.6% in 2003 to 16.6% in 2012.

In terms of inequalities, there has been some improvement, with rates falling across all deprivation quintiles. In males, the relative inequality widened although the absolute inequality narrowed, whereas in females both the absolute and relative inequalities narrowed (Figure 3.14).

Because adverse health behaviours tend to cluster, in particular in more deprived groups, local authorities and the NHS need to adopt an integrated holistic approach that is able to encompass multiple unhealthy behaviours and make "every contact count". This is the approach in Brighton & Hove, for example through the Health Trainers and Public Health Community Nurses.

3.7 What can we conclude?

There has been some progress in reducing health inequalities in Brighton & Hove over recent years although the picture is mixed, and as has been illustrated in Chapter 1 of this report, it may depend on your point of view and whether you consider relative or absolute inequalities to be more important.

The data on infant mortality stretches back over a century and there have been huge reductions in the absolute inequality and even some improvement in relative inequality. Birth rates are declining in Brighton & Hove and women living in the most affluent areas have the highest fertility rates. Low birthweight rates are increasing but inequalities, both absolute and relative are falling. The increase in low birthweight overall may reflect improved survival of premature babies as well as an increasing proportion of births coming from certain ethnic minority groups, known to give birth to smaller babies. Breastfeeding rates, already high in the city, continue to improve and there are increasing efforts to address the relatively lower breastfeeding rates in more deprived areas.

Life expectancy is increasing and the gap between male and female life expectancy has fallen in recent years. Compared to national rates however, there has been no significant change in males or females. Progress with regard to inequalities in mortality rates has been better, with a falling all cause mortality rate, and reductions in the gap between the most affluent and most deprived. There is still some way to go however, as each year in Brighton & Hove 500 extra people die, simply as a result of deprivation, with an extra 87 dying prematurely. Queen's Park, Westbourne and Withdean are the wards most affected by this premature mortality.

There is a clear relationship between deprivation and disability and this relationship appears to be strengthening. The impact of the welfare reforms with changes to the Disability Living Allowance discussed in Chapter 6 may make this relationship more acute yet. Similarly, there is a strong relationship between mental ill health and deprivation, however, locally there is some evidence that mental wellbeing inequalities may be falling.

The relationship between lifestyles and inequalities has changed over the years. There is currently no association between being overweight, nor drinking above recommended levels and deprivation. There is however a strong relationship between smoking, obesity, unhealthy diet and deprivation. Inequalities are widening regarding obesity but are improving in smoking and in consumption of a healthy diet. There are opportunities to look at screening programmes, including the chlamydia screening programme and monitor if these are tackling inequalities.

In order to tackle health inequalities, we need to take action across the life course, and especially early in life. We need to take population measures AND target individuals at risk. Making every contact with a health professional count, and recruiting local people with local knowledge, such as health trainers, can go a long way to addressing these health inequalities which continue to blight the city.

Tackling Inequalities NHS Health Checks

The NHS Health Checks programme aims to help prevent heart disease, stroke, diabetes, kidney disease and even certain types of dementia. Everyone between the ages of 40 and 74 years, who has not already been diagnosed with one of these conditions or has certain risk factors, is eligible for an NHS Health Check. To address the health inequalities better, the local programme has been redesigned, building on the success of the city's programme last year that delivered the highest numbers of checks (5,621) in one year since the programme began in 2009.

The new programme prioritises and supports GP surgeries to give a check to people living in the most deprived parts of the city. The check now includes an assessment of mental wellbeing. Participants are reporting that they find the new service friendly, efficient and very educational. The programme includes information on preventing cancer as well, and actively promotes referrals for people to improve their health such as stopping smoking or losing weight. A voluntary organisation, the Trust for Developing Communities is supporting the programme by working with community development workers and volunteers to encourage more men who live in deprived areas of the city to go for their NHS Health Checks.
To make sure the programme is addressing inequalities in health, we are collecting more information about who is attending the checks and a health equity audit will be carried out at the end of the year.

Figure 3.15 Summary of change in health inequalities over time in Brighton & Hove

Child poverty and poverty in older people

Annie Alexander, Sarah Colombo and Peter Wilkinson

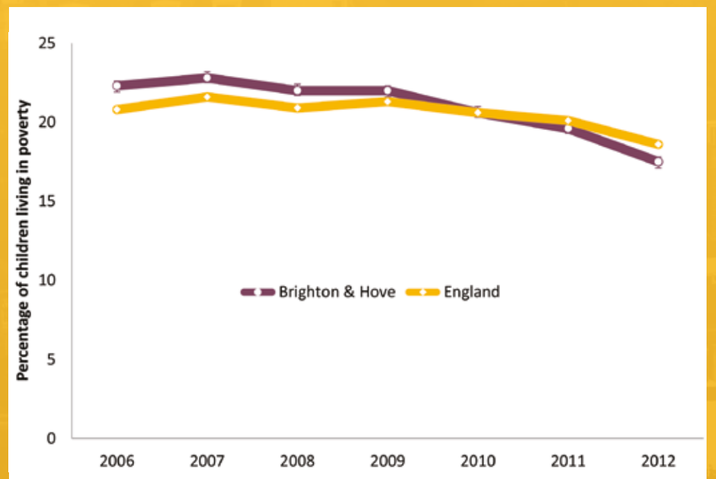
4.1 What do we know?

Child poverty

Inequalities affect children not only in early life, but also with adverse outcomes much later. Babies with a low birthweight are 5 times more likely to die in infancy than those of normal birth weight. The annual cost of caring for these babies, from birth to 18 years is around £3 billion for England and Wales.[1,2] A child's early development score at 22 months is an accurate predictor of educational outcomes at age 26, which in turn is related to long-term health outcomes.[3] The UK performs poorly in comparison to similar countries on mortality in the under 5 years: a recent index of child wellbeing in the European Union suggested that the UK ranked 24/29 for both child health from birth and overall child wellbeing.[4,5]

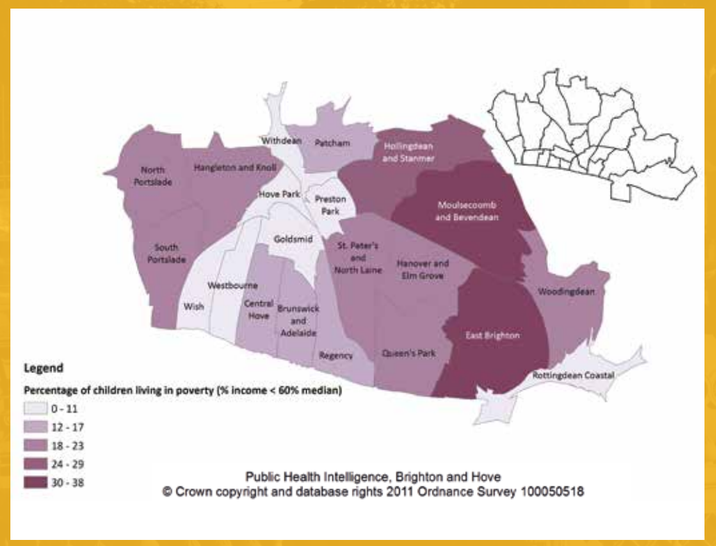
The Government measures child poverty as 'the proportion of children living in families in receipt of out of work (means-tested) benefits or in receipt of tax credits where their reported income is less than 60 per cent of median income'. Child poverty matters because as the Marmot review highlights, socio-economic inequalities in early childhood tend to persist across the life-course.[6] Therefore addressing childhood poverty has the potential to improve outcomes for the individual child and for the wider community too. The poorer you are, the more likely you or your children are to experience poorer health in early life. Furthermore, the size of the affect of different aspects of social disadvantage such as employment or income has remained static over the past 30 years.[7]

Figure 4.1 Child Poverty rates in Brighton & Hove and England (under 20 years) 2006-12



Source PHE 2015

Figure 4.2 Cartogram of percentage of dependent children living in poverty, Brighton & Hove, 2012



Source HM Revenue and Customs / Department for Work and Pensions

4.2 A city divided?

Child poverty

Every sixth child in Brighton & Hove is living in poverty although these rates are lower than the national rates (Figure 4.1). Although high, child poverty rates are falling as they are in many other places. In 2012 in Brighton & Hove, 17.5% of the total population of dependent children and young people under the age of twenty in the city were in families living on less than 60% of median national income: that is a 2.1% improvement on 2011. The proportion of children in poverty in Brighton & Hove is lower than the England average (18.6%). Child poverty is also higher in local comparator cities: between 2011 and 2012, in Portsmouth it fell from 24.4% to 22.3%, and in Southampton from 25.3% to 22.7%. However, child poverty is significantly lower in the South East regional average, which reduced from 14.6% in 2011 to 13.6% in 2012.

It is important to appreciate that child poverty is a relative indicator measured by reference to the median income, therefore it is affected by falls and increases in average income. The median income threshold for child poverty for a couple with two children aged 5 and 14 yrs dropped from £334 per week in 2011, to £312 per week in 2012. Thus a family on a low but stable income close to the threshold will be recorded as no longer living in poverty if the threshold reduces to just below their household income in actual terms. Hence, a reduction in relative child poverty does not necessarily mean that families are any better off than they were when recorded as in poverty. National (HMRC) commentary on the national fall in child poverty between 2011 and 2012 equates the fall primarily to this change in the income threshold.[8]

Child poverty is much more prevalent in single parent households. In 2012, of those children living in poverty in receipt of Income Support or Job Seekers Allowance, 5,540 were living in lone parent families compared with 1,695 in 'couple families'.

Whilst children in poverty live in all areas across the city, there are concentrations of families coping with poverty in the most financially deprived neighbourhoods, such as East Brighton (36%) and Moulsecoomb and Bevendean wards (37%). The wards with the lowest rates of child poverty are Hove Park and Withdean, both with 6% (Figure 4.2).

As well as lone parent families, larger families are also recognised as being more vulnerable to child poverty. In Brighton & Hove in 2012, there were 3,070 children living in poverty from families with three or four children compared with 7,450 from families with three or fewer children. National research also shows that black and minority ethnic families, Gypsy and Traveller families and families where children or adults have disabilities, are at greater risk of living in poverty. However, there is currently no data on this at local level.

The contributing factors to child poverty in Brighton & Hove include the high cost of housing, the lower than average wage levels and the highly competitive jobs market with degree level applicants competing well below their skill levels. These issues are discussed further in Chapter 6 on Welfare Reform.

Tackling child poverty

In August 2012 in Brighton & Hove, 7,235 (82%) children living in poverty were in families in receipt of out of work benefits and 1,550 (18%) were in families in receipt of child tax credit and/or working tax credit. The government's Child Poverty Strategy 2014-17 identifies the five key family characteristics, which make it harder for some families to find their way out of poverty.[9]

1 Long-term worklessness;

2 Low qualifications;

3 Raising children alone;

4 Having three or more children; and

5 Experiencing ill health.

The strategy plans to reduce child poverty through actions in three main areas:

1 Supporting families into work and increasing their earnings;

2 Improving living standards; and

3 Raising educational attainment.

There are several initiatives that aim to tackle child poverty in Brighton & Hove. The Stronger Families, Stronger Communities programme; a multi-agency programme, which supports families in the city with complex problems is successful locally in supporting families to reduce anti-social behaviour, increase school attendance and gain employment. The Council's Early Help Hub is a new Children's Services provision that coordinates and targets help to families before problems deteriorate thereby improving family resilience. The Moneyworks programme, delivered by a consortium of advice, adult

learning and employment support organisations helps residents to improve their financial situation and links money advice to skills, learning and employment. A fuller discussion of the strategies to tackle child poverty in Brighton & Hove is in Chapter 6 on Welfare Reform.

4.3 What can we conclude?

Child poverty

Child poverty is an important marker for reduced life chances. It affects substantial numbers of children in the city - 1 in 6, and although rates are lower than nationally and in comparator cities, recent reductions may owe more to changes in the threshold for defining child poverty rather than any real improvement. In Brighton & Hove the highest rates of child poverty are in East Brighton, and in Moulsecoomb and Bevendean wards where more than 1 in 3 children live in poverty.

Child poverty is more common in ethnic minority groups, in Gypsies and Travellers and in families where there are disabilities. Strategies to reduce child poverty, including in Brighton & Hove aim to raise educational attainment, improve living conditions and support families into work.

4.4 What do we know?

Poverty in older people

For many people retirement brings financial and social freedom, as well as increased choice - over 55 year olds control 80 per cent of the nation's wealth and account for 40% of the UK's annual consumer spending.[10] However for those

Tackling Inequalities

Troubled families? Vicky and Leanne (names have been changed).

Following the riots of August 2011 the Government introduced new legislation including a programme for local authorities to work in a more proactive and coordinated way with what was termed 'Troubled Families'. This led to the creation of a 'Stronger Families, Stronger Communities' team in Brighton & Hove. This team is seen as a key part of the city's efforts to intensively support families with multiple disadvantage. The case of Leanne illustrates well the extent of support required to tackle what may seem to be an intractable situation.

Teenage Leane lives with her mother Vicky. Her father lives separately with two children from another relationship and there is a history of domestic violence, which led to the family break up. Vicky works full time and had a difficult relationship with Leanne's dad. Leanne was said to use this to her advantage and played one off the other, often missing school, staying out all night and committing violent offences.

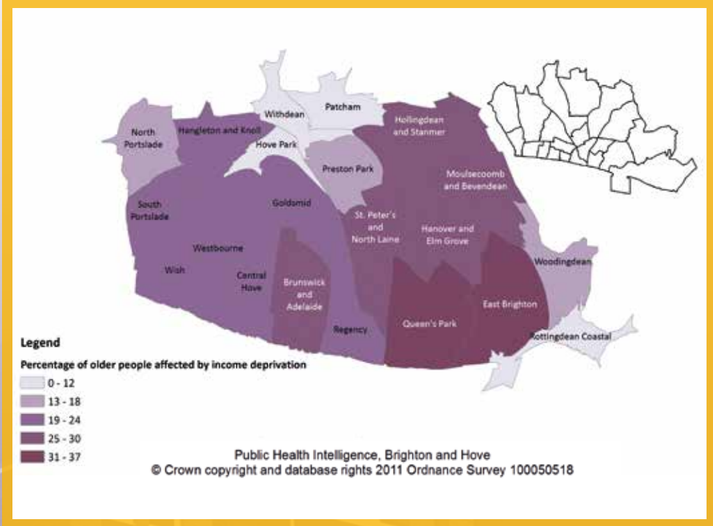
Leanne was mixing with a group of mostly older girls well known to the Police and Community Safety Team. She was smoking £20 of cannabis a day with these girls and they shoplifted to fund this. Leanne said that she felt pressured to shoplift with them. She was also drinking heavily and engaging in risky behaviours including unprotected sex. She committed all of her offences while drinking. Leanne was placed on a part-time timetable at school due to poor attendance, and her friends would wait for her on the way to school and persuade her to go out with them instead.

The Youth Offending Team assessed Leanne as vulnerable and at risk of harming others and she received an intensive package of support from a Family Coach. Her parents were supported to reflect on their parenting, particularly the lack of boundaries and the impact on their daughter's safety. Vicky was supported in putting boundaries in place, using consequences if Leanne was late home or received negative reports from school. The Family Coach received weekly school reports which were shared with Vicky who now rewards good behaviour as well as imposing consequences. Leanne received support in school to address her emotional regulation and consequential thinking. The Family Coach worked with her father on parenting and communication.

A social worker is overseeing the progress with the Family Coach as lead professional. A Special Education Needs Co-ordinator (SENCO) provided additional intensive support at school with input from the Teenage Pregnancy Prevention Service, and the Youth Substance Misuse Team (RUOK) assisted with tackling Leanne's use of drugs.

As a result of these intensive interventions, Leanne's attendance has increased to 100% on a full time timetable. She has not been arrested once since work began, and her mother now calls the Police if she stays out after her bail curfew. There has been no reports of her associating with her former peer group and no reports of criminal activity from the Community Safety Team, the Police or Business Crime Reduction Partnership.

Figure 4.3 Cartogram of percentage of older people affected by income deprivation by ward, Brighton & Hove, 2013



Source Department for Communities and Local Government, 2010, updated to 2013 ONS population estimates by Brighton & Hove City Council Public Health Intelligence team, 2015

pensioners living below the poverty line, poverty brings isolation and ill health.[i,10]

The government's Department for Communities and Local Government (DCLG) measures poverty amongst older people using the Income Deprivation Affecting Older People Index (the IDAOPI), which identifies the percentage of adults aged 60 years and over living in 'pension credit guarantee' households. The 2010-15 Conservative / Liberal Democrat Coalition Government protected the state pension, although alone it is not sufficient to support an older person. Older people without their own savings, pensions or investments rely on other age-related benefits such as Housing Benefit; Pension Credit Guarantee and Council Tax benefit to make ends meet.

As people grow older, they spend an increasing proportion of their income on essentials such as food, domestic energy bills, housing and council tax; in households headed by someone aged 75 years or over this amounts to 40% of the weekly expenditure. Older people find it harder to manage if they also have poor health and mobility, live in old housing with no or limited access to transport, and if they have few social networks.

Many older people live alone and almost one in ten people aged 65 years and over reports regularly or always feeling lonely.[11] Loneliness is triggered by a loss of social networks and companions, features commonly associated with later life. Low income is associated with an increased risk of social isolation. Ageing is also associated with reducing mobility, and so reliable, safe and accessible transport networks are vital for older people to access food, services and activities. Older people can use the buses for free although getting out may be difficult for people with mobility problems or lacking confidence. Transport is one of the main barriers that prevents older people (particularly those 80 years and over) from leaving their homes.

Poor health also puts pressure on material circumstances by imposing additional costs of living and undermining people's ability to live independently while good health has the opposite effect. [12] Many older people are carers and research suggests that financial pressures reduce the choices available to carers and exacerbate the practical demands upon them. This can put strain on the quality of the caring experience for both carer and care recipient alike.[13]

4.5 A city divided?

Poverty in older people

In Brighton & Hove older people (aged 65 years and over) comprise over 13% of all residents. The number of older people has declined over the last 12 years and the city has a lower proportion of older people compared to regionally and nationally. Older people (65 years and over) live across all areas of the city, although the largest communities are in Rottingdean Coastal (22%) and Woodingdean (19%). In six of the city's 21 wards, fewer than one in ten people is aged 65 years and over with the lowest percentage in St Peters and North Laine (6%) followed by Hanover and Elm Grove, and Brunswick and Adelaide (both 7%). The number (not proportion) of people aged 75 years and over is expected to increase by 10% between 2011 and 2021, with a growing proportion aged 85 years and over.[14]

In Brighton & Hove 23.6% of older people are affected by income deprivation (IDAOPI) (the percentage of adults aged 60 years or over living in pension credit guarantee households) compared with an

[i] Defined by Government as below 60 per cent of contemporary median net disposable income

average of 20.5% in England.[15] Older people in poverty are spread across the city although more concentrated in the city's more deprived areas, such as Hangleton and Knoll, Hollingbury, East Brighton and Queen's Park. The lowest concentrations of older people in poverty are in Withdean, Hove Park and Patcham and Rottingdean Coastal.

The changes in income in older people in recent decades, contrasts with the situation in younger and working age people. Over the last 20 years, there has been a large reduction in the proportion of pensioners living in poverty. This contrasts with a much slower decline in child poverty and working–age poverty. Nationally, in 2012/13, 13% of pensioners were living in a low-income household (defined as a household with a net income after housing costs of less than 60% of the median national household income for that year). For adults aged over 60 years, this represents a reduction from 2002/03, with the most substantial falls amongst the eldest: a fall of 15% for 75–79 years, and 14% for those aged 80 years and over.

The number of people aged 60 years and over in receipt of means tested rent or council tax reduction has decreased from 13,243 (26%) in 2009 to 10,690 (21%) in 2015; and the number in receipt of pension credit has fallen from 12,510 (24%) in 2009 to 7,490 (15.9%) in 2015. Older age is associated with a dramatic decline in employment. In Brighton & Hove, 70% of men aged 50 to 64 years are economically active: this compares to just over 10% for men aged 65 and 74 years. The picture is similar for women.

The city has good transport network although many older people live in isolation. Over 40,000 people aged 60 years and over in the city have a concessionary bus pass and they make over 10.5 million journeys a year. Approximately 14,500 (41%) people aged 65 years and over live alone in Brighton & Hove compared to 31% nationally.

Almost 24,000 (9%) people of all ages in Brighton & Hove provide some informal care[16], more than half (53%) of these are people aged 50 years and over. Even among people aged 85 years and over, 5% provide some form of unpaid care, and half of these carers provide 50 hours or more of care.[17]

Tackling poverty in older people

There are a number of initiatives in place in the city to tackle poverty in older people some of which are described more fully in Chapter 6 on Welfare Reform.

There are now three locality hubs in east, west and north/central, with partnerships of organisations providing a mix of community activities, befriending and day services. Several organisations in the city are commissioned just to help older people get out. There are over 1,000 free and low cost social activities for older people in Brighton & Hove. The council and the CCG have jointly commissioned the city wide Connect programme to coordinate activities, (see 'It's Local Actually' website). Age UK, Impact Initiatives with Barclays and the council Library Service are working together to enhance older people's digital skills. Some of these projects are inter-generational (eg Age UK and Impact) and there is potential for this work to improve financial inclusion via libraries and other 'access points'.

The council funds Citizens' Advice Bureau (CAB) welfare benefits advice in six GP surgeries in Brighton & Hove, four of which are in the city's most deprived quintile. Nearly one fifth of those accessing the service are aged 60 years and over and on average they receive an additional £2,445 in benefits. The city council in collaboration with older people's organisations is working to reshape the city's environment and services in order to be more age-friendly. Older People's Day on 1st October celebrates age and the achievements and contributions made to the city by older people through events such as quizzes, walks, volleyball, cycling, singing, IT lessons and photographic exhibitions. A new carers' strategy is in development, which will improve access by carers to assessments, advice, information and support.

4.6 What can we conclude?

Levels of poverty among older people in Brighton & Hove are lower than levels of child poverty and reductions have been much greater than the reductions in child poverty. Older people's benefits have, until now at least, been relatively protected compared to many other benefits. The population of older people in Brighton & Hove in recent years has been falling, especially in central wards. This is set to change and in particular the number and proportion of 85 year olds and over will increase.

Just under 24% of older people in Brighton & Hove experience income deprivation and the distribution of older people's poverty differs from child poverty. The area with the highest proportion of older people (Rottingdean) actually has the lowest concentration of older people in poverty.

Strategies to address poverty in older people need to include initiatives to tackle isolation and confidence, as well as practical issues such as transport, financial inclusion, and carer support.

Tony Mernagh (Happiness Champion)

Executive Director of the Economic Partnership

Interviewed by Tom Scanlon

Past

I grew up in the 1960s in the north east of England; we weren't dirt poor but we were certainly poor. Having failed the 11+ exam I went to a secondary school where I really flourished. They had just started to 'allow' secondary schools students to take 'O' Levels and I did well - inspired by some good teachers. I'm still in touch with one of them 45 years later. I went to university to study Botany and Zoology and I became a teacher myself. After university, my wife and I both taught just outside London before going off to work at a British School in El Salvador. It was, to say the least, very exciting; a civil war broke out shortly after we arrived, most of the other UK ex-pats left and we rose rapidly to senior positions. The 5 years there were probably the most formative years of my life, and we still keep in touch with several former pupils.

Present

Back in the UK, I taught in East Brighton for a short while and then we were invited into a family business partnership publishing greetings cards. We opened a retail outlet in Brighton and our classroom administrative skills transferred easily to the shop floor. It was 1980s boom time and we thrived. We had to steer our way through the 1991 crash but by the mid 1990s we had 5 shops. However, by then I was looking for a new challenge. I became the voluntary Chair of the North Laine Traders' Association, then, with the development of Churchill Square, I was appointed the Town Centre Manager. Through that position, I got involved in the Economic Partnership and took up the position of Executive Director in early the 2000s. We developed a Business Improvement District and the largest Business Crime Reduction Partnership (BCRP) in the UK. That has been so successful that we now administer other BCRPs including several in London. When I give up the Economic Partnership – I'm retiring this year – I'll carry on with some part-time BCRP outsourcing work.

Future

To tackle inequalities we need to focus on a number of things. Education was my way out of poverty and it is a sad indictment that so many young people do so poorly at our schools. We have two good universities and we end up importing highly qualified residents. Our universities have a responsibility to reach out to local disadvantaged pupils; we may be on the cusp of that but so far we haven't done nearly enough. We also have to start early and opportunity initiatives like Sure Start are crucial. Housing is a severe limiting factor in Brighton & Hove. We simply need to build up and build more as a matter of urgency; on the urban fringe, on brown field sites, and on some green spaces - we have 660,000 hectares just the other side of the A27. We also need to develop more business opportunities. I know from my own retail experience that graduates are too often in jobs for which they are overqualified and so they deny opportunities for school leavers. We are developing our digital sector and it could be a real leader and major employer in Brighton & Hove. However, sadly, I am not too optimistic for the city or the country. Brighton & Hove's may be brimming with creative ideas but further austerity in the public sector is simply undeliverable. Local authorities, the police and the NHS are all buckling at the knees and the poorest will inevitably suffer most. As a society, I believe you measure progress by how you treat the old and the sick, and the opportunities you provide for the young: making progress on that will require the reversal of a lot of inequality.

Money, income and the economy

Tom Perigo, Kate Gilchrist and Nicola Rosenberg

5.1 What do we know?

Poverty in the UK

The absolute versus the relative inequality debate is well illustrated in the case of income and poverty. For while across the UK relative income inequality has actually decreased since the economic downturn, average incomes have fallen and poverty increased.

In the UK, currently there are thirteen million people living in poverty.[1] Household incomes have fallen in real terms for three years in a row and median income in 2012/13 was 9%below where it was in 2007/08 and 4% lower than a decade ago. Falling average incomes have seen reductions in relative poverty, however in absolute terms the poor have become poorer. Young adults have fared particularly badly as they have struggled to find work and deal with the cost of housing. The income from work as opposed to from assets has fallen and earnings have risen much more slowly than prices. This has reversed some of the inequality that emerged in the 1980s but has contributed to further increases in the incomes of the old relative to those of the young.[2] Although relative poverty may have reduced, there has been no rise in living standards.

In the case of income, both absolute and relative levels matter, for health and wellbeing is influenced by both the position in social class hierarchies, as well as the spread of societal differences.[3] Countries with wider relative income levels (Figure 5.1) have worse outcomes in a range of health and social measures such as life expectancy, infant mortality, mental illness, teenage births, child wellbeing, educational attainment, levels of violence, prison populations and social mobility. These worse outcomes affect all sections of the population, not just the poor. Similarly, when countries experience improved income equality, the benefits are experienced by all sections of society, not just those who are poorest.[4]

A living wage

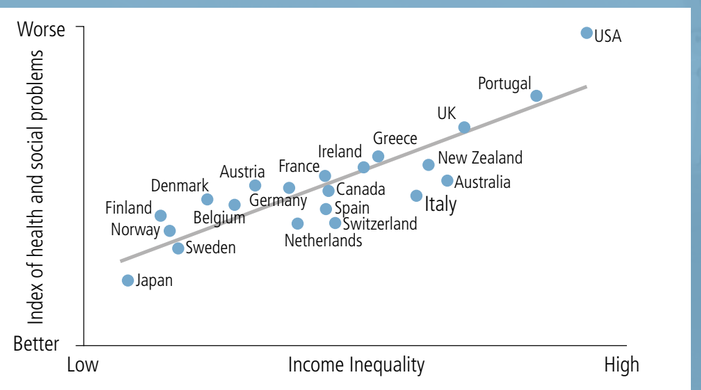
Political opinions differ as to how best to tackle wage inequality however, the evidence suggests that one of the most effective ways to tackle income inequality is to improve low wages, such as by providing a living wage. US studies have shown that the introduction of a living wage is associated with significant improvements in life expectancy, self-rated health, depression, alcohol consumption, activity-limiting illnesses and a fall in mortality.[5] Other research has shown that the living wage provides an incentive to work by reducing 'in work poverty,' and enhances health and wellbeing.[4] In the UK, the adoption of a living wage would be progressive, with the largest proportional gains in the poorest 10% of households who would see their disposable income rise by around 7%.[6]

Local authorities can lead by example, and in doing so persuade other public services to do the same particularly through contracts and commissioning.[4,7] Brighton & Hove City Council is a living wage employer and through its procurement process, requests contractors to submit a living wage and a non-living wage bid as mandatory. Currently 210 businesses in the city pay the living wage which, at the time of writing is £7.85 an hour compared to £9.15 per hour in London. This differs significantly from the national minimum wage of £6.50 for workers aged 21 years and over. This living wage is set independently, updated annually and has cross party support.

The Living Wage Commission, a national independent inquiry found that increasing coverage of the living wage could save up to £4.2billion in tax credits and other in-work benefits.[8] However, the inquiry stopped short at calling for a statutory living wage. Evidence suggests that some industries with relatively high numbers of low paid workers such as bars and restaurants might struggle with the rise in their wage bill.[9] The Living Wage Commission called for an extension of the living wage to include an additional 1 million workers by 2020.

Across the UK, 15 local authorities have set up Fairness Commissions to look at how to reduce inequality, each with a different remit and way of working but all with the same goal of reducing absolute and relative poverty locally.

Figure 5.1 Health and social problems by income inequalities in a selection of countries



Source Wilkinson, R. and Picket, K. (2010) The Spirit Level: why more equal societies almost always do better. London: Penguin.

Income inequality and economic growth

The economy has a huge impact on health and wellbeing. During economic recessions, suicides, homicides, domestic violence, mental illness and infectious disease all increase. However, due to reduced car use there are fewer deaths on the roads.[10] Research suggests that rising income inequality was one of the factors in the recent economic crisis, contributing to the conditions that resulted in financial collapse.[11]

Today the gap between rich and poor in most developed (OECD) counties is at its highest level for 30 years. The richest 10% of the population earn on average 9.5 times more than the poorest 10%. The Gini coefficient (a broad measure of inequality, which ranges from zero, where everybody has identical incomes, to 1, where all income goes to only one person) has increased by 3 points (to 0.32) since the mid 1980s.Recent research suggests that increasing income inequality actually reduces economic growth.

A rise of the Gini co-efficient of 3 points would, after 25 years, result in a loss of 8.5% GDP.[12] Anti-poverty programmes alone are insufficient to mitigate the effects of the inequalities. A combination of addressing low pay, investing in skills, targeted job creation and a more progressive tax system are all required to achieve greater income equality.[12,13]

In summary the economic downturn has seen a fall in most peoples' income and a reduction in the differences in income between most people. However, there is a small group of people who have seen their incomes increase substantially; hence the overall gap in income between the poorest and richest has increased.

Tackling Inequalities

Oldham Fairness Commission

Fairness Commissions look at how to address relative poverty and inequality within local areas. In March 2015 the Oldham Commission adopted a parliamentary select committee style inquiry approach with hearings on income, employment, education and inequalities faced by different population groups. The Commission found that 35% of jobs in Oldham were paid below the living wage; and there were higher levels of unemployment and consequently higher levels of Job Seekers Allowance claimants than elsewhere. The changes to benefits saw 65% of people accessing food banks because of sanctions or delays to benefits. The Commission recommended that Oldham become a Living Wage Borough; recruit locally, support disadvantaged groups in the labour market and for public sector organisations to publish data on the ratio of top pay to average pay.

5.2 A city divided?

The same tensions of absolute and relative income, and growth in the income of a small section of the population are played out in Brighton & Hove.

Wages - full-time and part-time, real and otherwise

There are two key measures of wages. The residence measure relates to people who live in a location but may work elsewhere (about 25% of employed local residents work outside of Brighton & Hove). The workplace measure relates to people who work in the city but do not necessarily live here (again, roughly 25% of employees in the city live outside Brighton & Hove).

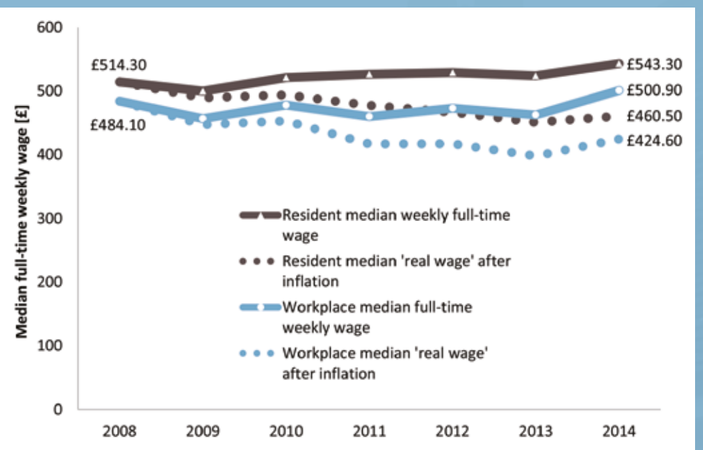
Historically, full-time 'residence

based' wages have been higher than 'workplace based' wages. A difference of £30.20 per week in 2008 (£514.30 - residence versus £484.10 - workplace, median full-time pay) grew to £42.80 by 2014. 'Median'(mid-point) wage levels are used in figures because mean average wages can appear higher, due to the disproportionate effect of a few very high earners. The disparity between residence and workplace wages reflects the need to commute to access higher wages in London. Brighton & Hove has over 9,000 highly skilled and qualified residents that commute, with Westminster, the City of London, and Camden and Islington the most popular London destinations. Most commuters work full-time.

The part-time picture is slightly different. In 2008, residence-based median part-time wages (£170.20) were £8 higher per week than workplace-based median part-time wages (£162.20), but by 2014 this trend had reversed and workplace part-time wages were £3.40 higher than residence-based wages. Furthermore, between 2013 and 2014 both resident and workplace median part-time wages fell (by £23 and £17 per week respectively). This fall in wages has been accompanied by a rise in part-time working. Since 2008, the number of residence-based part-time roles in the city has risen from 29,000 to 34,000 while workplace-based part-time roles have risen from 31,000 to 39,000.

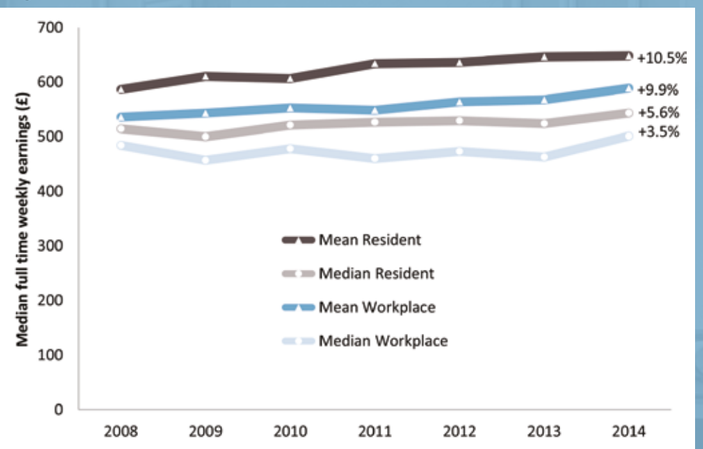
Adjusting wages for inflation shows changes in 'real' earnings. Over the last 6 years (Figure 5.2) both residence and workplace-based wages have fallen in real terms. Since 2008, while inflation has added 18% to the national index of consumer prices (CPI), median resident full-time weekly wages have grown by 5.6% in the same period, while workplace full-time weekly wages have grown by just 3.5%.

Figure 5.2 The effect of inflation on full-time weekly wages in Brighton & Hove (resident and workplace based), 2008 to 2014



Source Office for National Statistics Annual Survey of Hours and Earnings.

Figure 5.3 Mean and median resident and workplace full-time weekly earnings, Brighton & Hove, 2008 to 2014



Source Office for National Statistics Annual Survey of Hours and Earnings.

Income squeezed

'Fixed costs' like housing, fuel and food drive inflation more than consumer goods. Travel costs can also be substantial and represent another pressure on low paid workers who have to commute to work.

Electricity, gas and miscellaneous energy costs have risen to a consumer price index of 139% since 2008, and a separate category – housing rental costs, water, electricity, gas and other fuels have increased to a consumer price index of 124% in the same period.

The 'average' household's expenditure on housing, fuel and power is 13% of total expenditure. However, for the lowest 10% of earners it is 21%, and for the lowest 20% of earners it is 19%. People in these two groups spend 62% and 54% more of their incomes respectively on housing, fuel and power than the 'average' household.

While across England and Wales, the price of a mortgage has fallen to an index of 98 since 2008 (when it was 100– so it is on average 2% cheaper), in Brighton & Hove, there is a dramatic difference. Here, the price of a mortgage for properties in the city has risen to an index of 117 since 2008 (= 100).

While lower wages nationally are usually associated with lower housing costs and vice versa, Brighton & Hove bucks that trend with average wages, but high housing costs. As house prices continue to rise the proportion of income spent on housing is likely to rise further still.

Gender and income inequality

The average (mean) gender pay gap between men and women is lower in 2014 than it was in 2008 however, this average figure hides some nuances of inequality. Among higher earners (75th percentile full-time median wages), wages for women have grown faster than for men, although they remain lower in absolute terms. Resident women's earnings at the top (75th percentile) have grown by 11% or £67.60, suggesting that higher earning professions, including many in London, are increasingly accessed by women. For lower earners (25th percentile) however, men's wages have grown faster than women's wages. As discussed above these increases in part-time wages have been more than offset by inflation.

5.3 What can we conclude?

Income is the biggest driver of inequality. There are particular pressures in the city that stem from high housing costs and average wages. The wages of those who live in the city but commute to work elsewhere have risen more than those whose work is in Brighton & Hove however, rises in wages have been insufficient to meet the rising costs of inflation. This is particularly the case for those with the lowest wages. Part-time wages have fallen most recently and this fall has been accompanied by an increase in the number of people working part-time. There has been some reduction in inequality between male and female wages but only among those on higher earnings; women earning lower wages have seen no improvement in gender equality.

Evidence shows that economies benefit from less inequality in wages, across a range of health and social indicators. Some public sector organisations are seeking to address this by for example, adopting fairness commissions. While Brighton & Hove city council is a living wage employer, further strategic efforts to reduce wage inequality would benefit the whole of the population.

Reform of welfare

John Francis and Tabitha Cork

6.1 What do we know?

National reform

The Conservative / Liberal Democrat coalition government of 2010-2015 initiated a programme of welfare reform, with the stated intentions of simplifying the benefits system, ensuring that transition into work was financially advantageous and achieving better control of spending on working age benefits at a time of national deficit reduction.

Several benefits were reformed:

- Housing benefit
- Council tax benefit
- Tax credits
- Job seekers allowance
- Employment support allowance
- Disability living allowance / Personal independence payments
- Child benefit

Changes included:

- Reduced amounts of benefits payable (Housing benefit and Council tax benefit);
- Tightening up of financial eligibility criteria (Child tax credit);
- Tightening up of other eligibility criteria (Working tax credit);
- Ending some benefits and replacing them with others to which fewer people are entitled (Disability living allowance and Personal independence payments);
- Restricting annual increases to amounts less than inflation (nearly all working age benefits);
- Restricting the total amount in benefits a family out of work can receive.

All working age claimants of benefits have experienced at least one change, and many will see a cumulative reduction in income as they fall into two, three or maybe more reforms over time. The ability to absorb reductions in income may diminish and many may see their financial resilience significantly tested. Pensioners have been relatively protected from the reforms although those that rent in the private sector may be affected by housing benefit changes. Furthermore, as a new Conservative government has signalled further reforms, it is likely that the impact of these will widen.

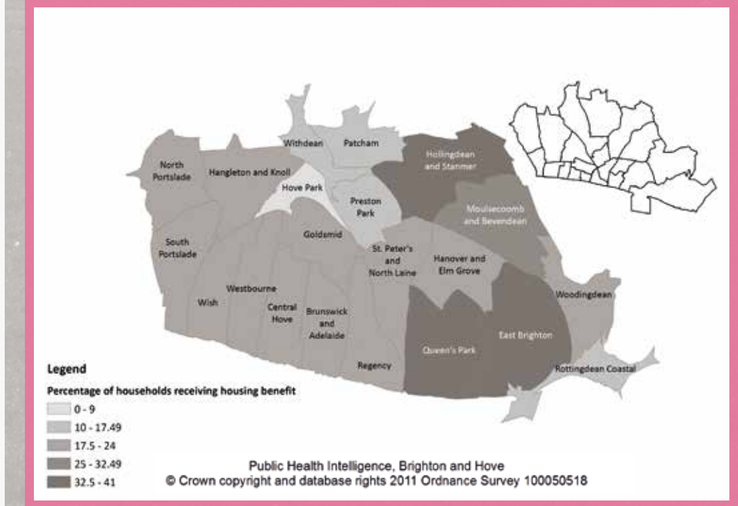
6.2 A city divided?

Local effects

In Brighton & Hove the potential impact is already considerable. The housing benefit caseload in the city is 27,000 households (Figure 6.1) of which 20,000 are working age and 7,000 are of pensionable age. There are 7,520 households where someone of working age is earning a salary as well as claiming for help with rent. There are 7,560 families with children in receipt of housing benefit, of whom 5,000 are lone parents, who may face a greater struggle to find work due to competing issues of childcare. There are 9,800 working age households on housing benefit, where someone is either disabled or affected by a health condition that restricts the ability to work. There are 1,200 households with a carer and 158 carers do not live with the person for whom they care.

With such a potentially serious impact, in order to better understand and predict the effects of welfare reform in Brighton & Hove, the city council commissioned some research, through the Public Health Directorate. The Centre for Economic and Social Inclusion (CESI) will publish a full report of this research in 2015.

Figure 6.1 Percentage of households claiming housing benefit, November 2014



Source Department for Work and Pensions

The results so far show:

- A total of 25,400 households have seen a reduction in income: this is equivalent to 20% of all households in the city (total household number is 127,000);
- The average loss in income in these households is £44 per week: equivalent to £2,300 per year;
- Of those households affected, half are working households and half rely solely on out of work benefits.

Within this group of residents that already sits at one end of the inequality spectrum, some will experience greater inequality:

- Around 40% of those affected are disabled and face a greater impact than able bodied people;
- The impact on households headed by women (22%) will be higher than for those headed by men.

The cumulative impact across the city is considerable. Brighton & Hove sits in the top 10% of most affected cities in the country and the annual financial loss in the city from reduced benefit spending is estimated at £59 million each year (Table 6.1). The large, high-cost, private rented sector makes the city particularly vulnerable. The cumulative impact on individuals and families is more concerning still. Local council and third sector services report that in order to manage their debts, residents are borrowing from friends and family, from crisis loans and from pay-day lenders. Several residents are tied into payment plans for household and electronic goods with hire purchase companies with high interest rates. Others have substantial debts from catalogues and store cards. Several report that they are eating less, heating their homes less, buying cheaper food, and using food banks to mitigate the effects on their children. The majority of residents affected also report significant effects on their own health and wellbeing.

Of the large number of those with private sector rents, 12,000 households receive housing benefit. Just 2% of one bedroom properties; 1% of two bedroom properties; 1% of 3 bedroom properties and 3% of four bedroom homes advertised for rent in Brighton & Hove are within housing benefit rates. This means that most families that live on a low income and rent privately will have to find the shortfall between their housing benefit and their rent from somewhere. Rents, already increasing year on year, are expected to continue to rise. Housing benefit, which used to track market rates in the private sector is now restricted to a maximum of 1% yearly rises. This means the gap between market prices and the amounts paid by housing benefit will increase. Many local landlords have now stated that they will not let to people on housing benefit. The large student population in the city already competes with low income families for 3 and 4 bedroom rented homes as well as

Table 6.1 Estimated total financial impact of welfare reforms in Brighton & Hove by ward

Ward	Total Households	Average Impact Per Household	Total Impact (£)
St.Peter's & North Laine	1,974	£2,028	£4,004,405
Queen's Park	2,162	£1,828	£3,952,447
East Brighton	2,024	£1,726	£3,493,099
Goldsmid	1,467	£2,346	£3,441,025
Moulsecoomb & Bevendean	1,582	£1,961	£3,102,160
Hanover & Elm Grove	1,388	£2,213	£3,071,603
Hollingdean & Stanmer	1,492	£1,984	£2,960,537
Regency	1,197	£2,452	£2,933,810
Brunswick & Adelaide	1,124	£2,535	£2,848,854
Hangleton & Knoll	1,287	£2,122	£2,730,140
Central Hove	1,009	£2,703	£2,726,911
Preston Park	1,067	£2,445	£2,607,105
South Portslade	899	£2,777	£2,497,150
Westbourne	920	£2,666	£2,452,897
Withdean	835	£2,850	£2,378,346
Rottingdean Coastal	778	£2,910	£2,263,348
Patcham	880	£2,561	£2,253,153
North Portslade	808	£2,660	£2,150,357
Wish	734	£2,903	£2,131,187
Woodingdean	707	£2,976	£2,105,543
Hove Park	487	£3,619	£1,763,042
Brighton Total	**25,442**	**£2,311**	**£58,802,661**

Source Centre for Economic and Social Inclusion (CESI)

for low skilled, part-time jobs. It is low income families who are most likely to lose out as lower levels of education and training, language barriers, lower confidence and digital exclusion are barriers to housing and employment.

The impact of these welfare reforms varies across the city depending on the average impact per household (highest at £3,619 in Hove Park, although just 487 households are affected) and the total number of households affected (highest at 2,162 households in Queen's Park where the average impact is £1,828 per household) (Table 6.1). The greater overall impacts are where a greater number of residents are affected, however the impact on individual households, even in wards where fewer residents are affected is considerable.

Services to reduce the impact in Brighton & Hove

The third and statutory sectors work in partnership to mitigate the impact of benefits changes. A Welfare Reform programme has been established by the city council's Revenues and Benefits service, working with the community and voluntary sector. The programme brings together advice, emergency provisions, training and employment support for residents. Learning from the Troubled Families' Family Coach programme, two intensive support officers work with complex families who face considerable reductions in income in an effort to support them into employment.

Jobcentre Plus and the city council are working together to help residents find work. The council identifies the vulnerabilities and needs of residents and shares these with Jobcentre Plus where Work Coaches devise a tailored, individualised programme of support. The city's Employment & Skills Plan sets out how, through partnership working, residents can benefit from local economic growth. The emphasis is on ensuring that those furthest from the labour market develop employability skills, vocational training skills and receive employment support, whilst also ensuring that businesses are able to grow and create jobs.

Section 17 of the Children's Act requires local authorities to provide for children in need and their families. A fund is managed though Children's Services and is used for a wide range of support including white goods as well as respite care. A Family Intervention Service provides assistance to people trying to organise child care, as well as helping people access free child care for 2, 3 and 4 year olds.

The city council, through the Public Health Directorate working alongside the clinical commissioning group, has for three years commissioned the Citizens' Advice Bureau to work within GP practices and take referrals of people who may present to their doctor because of low income related health problems. This initiative has been successful in supporting residents who might not present to services in other settings (See Chapter 5).

There are several discretionary short and long term payments to families who are on a low income, in crisis, at risk of homelessness or have other significant vulnerabilities. Financial advice and relief, however brief, can help to mitigate the cumulative effects of the reforms. The Local Discretionary Social Fund assists in the event of a crisis with help with food, utilities or other essential items like furniture and electrical items. Between April 2014 and February 2015, the service received 1700 applications and made 950 awards. Discretionary Payments can also help low income families with a short-term rent or Council Tax payment requirement, as well as help with moving to affordable accommodation. The 2014/15 budget for these in Brighton & Hove, which was spent in full, was just over £1 million. Around 75% of applicants received payments, although residents unlikely to be successful were discouraged from applying. In 2015/16, the budget will fall by 40% to £600,000, increasing further the pressures on low income families.

Moneyworks is a new free service commissioned through the city council's Financial Inclusion Strategy and aims to help the most vulnerable in the city deal with debt, manage money better, and avoid unscrupulous loan sharks. The service operates from different locations across the city and also provides online and telephone advice.

Universal Credit - another challenge

The national rollout of Universal Credit, begun in 2015, is expected to include single job seekers in Brighton & Hove during the second half of 2015. The current plan is for households with children to move onto Universal Credit from May 2016. The city council, third sector and landlords are preparing for the challenges that Universal Credit may present for vulnerable residents in the city.

Universal credit will require residents to be digitally able and financially robust in order to manage their claim online and budget on a monthly basis. Monthly payments will be paid to a single member of the household: a significant change from the currently system where multiple payments of different types of benefit are made across the month. Access to basic bank accounts, with minimal charges and penalties that allow individuals to separate off funds for regular outgoings such as rent, food or utilities will be vital to allow people to adapt to a new approach to financial management.

The city council is using the findings from projects and commissioned research on welfare reform and financial inclusion to map needs in the city regarding Universal Credit, including the wider implications of budgeting on a single monthly payment, made directly to the claimant.

6.3 What can we conclude?

Residents in receipt of benefits are already at one end of the inequality spectrum. Welfare reform has seen them experience greater financial pressure and households with disabled residents, headed by women, or who struggle to manage budgets digitally on a monthly basis will feel this most. The impact on individuals who may fall into serious debt is already considerable and is likely to increase as welfare reform continues.

Some wards are affected substantially, although the effects of welfare reform are being seen across the whole of the city. Even in wards where fewer people are affected the impact on individual households and families can be significant.

Reductions in benefit levels coupled with local housing costs mean that in Brighton & Hove securing employment is likely to be the only realistic route for many people to address the fall in income. Hence, improving the employability of residents on benefits, forms a very important part of the City Employment and Skills plan 2015 –20.

Holistic advice from the third sector, Jobcentre Plus and primary care support staff, working alongside core services such as the city's Revenues and Benefits and Housing Departments has demonstrated some success, particularly in helping people cope with short-term crises. The city will have to adopt a very proactive approach in order to support claimants who have been out of work for a long time into work, even where previously employment was not considered a viable option. Support staff are well informed, and very capable when advising residents on benefit rights and entitlements to statutory services. However, different skills are required to motivate and steer people into employment. Services across the city should consider the need to train staff on how to talk about employment opportunities, so that this discussion becomes an every-day part of the advice given to vulnerable residents who are set to face considerable long-term financial challenges.

Food and Hunger

Vic Borrill, Peter Wilkinson and Susie Haworth

7.1 What do we know?

Food poverty

Food poverty is the inability to afford, or have access to, the food necessary for a healthy diet.[1] It does not exist in isolation from the other forms of inequality and poverty discussed in this report: low pay, unaffordable housing, falling benefits, and a lack of disposable income. Nor do food prices exist in a vacuum from the prices of other important household goods and expenditure. However, food poverty has come much more to the fore in recent years and media images of people forming queues at food banks are resonant of a time long thought to have disappeared.

Nationally, the people most likely to experience food poverty are those on low incomes; unemployed people; those with dependent children; older people; people with disabilities; and members of BME communities.[2] Food poverty may be a short-term event in times of crisis such as a sudden drop in income due to deferred benefits, theft, or illness. It may also be long-term, reflecting ongoing low income, which may cause people to skip meals and make cheaper and unhealthier choices.

Households have three basic expenditures; food; housing and utilities. Whilst food prices have stabilised in the last few years, the UK experienced high food inflation for over a decade from 2003. During this period, food inflation was 17% in France, 22% in Germany, 30% in the United States and 47% in the UK. Between 2007 and 2012, the price of processed food, fruit and meat prices all increased by about one third. However, the price of healthier foods increased more quickly than unhealthy ones, increasing the chances that people on low incomes would opt for unhealthy dietary options.[3] These recent changes come against a background of contrasting fortunes in the price of 'healthy' and 'unhealthy' food over the last few decades. For example, between 1980 and 2012, the price of fresh vegetables tripled, while the price of an ice-cream halved.[4]

Good nutrition

In the UK, poor people are more likely to eat diets that are high in fat, sugar and salt. These in turn contribute to the higher rates of dental caries, obesity, Type II diabetes, heart disease and cancer, all of which are seen more frequently in more deprived groups. There is a clear correlation between income, diet and health outcomes. Although diet and associated wellbeing is improving in higher income groups, this is not the case in lower income groups. Hence, diet-related health inequality is growing. The National Diet and Nutrition Survey confirmed that lower income households consume fewer micronutrients and less fresh fruit and vegetables, than average income households.[5] It comes as no surprise then, that people on a lower income are one and a half times more likely to get diabetes than people on higher incomes.[6] While the reasons for this finding are multiple, the cost of food is very important.

In the UK, between 2003 and 2013, the price of electricity, gas and other fuels increased by 154%, while rents increased by 30%. Food prices also increased, and the steep rises in other costs put pressure on food purchases. Food is a 'flexible' item in a household budget and one where decisions to switch to cheaper, often less healthy products, or to skip meals to save money are being taken. Fresh produce has a shorter shelf life and is more likely to end up wasted. A 2014 study by Jones and colleagues found that healthy foods were approximately three times more expensive per calorie than 'less healthy foods'.[7]

Diet and nutrition in early years is crucial for the future health and wellbeing of children and early years dietary support can make a big difference.[8] Poor diet is linked to 30% of life years lost and disability.[2] Whilst in Brighton & Hove and across the population in the UK as a whole, levels of childhood obesity are now falling, the incidence of obesity in low income households is higher than it was in 2006.[6]

Access to good food is also important. The cost of travel to shops selling a range of healthy products may be a factor, particularly for people with disabilities or for older people who may be less able to shop online. Food banks provide a vital service for people in crisis. However, food parcels do not address the causes of food poverty and so are not the long-term solution. There are concerns that the nutritional content of food parcels is variable and that much of the donated food is highly processed.

Feeding Britain, the report of the All-Party Parliamentary Inquiry into hunger in the United Kingdom, put the focus on eliminating hunger rather than eliminating 'food poverty'.[3]

"The ambition is a Zero Hunger Britain in which everyone has the resources, abilities and facilities to purchase, prepare and cook fresh, healthy and affordable food no matter where they live... We also know that even if families have... just enough money to prevent hunger, this most basic of objectives is made that much more difficult if a family has only a very limited range of food on offer, little or no ability to prepare and cook food, and no facilities to cook that food, or if there are other fundamental crises afflicting their lives."

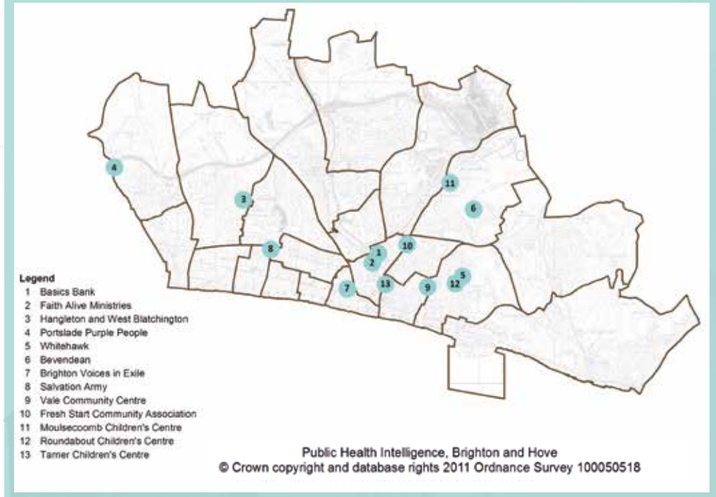
7.2 A city divided?

There is no comprehensive measure of food poverty at a national or local level, so it is not possible to say exactly how many people experience food poverty. However, a number of proxies can help paint a picture of food poverty in Brighton & Hove.

Food banks

Food banks are a relatively recent phenomenon with most of them having opened in the last 3-4 years. In Brighton & Hove in 2012, there were three food banks, by July 2013 this had increased to six, and by July 2014 there were 12, collectively giving out parcels to 270 households a week. A further food bank has opened since then (Figure 7.1). 'Basics Bank' is Brighton's largest food bank and supports over 20 households each day, ranging from families with young children to pensioners. This is a 53% increase from 2012-13 and reflects the Trussell Trust's national figures of a 54% increase over the same period.

Figure 7.1 Map of food banks in Brighton and Hove May 2015



Source Brighton & Hove Food Partnership

Community, voluntary or faith organisations and the city council all operate local food banks. The city council's food bank supports vulnerable families with children under five through some of its children's centres. FareShare, the city's main food collection and distribution project provides food to most food banks as well as lunch clubs, cooking and homeless projects. Emergency food providers come together via a network and link with advice services and other forms of support. Most local food banks require a referral to be able to use them.

Reports from local food banks show that the largest group of people using them are those who have experienced recent changes or delays to their benefits. This is in keeping with national findings from the Trussell Trust.[9] The number of food bank users however, is not a good indicator of the need for food, as most households only use them as a last resort and so it will underestimate food poverty. Nevertheless, the increase in the number of people using this "crisis provision" suggests very strongly that more people are experiencing food poverty.

Free school meals

Free school meals help mitigate the effects of food poverty on children. In January 2015 there were approximately 4,400 pupils in Reception to Year 11 in Brighton & Hove who were eligible for a free school meal. This is 14.5% of the school roll. The take-up of free school meals is between 80% and 85%. In September 2014, the Universal Infant Free School Meal Policy was introduced, offering a meal for no charge (not dependent on receiving a qualifying benefit) to pupils attending schools in Reception and Years One and Two. This initiative and the efforts of the school meals team means that at least 7,200 pupils across the city now have a healthy lunch. Take up of this offer varies daily and can range from 70-85% depending on the menu choice.

Some children may also experience food poverty in the

Tackling Inequalities – School meals

Suzie Haworth, School Meals Manager, and Madeleine Denyer, Head Teacher, Stanford Infant School

In 2009, the school meals service provided approximately 5,900 meals a day, rising steadily over 5 years to 8,000 meals per day. The introduction of the government's Universal Infant Free School Meals (UIFSM) policy in September 2014 saw this rise to 12,000 meals on average per day.

The city council supports schools to run food and cooking events. Stanford Infants school has run a Let's Get Cooking Club for 6 years and for the last four a "Big Cookathon" event has taken place. Last year 270 young pupils and their parents helped to jointly prepare their own lunch. This shared experience of preparing high quality and healthy food has knock-on effects in children's homes. The success of the event saw the school win in the South East category. Stanford Infants School is now compiling a School Cookbook with healthy options and a Breakfast Club which has 50 registered children and a rising waiting list.

In another initiative, the launch of the Marine Stewardship Council (MSC) certification in the city provided Bill Randall, (Mayor at the time), the school meals contractor and the Brighton & Hove Food Partnership, to join up with pupils and schools to make fishcakes. A local fish shop at Shoreham Harbour brought along fresh fish and crabs and the children were amazed to see that they came from the sea just off our coast.

A school lunch is much more than just food on a plate. The UIFSM policy and our School Food Plan have increased the opportunities to promote a balanced diet, and for children to try new foods, develop social skills, sit with friends, and of course learn to use a knife and fork. Young people need knowledge and confidence to make the right choices and eat "me-sized" meals. The quality of the ingredients used within the school meals service has improved and now includes local free-range eggs, more seasonal fresh fruit & vegetables, UK sourced Red Tractor meats and food accredited to Silver Food for Life (Soil Association).

school holidays. Many of these pupils will come from the same families and their parents will be expected to provide an extra daily meal per child over the holiday period. A local organisation Chomp, which provides a free holiday meal to families in this category, has reported a sharp increase in demand for their services.

Community meals

Around 200 housebound people in the city receive community meals and other residents are members of lunch clubs. There are 70 community food-growing projects, and 20 community cafés, lunch clubs and cookery groups that bring people together around food. These outlets provide opportunities for people to access affordable food and companionship.

A 2015 survey by Brighton & Hove Food Partnership of 68 community settings that offer a shared meal, identified that there are 38,460 meals a month being eaten in a shared setting (eg lunch clubs, growing projects, cookery groups, day centres). These settings provide shared meals for older people (47%) and, more surprisingly, working age people (43%). Surveys show that members come for companionship and because of food affordability problems.

Basic living costs

In the recent city tracker survey almost one in four (23%) of respondents were concerned about having enough money in the next year to cover basic living costs. The groups most likely to report this were women, people aged 18-34 years, and people with a long-term condition or a disability. In March 2014, Amaze reported that of the 103 parents of children with special needs who received their support, 15% said they had reduced or skipped meals for the family in the previous two months, because of insufficient money for food.

Local Discretionary Social Fund (LDSF) payments (see Chapter 6) are available to people on a lower income, and who face an unforeseen emergency or financial crisis. Many applications are for food and fuel-related expenses. Between April 2014 and February 2015, the service received 1700 applications and made 950 awards. These included many payments for cooking related equipment, which may indicate a lack of facilities to prepare nutritious, affordable meals. These payments were concentrated in East Brighton, Queens Park, and St Peter's and North Laine. There were also several hundred awards for fuel expenses excluding fuel arrears. This is significant because food and fuel poverty are often closely related – and households may face a choice between 'heat or eat'.

7.3 What can we conclude?

Solutions to food poverty are about more than simply handing over food and dealing with immediate hunger. As in other areas of inequality, the approach has to include initiatives to increase employment, promote a living wage, enhance financial inclusion including access to affordable credit and savings accounts, reduce fuel poverty and improve cooking and shopping skills.

As recommended in the Feeding Britain Enquiry, voluntary, private and public sector expertise needs to come together to tackle food poverty. In Brighton & Hove, there are several streams of work, and some excellent initiatives, but these are not always coordinated, with the potential for duplication or unnecessary gaps in provision. Relevant agencies need to work together closely to provide rapid referral to hardship funds and support to people experiencing food poverty. The Brighton & Hove Food Partnership provides training on food poverty to help advisors and health professionals.

Free school meals help mitigate the effects of food poverty on children. The introduction and promotion of Universal Infant Free School Meals has significantly increased the number of children receiving a healthy lunch. Promoting breastfeeding and the uptake of Healthy Start vouchers are also important for infants and small children.

Food poverty is already a priority in the MoneyWorks financial inclusion strategy and the city's Joint Strategic Needs Assessment. Advising people experiencing food poverty is complicated as they may be struggling with food purchases for many reasons. People need skills and knowledge to shop and cook well and to make the most of tight food budgets. Young people need to understand nutrition, how to grow food and how to cook food so that they can make food choices in the best interest of their health. A city Food Poverty Action Plan should form part of any comprehensive Inequalities Strategy, and it should take a life-stages approach to both prevention and crisis intervention.

No education - no opportunities

Nicola Rosenberg, Kate Gilchrist
Contributors: Ben Miles, Caroline Palmer, John Guzek

8.1 What do we know?

Evidence from many countries confirms the strong correlation between educational attainment and health, social and economic success, both within and across generations.[1] However, large differences in educational attainment persist despite decades of educational reform.[2]

The best early start in life

Learning capability is established in the first years of life, so the quality of pre-school and the home-learning environment is critical. A good transition to first school is also important, especially for those with particular needs.[3] Children's Centres bring together health, education and social services for families with young children, and evidence shows that the Sure Start Programme in these centres has resulted in improvements in health, parenting, behaviour and school readiness with poorest children benefitting the most.[4,5] The provision of 15 hours a week of free early education, available to disadvantaged children from 2 years has been effective in reducing educational inequalities. Success depends upon using programme designs founded on evidence-based practice.[6] Good home to school transition programmes also improve later outcomes, particularly for at-risk groups.

Schools

From 2015, the age when a young person is required to be taking part in appropriate education and training extends to 18 years. Schools are well placed to develop pupil and community resilience by improving pupils' attainment, supporting them through transitions, promoting better interpersonal relationships and developing wider community initiatives.[7] Risk factors often cluster and therefore a 'whole school' approach is important.[8] The impact of a 'whole school' approach has been calculated in 'pounds, shillings and pence'. Overall, every £1 spent in education returns £7.20 in health and other outcomes, therefore keeping disadvantaged young people in education is essential.[9]

There are evidence-based interventions that reduce drop out and exclusion rates, and raise educational standards amongst the most vulnerable children.[10] Bullying is extremely detrimental and programmes that reduce this can improve health and even increase future earnings, productivity and consequently public sector revenue.[10] Schools can also reduce conduct disorders by improving social skills, attitudes and behaviours as well as attainment.[11] Programmes that promote healthy lifestyles have been shown to improve diets in 6-12 year olds and can even halve adult obesity rates.[12] Wellness services that support clusters of children at risk of multiple poor behaviours are more effective than single issue focused interventions.[13]

Early intervention is also most effective in reducing the chances of young people failing to be in education, employment and training (NEET).[14] However, it needs to address educational barriers such as poor housing, substance misuse, debt, physical and mental ill health. The success of early intervention programmes depends upon connecting areas and organisations, and working to an evidence-base. National policy initiatives such as the Early Intervention Grant and the 'Troubled Families' Programme can help steer local authorities. Educational institutions also need to be flexible to accommodate young people with disabilities and chronic conditions, so that all students have the opportunity to reach their full educational potential.[15]

Adult and lifelong learning

A large part of the inequalities that adults face results from leaving school with few if any qualifications. Adult learning can improve social capital, connectedness, health behaviours, skills, employment outcomes and mental health. It also has a significant positive economic impact. The lifetime return on investment in Level 1 courses for those aged 19-24 years is estimated at £21.60 for every £1 spent, and £5.90 for those aged 25 years and over. [16] Improvements to mental health from adult learning have been estimated to reduce the health service costs of depression by £230 million per year.[17] Higher qualifications obtained during midlife are associated with lower coronary heart disease risk.[18] For older people, leisure rather than vocational courses have significant effects on psychological wellbeing and reduce isolation.[19]

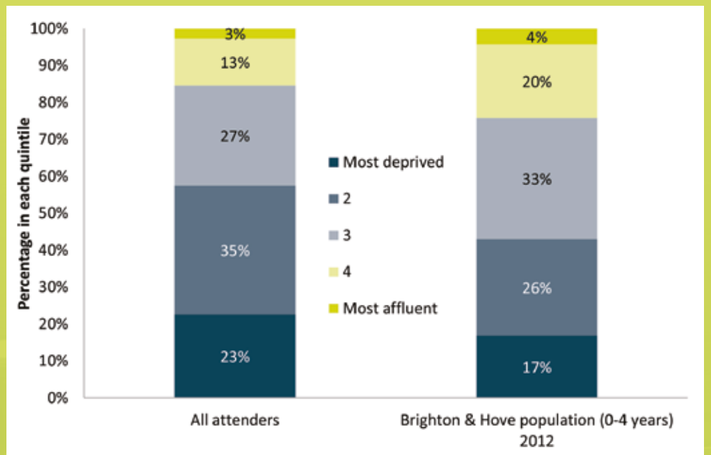
Education initiatives can also paradoxically increase inequalities and unfortunately, participation in adult learning still tends to be lower among those who need it most.[20] Cost is a barrier to learning so life-long learning opportunities need to be available to both unemployed and employed adults. Investment in those who left school with the poorest education has the potential to reduce inequalities.

So a life-course approach is required to address educational needs across different ages. Employers can help considerably with on the job training. Wide community engagement is important to understand how best to deliver adult learning courses, reach the people who can benefit most, and ensure that they are built on community assets - educational establishments, and most importantly, people.

8.2 A city divided?

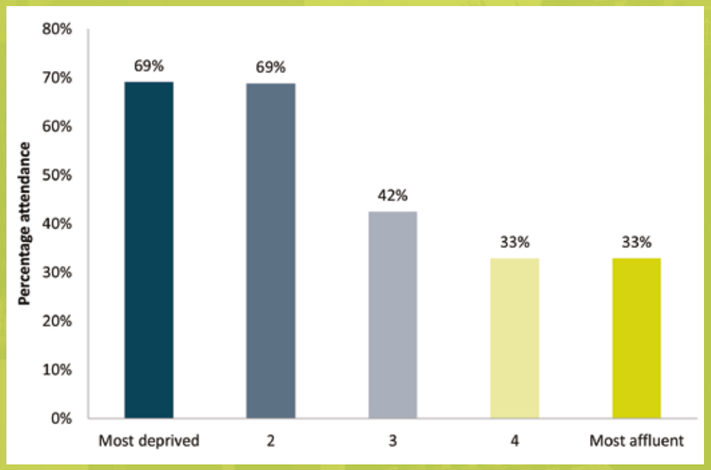
The compelling evidence for a whole school approach has seen much progress in recent years in Brighton & Hove. There are initiatives to combat bullying, and improvements in mental and physical wellbeing, including a Public Health Schools Programme that supports pupils, parents and teachers. The use of educational attainment to measure the success or otherwise of local schools is unfortunately a blunt and imperfect tool, however, it is the one tool that allows us to make comparisons with other areas and over time.

Figure 8.1 Comparison of children aged 0-4 years attending children's centres between April 2013 and March 2015 by IDACI quintile (in England), and the population aged 0-4 in the Children's Centre Area 2013 by IDACI quintile



Source Children's Centre data on unique attenders, Income Deprivation Affecting Children Index and Office for National Statistics

Figure 8.2 Rates of attendance at Children's Centres by IDACI quintile, attenders between April 2013 and March 2015



Source Children's Centre data on unique attenders, Income Deprivation Affecting Children Index and Office for National Statistics

Early years

Health visitors are integrated into the children's centre services and deliver the Universal Healthy Child Programme, reaching close to 100% of the local under-5 population. Therefore, in order to consider if inequalities exist, this section looks at those attending children's centres over the last two years.

Over the last two years, 8,623 different children aged 0-4 years attended a children's centre in the city – that's 56% of children in that age group who live in the city. There is some evidence that local children's centres are reducing inequalities. Whilst 17% of children aged 0-4 years in the city live in the 20% most deprived areas in England, in terms of the income deprivation affecting children index (IDACI), 23% of children attending children's centres are resident in these most deprived areas (Figure 8.1). If we look at local children resident in areas among the 40% most deprived areas in the country, then 43% of the city's children aged 0-4 live in these areas, but 57% of those attend Children's Centres. This suggests that the deprived children are benefitting more from local Children's Centres.

We can also calculate the percentage of children living in the areas surrounding each children's centre that attend there. This confirms that children from more deprived areas are more likely to attend a children's centre, with 69% of children in the most deprived quintile and the second most deprived quintile attending, falling to 42% in the middle quintile and 33% in the two least deprived quintiles (Figure 8.2).

We can also look at the attendance at each centre by deprivation profile and compare this to the deprivation profile of the surrounding neighbourhood. This analysis is not included here, but will inform any future discussion on children's centres. In terms of improvements for individuals and families, the city council is implementing a new evaluation framework that measures improvements against outcomes for families using children's centres. However, it is at a very early stage and therefore not included here.

Figure 8.3 Achievement in early years' foundation stage (EYFSP) profile: teacher assessments by pupil characteristics, 2013/14. Percentage achieving at least expected standard in all early learning goals

Source Department for Education

Early learning for low income two year olds

Eligible two year olds are entitled to 570 hours a year of free early learning from the term after their second birthday. To be eligible children must be from a family in receipt of out of work benefits, or on a low income (not more than £16,190) and in receipt of working tax credit. Children who are disabled or have Special Education Needs (SEN) are also eligible, along with looked after children, those adopted from care, or who have left care under a special guardianship or residence order.

Latest figures from the Department for Education show that in February 2015, Brighton & Hove had a take-up rate of 83%. This was the highest rate of the 19 South East authorities, top amongst 10 statistical neighbours, and ninth of 152 local authorities nationally. The average take-up in the South East was 63%, amongst statistical neighbours 65% per cent, and nationally 62%. The highest take-up is by parents in receipt of out of work benefits, with 87% (415 children) of those eligible taking up a place, while parents on working tax credit have a take-up rate of 71% (313 children).

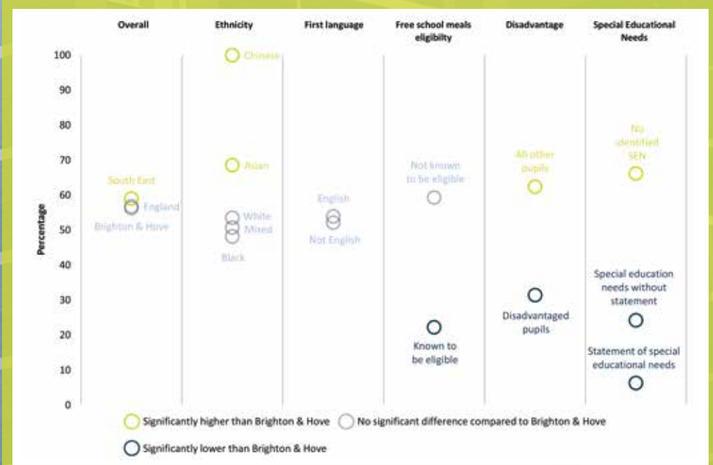
Early schooling

Children in Brighton & Hove achieve a similar level of development (school readiness) at the end of reception, as children in England (59% and 58% respectively), though worse than in the South East.[21] Furthermore, achievement varies considerably by pupil characteristics. Among pupils eligible for free school meals, just 43% achieve at least expected standards across all early learning goals, compared with 65% of pupils not eligible for free school meals. There are also differences by ethnicity, first language and special educational needs (Figure 8.3).

Figure 8.4 The percentage of pupils achieving level 4 or above in Primary School Key Stage 2 by pupil characteristics, 2013/14.

* Data not available for Chinese pupils due to small numbers (<5)
Source Department for Education

Figure 8.5 The percentage of pupils achieving 5 A*-C grades at GCSE by pupil characteristics, 2013/14



Source Department for Education

Primary schools

Primary school performance has improved in the city in recent years as measured by academic achievement. Primary school attainment is assessed at the end of Key Stage 2 (age 10-11 years) and measured at five levels in reading (test), writing (teacher assessment) and mathematics (test); these results are based on a child achieving at least level four in all three subjects.[22] Children in Brighton & Hove in 2014, achieved a similar level at the end of Key Stage 2 as children in the South East and England (81%, 79% and 79% respectively).[23] Achievement varies considerably by pupil characteristics. Among pupils whose first language is not English, 76% achieved level four or above, compared with 81% of those whose first language is English. Fifty eight per cent of pupils eligible for free school meals achieved at least level four, compared with 85% of pupils not eligible for free school meals. Just 12% of pupils with a statement of special education needs achieved level four or above, compared with 47% of those with special educational needs but no statement and 94% among pupils with no special educational needs.

Secondary schools

Secondary schools educational attainment at GCSE level in the city has lagged behind the South East and England for many years although, as documented in previous Public Health Annual Reports, there had been some progress in recent years. Even so, in 2013/14, 56% of pupils achieved five or more A*-C grades, including English and Maths, at GCSE in the city compared with 57% in England and 59% in the South East.[24] Because of changes in GCSE grading in 2013/14 these figures cannot be compared with those from previous years.

As is the case in primary school children, inequalities exist (Figure 8.5) and in some cases they are wider. Pupils from Mixed and White ethnic backgrounds, pupils known to be eligible for free school meals, disadvantaged pupils (that is pupils eligible for free schools meals or looked after), are less likely to achieve at this level. The absolute inequality gap in attainment by free schools meals eligibility is notably wider at GCSE than seen in early years: 22%at early years (65% - 43%) and 37% at GCSE (70% - 33%).

Relative inequality is also wider at GCSE level: pupils not eligible for free school meals are 1.5 times more likely to achieve expected standards at reception, but 2.1 times more likely to achieve five or more A*-C GCSE grades than those known to be eligible for free school meals.

The inequality education gap at GCSE level in Brighton & Hove, which had been reducing up until 2012/13, has now reversed. It had fallen from a pupil not eligible for free school meals being 2.9 times more likely to get five GCSEs at this level in 2005/06, to 2.2 times more likely by 2012/13. However, in 2013/14 we saw this rise again to 2.7 times more likely, and whilst there was also a widening of inequalities across England, the difference in Brighton & Hove is much greater than nationally. Were we therefore too optimistic in saying in last year's futurist '2024' report this ratio steadily improved, or perhaps there's time still to make this prediction reality? (figure 8.6).

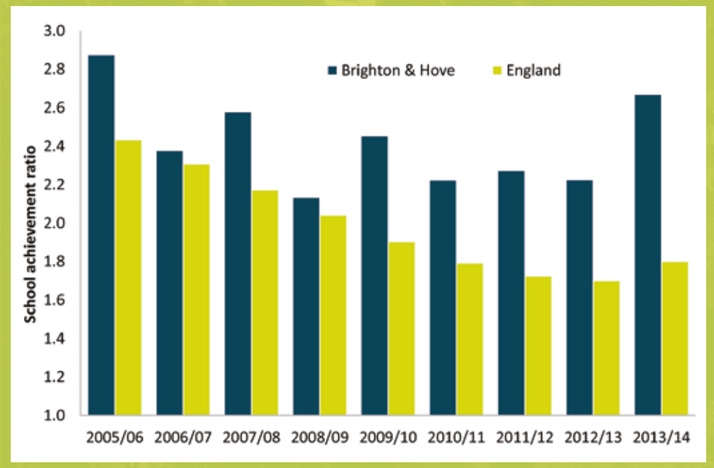
Special educational needs

It may be expected that children with special educational needs fare poorest in terms of educational achievement, and they could be achieving below or above their potential. There are identifiable inequalities in this group of children. Just as children in low income families are more concentrated in the city's more deprived areas, so are children with special educational needs. In 2005, 33% of children with special educational needs lived in the 20% most deprived areas of the city, although by 2015 this has fallen to 30%.

Adult education

The inequality picture is better for adults. Overall, the city is increasingly populated by adults with degree qualifications as shown by the changes between 2001 and 2011 (Figures 8.7 and 8.8). Furthermore, between 2001 and 2011, the absolute inequality gap in adults having no qualifications fell from 14 to 9 percentage points. The relative inequality gap saw a small reduction: in 2001, the most deprived person was 1.9 times more likely to have no qualifications than the least deprived person; by 2011 this figure had fallen to 1.8 times more likely. Therefore, whilst significant inequalities remain, the gap is moving in the right direction. However, given the educational inequality and performance at secondary school level, it is likely that this finding is at least partly due to migration to Brighton & Hove of students and other adults with higher qualifications.

Figure 8.6 Year 11 School Achievement Ratio: Children Eligible and Not Eligible for Free School Meals 2005/06 to 2013/14. GCSE achievement at 5 A*-C grades including English and Maths.



8.3 What can we conclude?

The evidence for how powerful education is in improving life chances and reducing inequalities – health, social and economic, is substantial. It is strongest in the early years and programmes like Sure Start and the effective use of Children's Centres can make a huge difference to life chances. Within schools, taking a whole school approach that does not simply focus on academic achievement, but tackles health, social skills, attitudes and behaviours in pupils and surrounding communities, can in fact have a greater impact on academic achievement. There is also evidence that lifelong learning can improve wellbeing and social and economic prospects. In adult life, cost is a potential barrier to learning and inequalities can actually widen unless access to adult learning is targeted at those who need it most. Employers have an important role in encouraging on the job training.

Brighton & Hove invested considerably in Sure Start and Children's Centres and there is evidence that these initiatives are reaching the children who need them most, although there is a potential for this to go further. This report does not include data on individual centres nor on outcomes for individual families.

Academic achievement is a blunt tool for assessing the overall influence of schools. That said; there have been some improvements in primary school performance in recent years, although last year saw a fall in secondary school performance at GCSE level. Furthermore, the relative performance of more deprived children (on free school meals) fell by much more than those less deprived children. These relatively poor outcomes in secondary schools are not reflected in the adult population which is highly educated and there is evidence that inequalities in adult educational are falling. This finding is likely however to be at least in part a migration effect, with more qualified adults moving to the city, including into areas of relative deprivation. The challenge in secondary school remains, although the recent improvements in early years and primary school education may start to work their way into secondary school.

Figure 8.7 Percentage of adult residents with degree level qualifications 2001

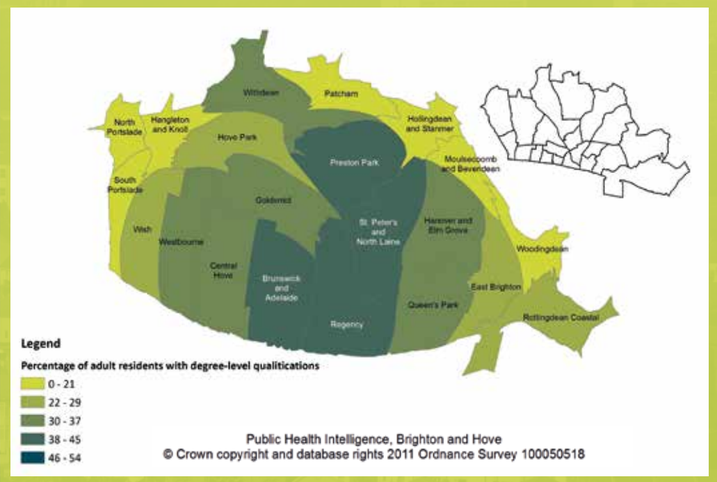
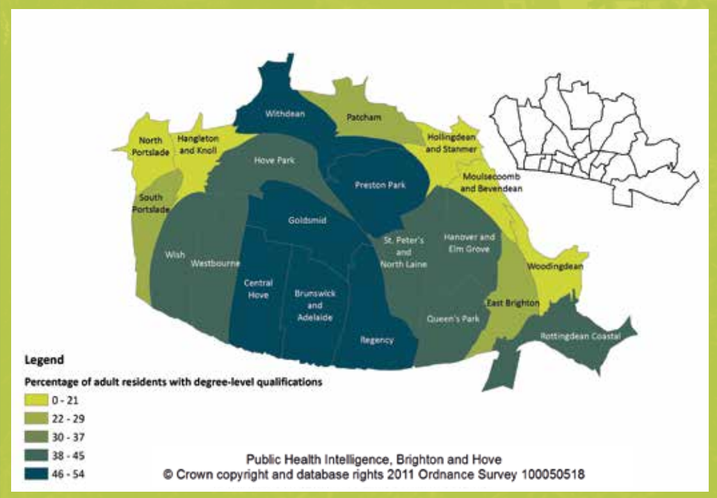


Figure 8.8 Percentage of adult residents with degree level qualifications 2011



Source ONS Census 2011

No job, no opportunities

Paul Sweeting, Vicky Watson, Kate Gilchrist, Nicola Rosenberg
David Golding and John Guzek

9.1 What do we know?

Unemployment and bad work

The effects of unemployment can last for many years. It is associated with poor physical and mental health, as well as unhealthy behaviours such as increased smoking and alcohol consumption and decreased physical exercise.[1-3] Young people designated as not in employment, education or training (NEET) also experience the adverse impact of reduced job opportunities later in life.[4-6] Youth unemployment is associated with several health indices, including lower immunisation rates and increased cases of HIV, sexually transmitted infections and respiratory diseases.[7] In this recent economic downturn, young people, men, and those with lower skills or education have experienced greater unemployment.

Low paid workers in poor working conditions also experience similar poor health.[8] Bad employment conditions are more common during economic downturns, when there are higher levels of anxiety regarding job security, bigger work demands, financial problems resulting from pay constraints and less control over working conditions.[9]

As discussed in Chapter 8, policies that target inequalities in education can reduce employment barriers, this includes those faced by young black men and Muslim women.[10] However, although ethnic minority groups have seen improvements in educational attainment, and experienced growth in clerical, professional and managerial employment, they have not seen the same levels of social mobility as their white British peers.

Tackling inequalities - Business in the community

'Business in the Community (BITC)', a Prince of Wales Charity supports businesses to provide training, work placements and volunteers who can act as job coaches and buddies to those most disadvantaged and struggling to find work. This includes people who have been in the criminal justice system, leaving care, homeless and people not in employment, education or training.

Currently over 40% of programme participants gain work following their placement and 75% of those that move into a job sustain this work for over three months.

Good work

Good work is work that gives employees some control, rewards achievements, is safe, provides a decent standard of living, and is protective to health. In order to maximise these positive effects, local areas need to stimulate demand for the right sort of labour, particularly for those most affected by unemployment.[4] Good work should also offer opportunities for in-work development, and the flexibility to balance work and family life.

Improving employment conditions

There are several ways of promoting good working conditions and the associated benefits. Employers can provide good quality part-time work opportunities and build resilience training into, for example, apprenticeship programmes. Local authorities can support this with local employer guidance; by enforcing legal obligations, by developing local work programmes, and by procuring services from employers that promote good working conditions of employees.

Getting disadvantaged groups back into work provides a net return for the public purse; from reduced benefits claims, increased tax payments and reduced re-offending. Employee wellness programmes can return between £2 and £10 for every £1 spent.[11,12] Workplace health and wellbeing interventions can encourage healthy behaviours like a better diet, physical exercise, smoking cessation and stress management. They also reduce sickness absence, improve staff morale, and increase productivity and performance.[13]

However, in order to address inequalities in health, work place programmes also need to improve the psycho-social work environment. Research shows that people with chronic conditions face negative attitudes from employers and fear these attitudes themselves - 'self stigma'. These attitudes discourage them from even applying for jobs.[14] Although there has been a shift in disability policies, the pace of change has been slow.[15] The UK Equality Act 2010 requires employers to make reasonable workplace adjustments to support people with health problems at work through flexible working, tailored support, individual placements, and training.[16] Raising awareness among employers through programmes like Access to Work, the 'Line Manager's Resource,' is a good starting point to help businesses improve.

Public Health England and the Audit Commission recommend that local authorities stimulate youth employment by encouraging local businesses to increase contact with young people, by working with local schools, providing information and offering work experience.[17,18] Fewer than half of UK students complete a work placement, compared with 87% of those in France.[19] Part-time work, training at workplaces or apprenticeships for those over 16, can increase employability and reduce risk of becoming 'Not in Employment , Education or Training' 'NEET'.[20]

Older people are living longer and the increase in pension age means many of them need to, or wish to, work longer. Retirement can be associated with reduced physical and mental health through sedentary and isolated living, just as poor working conditions can result in people retiring early.[21,22] Older people in more disadvantaged socio-economic positions face greater employment challenges, as they are less likely to have built up work skills and more likely to have experienced working age disability. Measures that promote good working conditions for an older workforce can reduce inequalities, so employers should promote recruitment practices that encourage applications from older people, flexible working, and flexible retirement options.

9.2 A city divided?

Ethnicity

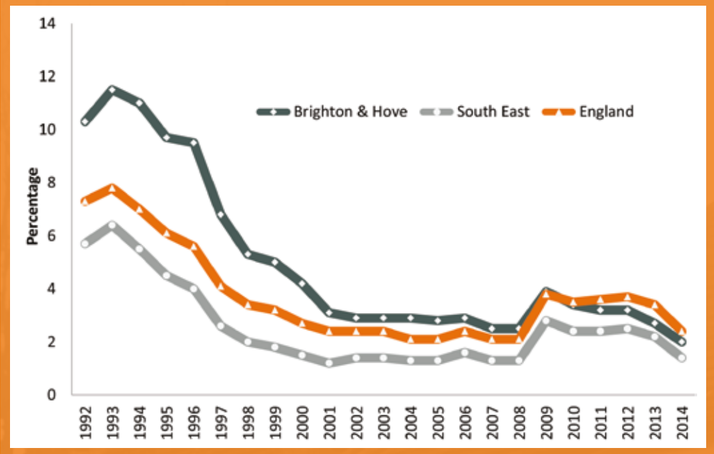
Unemployment figures are not generally available for areas smaller than local authority areas. Therefore, in order to examine inequalities in employment within Brighton & Hove we have analysed a number of indicative statistics, such as jobseekers allowance claimants.

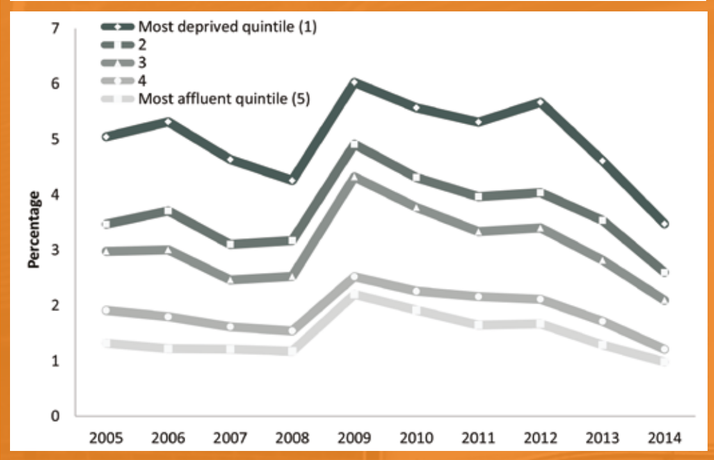
The only data on employment /unemployment and ethnicity comes from the Census. In 2011 in Brighton & Hove, 61% of adults were employed (62% of White British, 61% of BME). The highest employment rate (71%) was amongst 'Other White' residents, with the next highest being 64% for 'Black African' and 'Other Black' residents. The lowest employment rates were for Arab (41%) and Chinese residents (35%). Black & minority ethnic residents had a higher unemployment rate (9%) compared to the city average (7.3%). Four groups had unemployment rates of at least twice the city average; Black African (18.7%), White & Black African (16.9%), White & Black Caribbean (15.9%) and Gypsy or Irish Traveller (15.3%).[23]

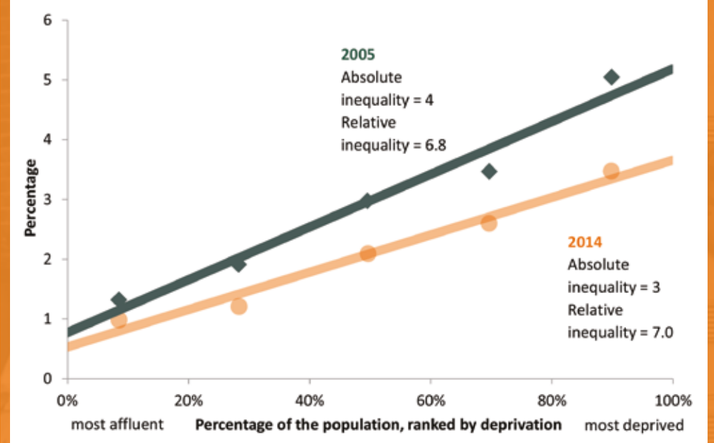
There was only a 1% difference in employment rates of BME and White British men (64% and 65% respectively). The highest male employment rates were among Other Black (77%), Other White (73%), Bangladeshi (70%) and Indian (67%) men. The lowest male employment rates were Chinese (34%) and Arab (41%) men. The lowest unemployment rate in men was among Other White (6%), which compares with White British (8%), Black Caribbean (16%), White & Black Caribbean (17%), White & Black Africans (20%), and Gypsy or Irish Travellers (23%).

Among women, overall employment rates of White British and BME groups were the same (58%). However again there were big differences between ethnic minority groups. Other White (69%), Black Caribbean (65%) and Other Mixed ethnicity women (60%) had high rates of employment compared to Black African (49%), 'Other ethnicity' (45%), Chinese (35%), Bangladeshi (33%), and Arab (26%) women. All White ethnic groups had female unemployment rates of 6% but rates were much higher in Black African (19%),

Figures 9.1 – 9.3 Claimant count – percentage of people aged 16-64 years by region, June 1992 to June 2014 (1), by IMD quintile in Brighton & Hove, June 2005 to June 2014 (2) and the Slope Index of Inequality in claimant count, June 2005 to June 2014 (3)







Source Department for work and pensions

Bangladeshi (21%) and Arab (22%) women. There were large differences in employment by gender within ethnic groups, the largest of which was within the Bangladeshi community, where, compared to 70% of men, just 33% of women were employed.

A full table of unemployment data by ethnicity can be found with the references

Jobseekers

Jobseekers Allowance figures record the number of people claiming Jobseekers Allowance and National Insurance credits. Claimants must be out of work, capable of, available for and actively seeking work. 'Residence-based proportions'; the official measure below national and regional level, expresses the number of claimants as a percentage of the population aged 16-64 years (mid-year population estimates). Over the past two decades the claimant count has fallen from a high of 11.5% of 16-64 year olds in Brighton & Hove in June 1992, to 2.0% in June 2014 (Figure 9.1). Following an increase in 2008-2009 at the start of the economic downturn, Brighton & Hove has continued to see reductions most years. Furthermore, from the rate of claiming being considerably higher than England 20 years ago, the rate in the city has been lower than that of England since June 2011, although it is still higher than across the South East as a whole.

Small area data, (only available from 2005) also suggests some local progress in reducing inequalities (Figure 9.2). The increases of 2008 / 2009 were seen across all deprivation quintiles, and overall the percentage of people aged 16-64 years claiming Jobseekers Allowance and National Insurance credits is lower for all groups in 2014 compared to 2005. The Slope Index (Figure 9.3) confirms that absolute inequalities (between the most deprived and most affluent) have fallen from a difference of 4 percentage points to 3 percentage points. There has, however been a very slight increase in relative inequalities from the most deprived person being 6.8 times more likely (than the most affluent person) to be claiming in 2005, to 7 times more likely in 2014.

Employment and Support Allowance and Incapacity benefits

Employment and Support Allowance (ESA) is a sickness benefit introduced in October 2008. It has gradually replaced Incapacity Benefit (1995-2014) but both are included here so that trends can be assessed. There has been a slight drop in the proportion of people aged 16-64 years claiming Incapacity Benefit / Employment and Support Allowance. In May 2000 in Brighton & Hove, 7.1% of 16-64 year olds received these benefits and by May 2014, this figure was 6.5% (for the South East this went from 4.3% to 4.4%, and for England from 6.8% to 5.9%).

Between 2000 and 2014 there has been a slight increase in absolute inequalities. The difference between the most deprived and most affluent individuals claiming these benefits has risen from 11% to 13%. Relative inequality however, has grown even wider. In May 2000, the most deprived individual was 7.6 times more likely to receive Incapacity Benefit / Employment and Support Allowance (ESA). By May 2014, this had increased to a figure of 33.1 (Figure 9.4). This increase has been particularly dramatic over the last year.

Figure 9.4 Slope index of inequality and Relative index of inequality trend (with 95% confidence intervals) for Employment and Support Allowance (ESA) and Incapacity Benefit May 2000 to May 2014, Brighton & Hove

Source Department for work and pensions

Tackling inequalities - CAB advice in Primary care

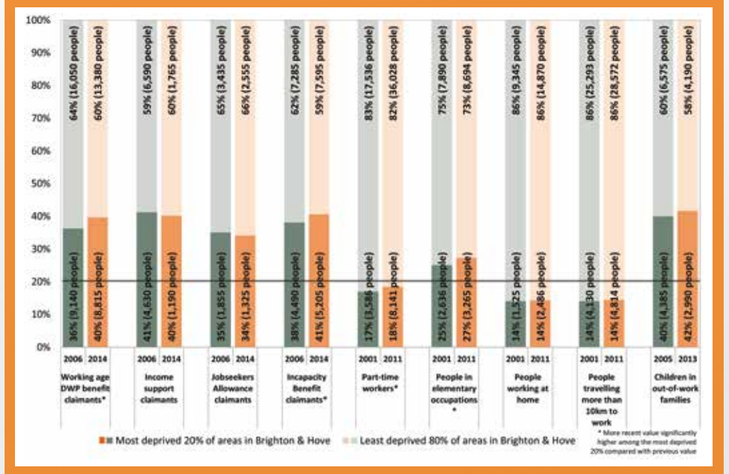
The Citizen Advice Bureau has been commissioned to provide Welfare Benefits Advice, with advisers based in six GP practices in more deprived areas of Brighton & Hove. In six months from April to September 2014, the Advisers supported 81 people. The annual cost of the service is £30,000 however an average annual total of £180,000, or £2,200 in welfare support per person, has been achieved following receipt of advice.

Worklessness (Unemployed, and actively or not actively seeking a job)

We know from the recent Inequality Review research in the city, that while unemployment and job seekers allowance claimant levels are falling, wider 'worklessness' remains a challenge. Nearly three times as many people (just under 13,000 people) are on Incapacity Benefit than on Jobseekers Allowance (4,500 people). Groups with higher levels of worklessness and long-term unemployment include; older people, women, Black Caribbean, Black African and Pakistani ethnic groups, those with low skills, the homeless, ex-offenders and drug users.

Low skilled residents face particular pressures in competing for work in Brighton & Hove through scarcity of appropriate jobs; competition from residents with higher qualifications including students; as well as from migrant workers. The employment rate for those with low or no skills

Figure 9.5 Changes in employment and employment related benefit changes in Brighton & Hove by deprivation



Source Department for Work and Pensions 2006 and 2014, and Office for National Statistics Census 2001 and 2011

is low at 53% (a third lower than the Brighton & Hove average). Nearly one-quarter of the city's children (11,000) live in 'out of work' households. Lone parent households, mainly headed by women, account for nearly 70% of all out of work households, and 650 young people are 'Not in Employment , Education or Training' (NEET). This group is likely to face health and housing problems.

Figure 9.5 summarises some of the employment changes seen in the most deprived quintile in the city over the last 15 years or so. There is further discussion on this in the chapters on Income and Welfare reform.

9.3 What can we conclude?

Employment and income are the two largest contributors to the Index of Multiple Deprivation (IMD, Chapter 1). The effects of unemployment and bad work can last for years. Young people, many of whom are not in employment, education or training (NEET) are among those who have suffered most in this last economic downturn. Employers and local authorities can do much to improve working conditions and to generate local employment, and the evidence is that in terms of health, social and economic outcomes, this is money well spent.

Identifying and interpreting inequalities in employment and unemployment is not straightforward. Data on ethnicity dates from the 2011 census and shows that locally, 'Other (not British) White' residents have the highest overall employment rates (72%). Among men, it is 'Other Black (not African or Caribbean)' (77%) and among women, it is 'Other White' (69%). Four ethnic groups - Black African (18.7%), White & Black African (16.9%), White & Black Caribbean (15.9%), and Gypsy or Irish Traveller (15.3%) have unemployment rates at least double the city average (7.3%).

To examine employment by deprivation in the city, we need to use proxies such as claimants for Jobseekers Allowance, Employment and Support Allowance and Incapacity Benefit. In terms of Jobseekers Allowance claimants, the trend in the city appears positive with overall a reducing gap between the deprived and affluent residents. In terms of people who are too sick to work however, the picture is different. While the overall numbers of claimants has also fallen, there has been an increase in inequalities, most dramatic in the last year. The people who are in receipt of Employment Support Allowance / Incapacity Benefit are more deprived than they have been in previous years. This may be because since 2011 Incapacity Benefit claimants have undergone reassessment using the Work Capability Assessment, and either transferred to the Employment and Support Allowance or to the Jobseekers Allowance where they have to be seeking work. Even so, in Brighton & Hove, nearly three times as many people (just under 13,000 people) are on Incapacity Benefit as are on Jobseekers Allowance (4,500 people).

Groups with higher levels of worklessness include; older people, women, Black Caribbean, Black African and Pakistani ethnic groups, those with low skills, the homeless, ex-offenders and drug users. In Brighton & Hove, there is competition from higher skilled and educated migrants to the city. Low skilled residents, including young people and lone parents, face the biggest employment challenge. Any employment strategy for the city needs a particular focus on these groups.

Dr Becky Jarvis (Happiness Champion)

GP, Brighton & Hove

Interviewed by Tom Scanlon

Past

Both my parents grew up in what would today be considered quite extreme poverty – one in the East End of London and the other in rural Derbyshire. Neither had inside toilets, or reliable electricity, and both were the first in their families to stay on at school over the age of twelve. But they did well and as a result I was bought up to feel a sense of my good luck in being born in to a family with advantages over the rest of the population; where there was enough money, and where we took health care and education for granted. This sense of what might be undeserved good fortune for me, was also linked to a fear that at any moment my luck might change for any capricious reason, and if it did then what would happen?

Present

My work as a GP has reinforced the sense that there are things that you can do to improve your health and build your own luck, but that at other times there is no rhyme or reason or fairness behind illnesses. From my interest in mental health, I know that there is evidence that through the five ways – Connecting, Learning, staying Active, taking Notice and Giving – we can all reduce the risk of becoming unwell. Some people however will develop a serious mental illness such a schizophrenia, no matter how hard they try to improve their wellbeing. If this happens then we know that the chances are that their illness will affect their physical and social health, as well as them experiencing the symptoms of their mental ill health. Their life expectancy will be shortened by about 20 years – partly because health professionals looking after them will not screen for cardiovascular disease or diabetes, or offer health promotion interventions such as smoking cessation. They will be more likely to find themselves homeless and socially isolated, and less likely to work or finish their education. People with serious mental illness also will experience stigma on a daily basis.

Future

It can feel a bit overwhelming if you think about trying to reduce all the inequalities in Brighton & Hove, but there is so much that we can do as GPs to help people with all kinds of illnesses. You have to start somewhere, and my role at the clinical commissioning group is to focus on mental health. We need to acknowledge that mental health problems can happen to anyone; that they are not illnesses to be scared of, that make a person weaker, or less intelligent or somehow different, only then can we start to reduce stigma. We need to make our GP surgeries more accessible and offer people more health screening and support with smoking, diet and exercise. Then we can improve things for people with mental illness. If we also offer support in the surgery for people with financial difficulties, or who need help to access community services, then we can really help reduce social poverty and inequality. If we can get this right, or even just better, then we can improve the lives of people with mental health problems. Also from a selfish perspective, if my own luck does change and it happens to me, at least there will be a better safety net waiting for me.

A secure and warm home

Kate Gilchrist, Sarah Podmore, Nicola Rosenberg and Alistair Hill

10.1 What do we know?

There is a wealth of literature on housing and health. It has not been possible to summarise it all here and a selection, related to some features of housing in Brighton & Hove, is included in this report.

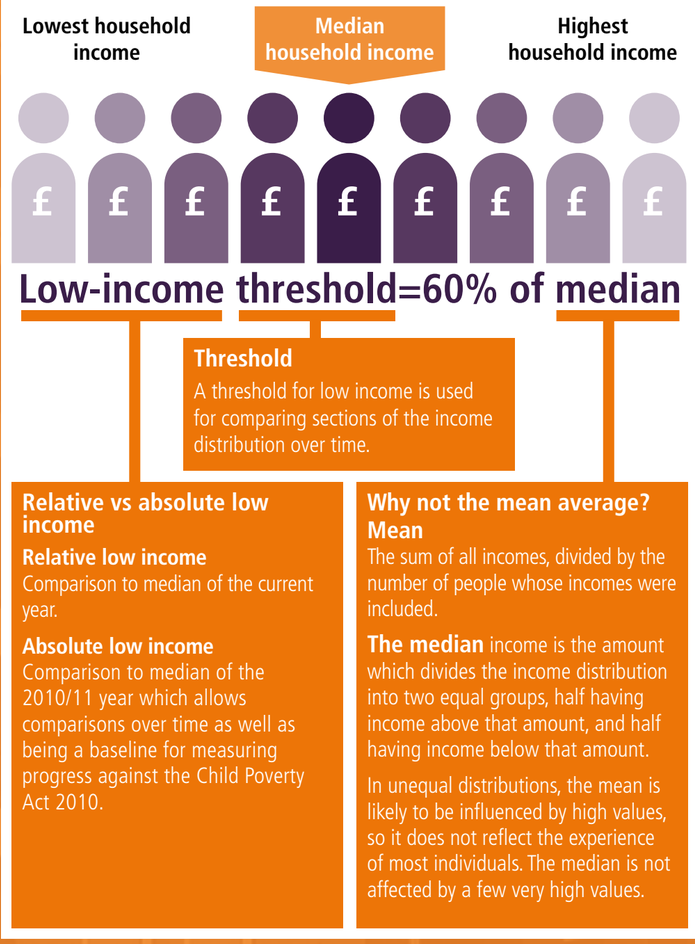
Housing costs and impact on income

Just like food, clothing and essential medical / social care, the right to housing is recognised in the Universal Declaration of Human Rights. However, a good quality home is highly dependent on income.

The impact of housing costs is pushing many households into relative and absolute low income (these terms are explained in Figure 10.1). According to a 2014 Department of Work and Pensions report, the percentage of individuals living on a relative low income in the UK has been decreasing gradually since 2008/09 and is at its lowest level (15%) before housing costs since the 1980s (Figure 10.2).[2] However, when housing costs are added, the level of relative low income is much higher (21%), and has been stable for the last three years, which is no better than figures from a decade ago. An estimated 9.7 million people are on a relative low income.

The percentage living on an absolute low income before housing costs is at 17% following increases over the previous two years. The percentage of people living on an absolute low income after housing costs has increased recently to 23%, the highest it has been in the 21st century. An estimated 10.6 million people are living on an absolute low income.

Figure 10.1 Definition of relative and absolute low income



Source Department for Work and Pensions

Overcrowding

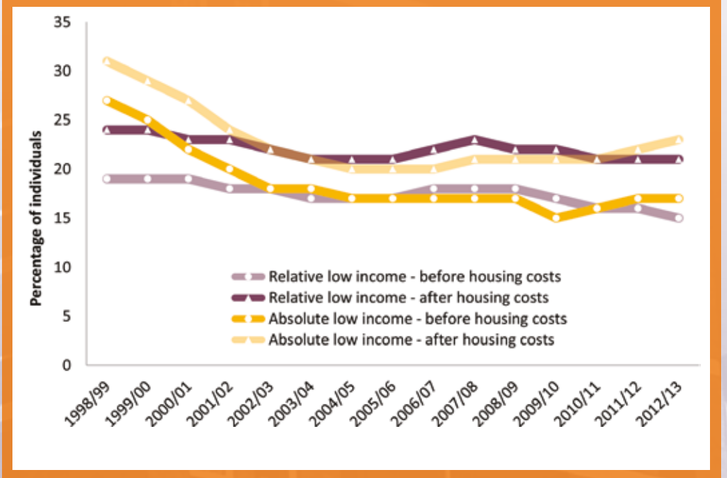
Across England and Wales, 1.1 million households were considered to be overcrowded in 2011. This was greater in rented housing, with 8.6% of privately rented households and 8.7% of socially rented households overcrowded, compared with just 2.3% of owner occupied households. Almost half (48%) of overcrowded households in England and Wales have a Household Reference Person from a Black and Minority Ethnic group (defined as groups other than White British).[i,3] As the analysis focuses on households rather than individual residents, the ethnic group of the Household Reference Person is used to characterise each household's ethnic group. This means that some individuals from a specific ethnic group may be classified as being in a household from a different group because of the ethnicity of the Household Reference Person.

Over two-thirds (68%, 724,000) are households with dependent children. Couples with dependent children were the most common household type among overcrowded households, accounting for almost three in ten (28%) overcrowded households, while lone parents and 'other' households with dependent children each accounted for around a fifth.

Among overcrowded households without dependent children, those in the 'other' household category were the most common household type, accounting for over a fifth (22%) of overcrowded households. This 'other' category includes multi-person and student households.[4]

Conversely, 16.1 million households in 2011 had at least one spare room (referred to as under-occupied): 83% of owner occupied, 50% of private rented and 39% of socially rented households.

Figure 10.2 Estimated percentage of individuals in relative/absolute low income, United Kingdom



Source Department for Work and Pensions

Fuel Poverty

People are said to be living "in fuel poverty" when they have a lower income that means that they cannot keep their home warm at reasonable cost. Fuel poverty is driven by three main factors: household income, cost of energy and the energy efficiency of a home. People who are unemployed, have a long-term illness or disability, or who live in a lone parent household are more likely to experience fuel poverty.

Fuel poverty is now measured using the Low Income High Costs (LIHC) indicator which identifies:

- the number of fuel poor households (that have both low incomes and high fuel costs), and
- the depth of fuel poverty experienced by fuel poor households, known as the fuel poverty gap (the difference between the required fuel costs for each household and the national median required fuel costs).[6]

In 2012, the number of households in fuel poverty in England was estimated at around 2.28 million, equivalent to 10.4% of all households.[1] This was a relatively small reduction from 2.39 million households in 2011, mainly due to income increases in higher income fuel poor households. The average fuel poverty gap remained similar (£445 in 2011 and £443 in 2012).[1]

Cold weather in the winter months can precipitate a range of health problems. In England, there were an estimated 29,200 excess winter deaths in 2012-13. Estimates suggest that some 10% of excess winter deaths are directly attributable to fuel poverty.

Homelessness

There are two distinct routes into homelessness: a 'life events' pathway which may occur suddenly; and a 'life-long' pathway which is often economically driven and made more likely by childhood disadvantage.[9]

[i] The concept of a Household Reference Person (HRP) was introduced in the 2001 Census to replace the traditional concept of the 'head of the household'. The HRP is the individual within the household that acts as the reference point for the whole household. Statistics for the whole household are made with reference to the HRP which may not reflect the whole household. You can find a full definition at http://www.nisra.gov.uk/Census/pop_def_2011.pdf

Homelessness is often not simply a housing problem, but the result of a multitude of social, individual and economic factors.[10] The most vulnerable homeless people are more likely to report physical health, mental health and substance misuse issues (often in combination) than the general population, and are often intensive users of emergency and unplanned healthcare.[11] In 2011, the charity Crisis estimated the mean age of death of a homeless person to be just 47 years.[12]

Preventing homelessness benefits individuals and society. Policies and action to prevent homelessness should include tenancy support, family mediation services, programmes for those leaving the armed forces, care and prison, as well as measures to improve housing affordability.[13,14]

Homeless people require individualised specialised support delivered by multiagency services to address their needs.[15] International evidence suggests that supporting people to move to stable accommodation is more effective than moving people through emergency and transitional accommodation.[16]

10.2 A city divided?

The cost of housing

Housing costs are high in Brighton & Hove. Demand for homes significantly outstrips supply, and this is unlikely to improve as it is estimated that an additional 17,400 affordable homes – in addition to those already planned – are needed by 2017 above that planned.[17]

The option of buying a home is unaffordable for many local people. Prices are 44% higher than the England and Wales average. Local research indicates that an income of £47,000 per year is required to afford a one bed flat and an income of £85,000 per year is required to afford a three bed home.[18]

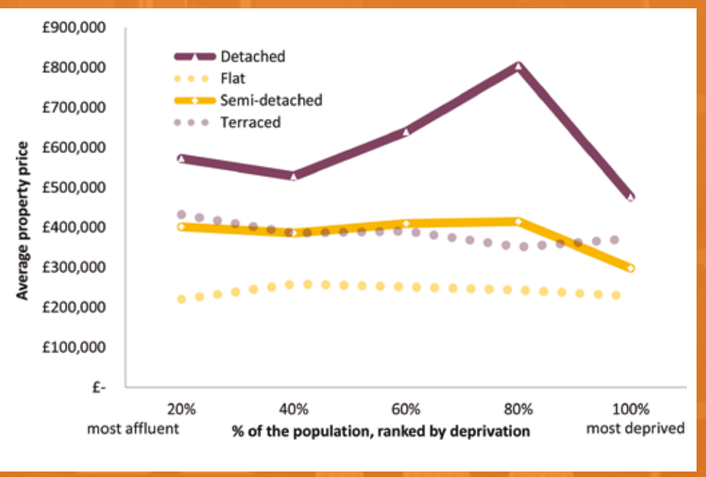
The average prices for local properties sold in 2014 by area of deprivation are shown in Figure 10.3. The picture is complex but the analysis illustrates the high cost of homes across the city. Average house prices are lower in the most deprived 20% of areas in the city, however this difference is less marked regarding flat prices. Average flat sales prices in the most affluent 20% of areas are actually lower than in the most deprived 20% of areas. The reasons for this are not completely understood but may include current market activity (these figures relate only to flats sold), new builds and the presence of some well-established expensive properties on the fringes of more deprived areas. There are of course still some very expensive flats in the more affluent parts of the city.

Whereas nationally the poorest 10% of the population spend 21% on housing, fuel and power, in Brighton & Hove just under 10% of workers in the city (11,935 people) spend almost half (49%) of their income on housing.[19]

The part-time worker's disposable income

Brighton & Hove has a large private rented sector, however rental costs are prohibitively expensive for those on low and average incomes. For example, the average (median) earnings of a part-time employee in Brighton & Hove working an average of 18.6 hours per week (in 2014) is £178.75. The average market rent for a single room from a private landlord is £511 per month or £117.92 per week. For those on this weekly wage who are not disabled or a carer, there is an entitlement to £17.24 per week in housing benefit. This leaves a remainder of £100.68 in rent and £15.03 in council tax for a 'band A' property. Therefore, of the £178.75 earned, £115.71 (64.7%) will be spent on housing leaving a weekly disposable income of £63.04.

Figure 10.3 Average property prices by deprivation quintile and type of housing in Brighton & Hove 2014



Source Land Registry

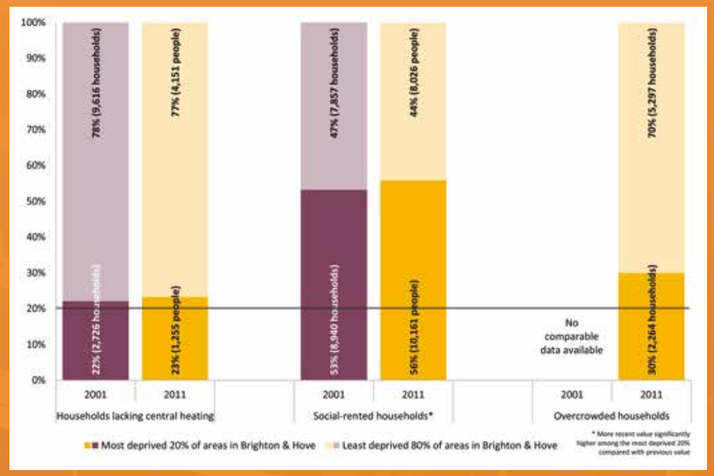
Overcrowding

As recorded in the 2011 Census 7,561 households (6.2% of the 121,540 households in the city) lived in overcrowded accommodation (as defined by number of bedrooms). If there were no inequality in overcrowding, then 20% of these overcrowded households would be located within the 20% most deprived areas. However, 30% of overcrowded households were in the 20% most deprived areas. The relative inequality in overcrowding between the least and most deprived households in Brighton & Hove is 3.9. This means that the most deprived household is 3.9 times more likely to be overcrowded than the least deprived household.

Nationally, 48% of overcrowded households have a Household Reference Person[i] from a Black and Minority Ethnic group; in Brighton & Hove the equivalent figure is 31%.[3] However, this figure is still relatively high since 17% of all households in the city have a Household Reference Person from a Black and Minority Ethnic group.

Nationally, over two-thirds (68%) of overcrowded households contain dependent children; in Brighton & Hove this is lower at 52%. Couples with dependent children were the most common household type among overcrowded households, accounting for 28% of overcrowded households in England and Wales and 21% in Brighton & Hove. Lone parents and 'other' households with dependent children each account for around a fifth of overcrowded households nationally, but whilst locally lone parents with dependent children account for 21% of overcrowded households, 'other' households with dependent children account for only 9%.

Figure 10.4 Percentage of the population living in the most deprived quintile, and the rest of the city, by various housing indicators, 2001 and 2011.



Source 2001 and 2011 Census, Office for National Statistics.

Among overcrowded households without dependent children, those in the 'other' household category (which includes multi-person and student households) are the most common household type, accounting for 22% of overcrowded households nationally but much higher at 42% in Brighton & Hove.[3]

In Brighton & Hove, 63,879 households have at least one spare bedroom according to the 2011 Census. This is equivalent to 53% of the total of 121,540 households in the city, 73% of owned or shared ownership households, 30% of socially rented households and 28% of privately rented households. This compares with 83% of owner occupied, 39% of socially rented households and 50% of private rented households nationally.[3]

Spare bedroom availability varies by deprivation; 77% of households in the most affluent areas have at least one spare bedroom, compared with 38% in the most deprived 20% of areas. The relative inequality in having a spare bedroom is 2.5. This means that the most affluent household is 2.5 times more likely to have at least one spare bedroom than the most deprived.

Homelessness

The number of approaches to the city council for help regarding homelessness has increased by 17% from 3,396 in 2010/11 to 3,960 in 2014/15. In terms of outcomes:

- the number of households that were helped to either sustain living in their current accommodation, or find alternative accommodation, and did not need to make a homelessness application was 2,751 households in 2010/11, and 2,538 in 2014/15.
- the number of homeless applications by households that were accepted by the city council increased from 426 in 2010/11 to 510 in 2013/14, then fell back to 420 in 2014/15. These are households who meet specific criteria of priority need set out in legislation, and to whom a homelessness duty has been accepted by the city council.
- The number of homeless applications that were not accepted by the city council increased year on year from 399 in 2010/11 to 864 in 2014/15.[21]

The number of households on the housing register has increased from 11,409 in April 2010 to 21,273 in March 2015, illustrating the housing pressures faced by the city.

In Brighton & Hove, the crude rate of homeless acceptances is higher than average at 4.1 per 1000 population in 2013/14, compared with 2.3 for England and 1.7 for the South East.[22]

There are more people rough sleeping in Brighton & Hove compared with five years ago. The number of rough sleepers identified by the official annual count increased from 14 in 2010 to 50 in 2013, and then fell back to 41 in 2014. However, this official count is known to underestimate the actual number of people sleeping rough, and service providers estimated there were 132 rough sleepers in March 2014.

Locally there are also 500 single homeless people living in hostels and other supported accommodation, nearly 400 households living in emergency accommodation and an unknown number of people sofa surfing and squatting.

Housing quality and fuel poverty

Too many homes in the city are in poor condition (referred to as non-decent). The majority of these are in the private sector, and many are rented to tenants with few other options. Past housing condition surveys conducted by the city council have shown that around 20% of private sector homes surveyed in Hove, Central Brighton and Hollingbury and Bevendean fail fitness standards. One of the standards commonly failed is cold and damp.

Unlike many other parts of the country, housing conditions in Brighton & Hove do not bear a strong relationship with area level deprivation. At the time of the 2001 Census, 22% of all households without central heating were located in the 20% most deprived areas of the city, and this changed little over the ensuing decade (23% in 2011). This reflects the older housing stock seen across the city including affluent areas.

In Brighton & Hove, an estimated 13,025 (10.7%) of households were fuel poor in 2012 (Low Income High Costs (LIHC) indicator),[6,25] compared with 7.8% in the South East. In line with the national trend, this is a small reduction from 11.3% in 2011. Households in the South East region have the lowest rate of fuel poverty in England, but the largest average fuel poverty gap. This means that although there are relatively fewer people in the South East of the country who are in fuel poverty, the depth of that fuel poverty is higher than average

In the Brighton & Hove Health Counts Survey 2012, 17% of respondents said they could not keep their home warm enough in the winter 'quite often' or 'most of the time'. This has increased from 13% in 2003. Just half of respondents (52%) in 2012 said that they can always keep their home warm enough in winter; this is a significant decrease from 60% in 2003.[26]

Although the official fuel poverty figures seem to be decreasing, over the last 10 years there has been an increase in the proportion of people in the city who report that they find it difficult to heat their home.

Health, wellbeing and housing

The best local information on health, wellbeing and housing comes from Health Counts surveys (Table 10.1). The results illustrate the strong association between housing tenure and health. In the 2012 survey, the general health of residents privately renting was the same as those who own their own home: just 14% of both groups were in fair or poor health. However, this compares with 43% of those renting from a housing association or local authority. This is a substantial absolute gap of 29 percentage points and a relative inequality of 3.1 and means that people renting from a housing association or the city council are 3.1 times more likely to be in fair or poor health than those privately renting or home owners.

These inequalities have widened in both absolute and relative terms compared since the earlier survey of 1992, although interestingly, in 2012 there was no inequality between private renters and home owners in terms of general health. These figures do not take into account the age profiles of the different groups and so the findings may relate to differences between the groups (for example, those privately renting may be younger on average).

Similarly, regarding limiting long-term illness and disability, residents that rent from a housing association or the city council are also significantly more likely (53%) than those who rent privately (19%) or own their own home (26%), to be so affected. The absolute inequality gap between social housing tenants and homeowners is 27%, and the relative gap 2.0. Both absolute and relative inequalities have increased for those renting from a housing association or local authority since 1992.

Regarding emotional wellbeing, using the measure of 'risk of major depression', the picture is different. Both those who rent privately, or from a housing association or the local authority are more likely to be at risk (48% and 59% respectively) than those who own their home (29%). This is an absolute inequality gap of 19 percentage points for private renters and 30 percentage points for those renting from a housing association or local authority (with absolute gaps of 1.7 and 2.0 respectively). For both groups of renters, absolute and relative inequalities have increased compared with home owners since 1992.

These data highlight that housing tenure is an important factor to take into account when planning the delivery of health services or public health programmes.

Table 10.1 General health, limiting long-term illness and risk of major depression by housing tenure, Brighton & Hove, 1992 to 2012

		1992	2003	2012
Fair or poor health	**Home owner**	**16%**	**16%**	**14%**
	Private rented	**27%**	**17%**	**14%**
	Rent from housing association/ local authority	**31%**	**45%**	**43%**
Limiting long-term illness or disability	**Home owner**	**30%**	**30%**	**26%**
	Private rented	**32%**	**22%**	**19%**
	Rent from housing association/ local authority	**38%**	**52%**	**53%**
At risk of major depression	**Home owner**	**34%**	**33%**	**29%**
	Private rented	**40%**	**46%**	**48%**
	Rent from housing association/ local authority	**45%**	**58%**	**59%**

Source Brighton & Hove Health Counts Surveys 1992-2012.

10.3 What can we conclude?

Nationally, the number of people on a low income after housing costs are taken into account has been rising in recent years. In Brighton & Hove, where housing costs relative to average income are high, the inequalities related to housing are substantial. The effect of high housing costs is to drive substantial numbers of residents into low income. Many residents now face little chance of ever purchasing a home. Part-time low wage residents on average will spend two thirds of their salaries just on rent.

Overcrowding is more prevalent in more deprived areas, with families more likely to be living in overcrowded accommodation.

The last 20 years have seen increases in the inequalities in health and housing in the city. Residents renting from a housing association or the city council are more likely to have a long-term illness or disability and residents renting from a housing association, city council or privately are more likely to be at risk of major depression than home owners.

Fuel poverty has reduced slightly over the last couple of years nationally and locally, however over 1 in 10 households in the city are still fuel poor and 1 in 6 people report that they cannot keep their home adequately warm in the winter.

The number of people approaching the city council for help related to homelessness is 17% higher in 2014/15 compared with 2010/11, and the number of households on the local housing register nearly doubled over the same period, indicating the extent of local housing pressures.

Rough sleeping is higher than five years ago, although the numbers may have peaked. The most vulnerable homeless are likely to have complex physical health, mental health and/or substance misuse problems, and national research highlights the mean age of death of a homeless person to be just 47 years.

Homelessness represents one of the greatest inequality challenges to the city: one that will not be resolved overnight but that will require a determined, resolute and coordinated effort from many people to resolve.

Tackling inequalities - Warm homes and healthy people

In Brighton & Hove the city council's Public Health and Housing teams jointly deliver a Warm Homes, Healthy People (WHHP) programme. For the last 4 years the programme has provided emergency grants (e.g. for fuel bills, broken windows), warm packs (clothing and blankets for rough sleepers) and financial inclusion checks to make sure people can access the support that they need. The programme has helped over 400 vulnerable people access over £0.75 million in income.

A new 'Warmth for Wellbeing' scheme is also being piloted in two GP practices. Practice patients with long term conditions, such as chronic obstructive pulmonary disease (a respiratory disorder) or heart failure, are offered a comprehensive review to help improve their finances and support them in keeping their home warm.

Crimes, victims and perpetrators

Caroline Palmer, Peter Castleton and Nicola Rosenberg

11.1 What do we know?

Inequalities and crime

Crime, anti-social behaviour, and feelings of safety, all have a significant impact on physical and mental wellbeing. Deprivation is an important factor, in both perception and experience of anti-social behaviour. Those living in the 20% most deprived areas in England are five times more likely to have a higher level of perceived anti-social behaviour than those living in the 20% most affluent areas.[1] The harm caused by anti-social behaviour is amplified by context. Socially and economically stressed neighbourhoods, and areas with low levels of social capital are more vulnerable to anti-social behaviour.[2]

Inequality too is significantly associated with increased levels of burglary, robbery, violence, vehicle crime and criminal damage, and acquisitive crime in particular increases with rising income inequalities.[3,4] Violent crime is associated with inequalities in visible expenditure – conspicuous consumption rather than total expenditure, suggesting that information on a person's wealth also plays a role in the determination of crime.[5]

People who offend or are at risk of offending frequently are much more likely to suffer from multiple and complex health issues, including mental and physical health problems, learning difficulties, substance misuse and carry an increased risk of premature mortality.[6] Hospital admission rates as a result of violence, are highest in the most deprived communities.[7]

Children exposed to violence are much more likely to be involved in violence later in life. However, most significantly, societal inequalities are a more powerful predictor of violence than poverty.[8]

Supportive partnerships

Inequalities in crime and fear of crime should be seen in the context of other inequalities mentioned throughout this report.[9] Action to tackle inequalities across a range of fronts will have an impact on crime.

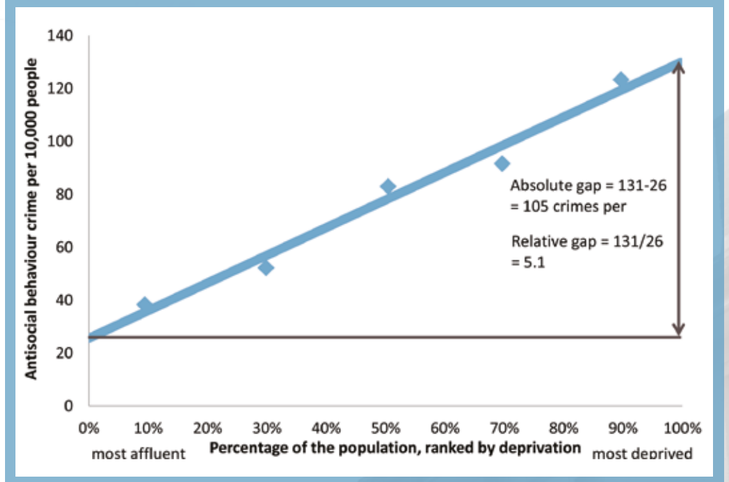
A range of different interventions throughout an individual's life can reduce their propensity for crime, lower the chances of those involved in crime being involved again and ensure that those affected get the support they require. A number of interventions with high risk young people and gangs can change behaviour and are effective at preventing future violence.[7] Reducing the availability and harmful use of alcohol, community youth crime prevention programmes, changing social norms by making violence less socially acceptable and identifying victims of violence and providing quality care and support, are all ways to prevent violence.[7]

Complex cross agency working is required across education, employment, health, social care, the Police, courts, and the voluntary sector. Much of the evidence for tackling crime and inequalities is about building on, and improving partnerships across organisations, as well as tackling the root causes of inequalities themselves.

Data collection is essential to identify risk and protective factors, to help with targeting interventions and monitoring progress. This can be problematic as it often crosses organisations, each with their own code of practice. The inclusion of violence indicators in the national Public Health Outcomes framework is a positive step and means areas can compare measures and trends.

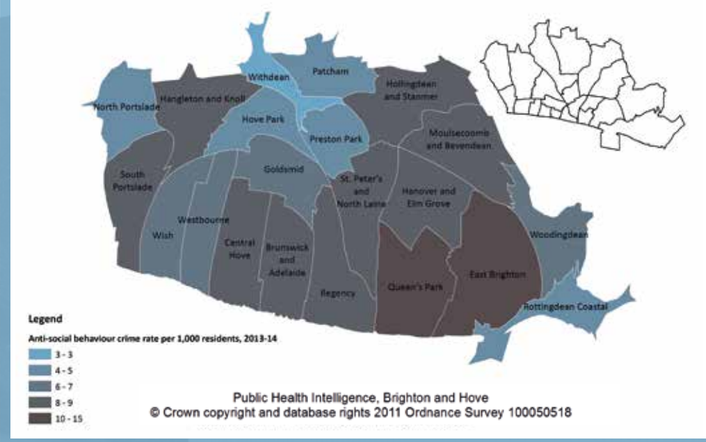
Furthermore, reporting rates vary depending on crime type, and a large proportion of some crime goes unreported to the Police. The 2013/14 Crime Survey for England and Wales showed that the police were informed of about 39% of all crimes. Thefts of vehicles are most likely to be reported (97%), and incidents of domestic burglary with loss are also well reported (89%). Reporting rates are much lower for crimes such as assault with minor injury or no injury, criminal damage and theft from the person (47%, 32% and 32% respectively).[10] Any interpretation of crime figures has to bear this in mind.

Figure 11.1 Slope Index of Inequality in anti-social behaviour crimes (a group of offences including criminal damage offences, harassment, affray and assault without injury) in Brighton & Hove 2013/14



Source Brighton & Hove City Council Public Health Directorate

Figure 11.2 Anti-social behaviour crime rate per 1,000 residents in Brighton & Hove (2013-14)



Source Brighton & Hove City Council Public Health Directorate

11.2 A city divided?

Anti-social behaviour

The 'anti-social behaviour crime basket' – a group of offences including criminal damage offences, harassment, affray and assault without injury – have been used as a proxy measure for anti-social behaviour locally.[1] These are analysed according to the address of the victim, and help define the relationship between anti-social behaviour reported to the Police, and deprivation in Brighton & Hove.

Just as there is nationally, in Brighton & Hove there is a strong relationship between anti-social behaviour and deprivation. In the most deprived 20% of areas in the city, there are 123 police recorded anti-social behaviour crimes for every 10,000 residents. This compares with 38 per 10,000 in the least deprived 20% of areas; an absolute range of 85 crimes per 10,000 people. In relative inequality terms, this means that people living in the most deprived 20% of areas are 3.2 times more likely to be a victim of a Police recorded anti-social behaviour crime than those in the 20% most affluent areas. We can account for the whole range of deprivation in the city (not just quintiles), by using the slope index. This shows that the absolute range is 105 crimes per 10,000 people and the most deprived individual in the city is 5.1 times more likely to be a victim of a police recorded anti-social behaviour crime than the most affluent (Figure 11.1).

Just over half of all anti-social behaviour crimes within Brighton & Hove can be said to be attributable to the differences in deprivation. If everyone experienced the lower rates of crime seen in the least deprived 20% of areas, there would be over one thousand (1,087) fewer anti-social behaviour crimes in the city in a year, out of a total of 2,145 crimes.

Across the city rates are highest in the wards of Queens Park and East Brighton with rates lowest in Withdean (Figure 11.2)

Acquisitive crime

Acquisitive crime includes domestic burglary, vehicle theft offences, and other theft offences such as theft from dwellings, theft from person, cycle theft offences and theft offences where belongings have been left unattended.

There is some relationship between acquisitive crime and deprivation in the city; however

this is not as strong as seen when looking at anti-social behaviour crime. In the most deprived 20% of areas in the city there are 244 offences for every 10,000 people resident there, compared with 166 per 10,000 in the least deprived 20% of areas: an absolute range of 78 crimes per 10,000 people and a relative difference of 1.5.

Again, taking into account the whole range of deprivation in the city, the absolute range is 104 crimes per 10,000 people and the most deprived individual in the city is 1.6 times more likely to be a victim of a police recorded acquisitive crime than the most affluent (Figure 11.3). Just under a quarter (23%) of these acquisitive crimes can be said to be attributable to the differences in deprivation within the city. If everyone experienced the lower rates of crime seen in the least deprived 20% of areas, there would be 1,385 fewer acquisitive crimes in the city in a year out of a total of 5,956 crimes.

11.3 What can we conclude?

Inequality is associated with crime and anti-social behaviour: socially and economically stressed neighbourhoods are more vulnerable to crime and anti-social behaviour, and people who offend are more likely to suffer multiple and complex health problems. Children exposed to violence are more likely to be involved in violent crime later in life. The data on crime does not reflect the full extent of certain crimes such as assault with minor injury, criminal damage and theft, more than half of which are unreported.

Just as there is nationally, in Brighton & Hove there is a strong relationship between crime, anti-social behaviour and deprivation. The relationship is particularly strong regarding anti-social behaviour. Compared to the least deprived person, the most deprived person in the city is 5.1 times more likely to be a victim of anti-social behaviour and 1.6 times more likely to be a victim of acquisitive crime. As in other areas where inequalities apply, finding a solution to crime requires action across education, employment, health and social care as well as the criminal justice system. There is some evidence of this in the city.

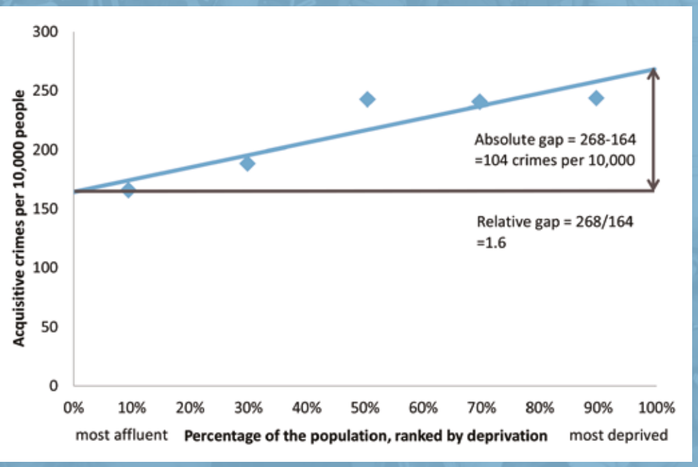
Tackling Inequality – Anti-Social Behaviour

In Brighton & Hove, the Police and city council have adopted a harm-based approach, sharing intelligence, with Police posts embedded in the council's Community Safety Anti-social Behaviour casework team.

In a typical case a victim will report an incident to the Community Safety Casework Team. There will be an initial response within 24 hours acknowledging the incident and making a quick assessment of risk. A caseworker will visit the victim, usually at their home address the next day and explore how the victim would like the case resolved. An agreed plan is quickly put in place to reduce risk and harm. These actions might include a swift response from the police to warn perpetrators about their behaviour and may include enforcement action such as an anti-social behaviour injunction or tenancy action.

The impact of anti-social behaviour is often greater when it occurs between neighbours. Victims feel more vulnerable because they can't avoid the behaviour of the perpetrator. Most of these more harmful incidents occur in areas of social housing, or high-density poor quality housing in deprived neighbourhoods. A significant number of high risk and intractable cases involve either a victim or perpetrator with diagnosed or undiagnosed mental health issues. Targeted work to address the harm caused by anti-social behaviour is therefore essential to tackling broader inequalities in the city.

Figure 11.3 Slope Index of Inequality in acquisitive crimes in Brighton & Hove 2013/14



Source Brighton & Hove City Council Public Health Directorate

Dave Padwick (Happiness Champion)
Police Chief Inspector
Interviewed by Tom Scanlon

Past

I was born in Mid-Hampshire and brought up on a farm. My dad, who had been in RAF Bomber Command during the war was a farmer; mixed arable and dairy, but I always wanted to be a police officer. Dad had a drink problem and an eye for the ladies and my parents split when I was seven. This took its toll on my mum and for a few years, I lived with my grandparents. Then my mum got a council house in Harrington and we moved there. She later remarried and I had a great step-dad but I didn't do very well at school and failed my police entrance exam first time round so I worked in a London Office for 4 years. Then I reapplied to the police in 1988 and was successful. The same year my dad went bankrupt but because he was well liked locally, he was given a grace and favour cottage on a local estate.

Present

I first worked in Whitechapel, very different from rural Hampshire with a 75% Bengali population and a lot of street homelessness. I worked in uniform, in crime, and in vice. There were a lot of sex workers and they were often young mothers trying to make ends meet. Later I noticed that there were more and more with drug problems. My wife - who is also from rural Hampshire - and I wanted to our children to have a more rural upbringing and we were told that they might get some grief at the local school, their dad being a police officer. So, in 1997, as Sussex were recruiting for sergeants, we moved to Barcombe and we're still in the same house. We couldn't afford to buy the same house now and I worry for my children. I'm a chief inspector now and I'd like to finish my police career in Brighton. My son is autistic and that is partly why I'm the lead police officer for mental health. Also, Sir David Ramsbotham's prison review made a big impression on me. So many prisoners with illiteracy, mental health problems, and virtually no support on release; No wonder re-offending rates are so high, and so many become street homeless. I often wonder what would have happened to my dad, or my son if they didn't have the support they needed.

Future

I don't believe it's entirely in our gift as local people or organisations to sort some inequality issues like homelessness. We need to build more affordable, sustainable homes and use empty properties much better, but the five-year political cycle hinders that and the media doesn't help. We can't ever have a proper debate on offending or homelessness as politicians don't want to appear weak. Sadly, I am not that optimistic for the immediate future, as austerity seems to be hurting the most vulnerable. That said, if we work together well at a local level, I believe we can make a difference. Our joint work on suicide prevention, street triage work with mental health and police services working together is great. We all need to step up, whenever I hear people say 'Homelessness is an embarrassment to Brighton' I say to them, 'Well, do something about it'.

Living environment

Rebecca Fry, Nicola Rosenberg and Kate Gilchrist

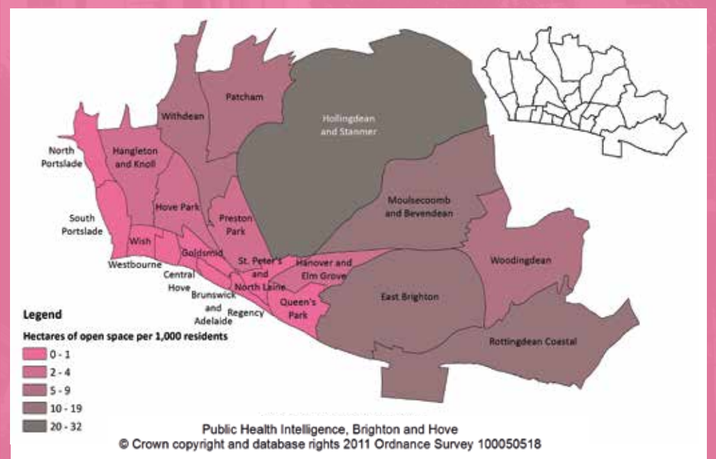
12.1 What do we know?

More deprived people are less likely to be physically active at the level recommended for a healthy life.[1] As the workplace has become more sedentary, the living environment provides the opportunities for physical activity, as well as improved mental wellbeing. Access to green space is associated with better self-rated health, lower body mass index scores, reduced overweight and obesity levels, improved mental health and wellbeing and increased longevity in older people.[2] However, in the UK people living in the most deprived areas are less likely to benefit from green space and children living in deprived areas are nine times less likely to have access to green space and places to play.[3]

Increasing access to parks and open spaces could reduce the NHS treatment costs for obesity annually by £2 billion.[4] In order to address inequalities, as opposed to just the wellbeing of those who make most use of green spaces, it is necessary to understand local needs, cultural contexts and attitudes. Unless initiatives are targeted, inequalities can easily widen as people with high-incomes increase their use of green spaces more readily, as has been seen in the development of Derbyshire's forest.[5] Communities therefore need to be involved in the planning and running of green spaces.[6]

Spatial planning is an important tool for helping people to adopt healthier lifestyles. However, planners can better understand how different planning decisions affect the take up of services by carrying out health impact assessments. Taking action to improve the living environment needs to focus not just on 'place management', but the issues that affect local people.[7] Community-centred approaches that mobilise assets within communities, promoting equity and increasing people's control over their health and lives, are more likely to be successful and improve the living environment for whole communities.[8]

Figure 12.1 Cartogram showing the amount of open space in hectares per 1,000 residents (2007 open spaces mapping and 2012 population estimates)



Source: Brighton & Hove City Council. Council (open spaces figures), Office for National Statistics 2012 Mid Year Estimates and Association for Public Health Observatories weighted Index of Multiple Deprivation Scores for wards.[9]

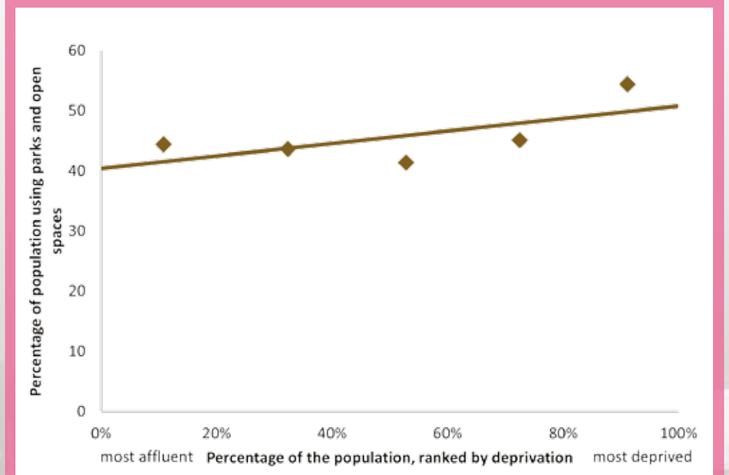
12.2 A city divided?

Open spaces

Brighton & Hove City Council has collected data on all the open spaces in the city (although the last formal audit was in 2007). Nevertheless, the availability of open spaces has not changed substantially and so a Slope Index of Inequality can be calculated to consider inequalities in terms of availability of open spaces by deprivation. Interestingly, unlike the national picture, when the Slope Index is drawn at ward level data weighted for Index of Multiple Deprivation scores, there is no clear relationship between the amount of open space available (in hectares) for every 1,000 people living in a ward (2012 Mid-year estimates), and the level of deprivation in the ward.

Indeed, the cartogram map (Figure 12.1) of the relative size of wards based upon the amount of open space available for the people who live there, shows how some of the more deprived areas of the city such as East Brighton, Moulsecoomb and Bevendean, and Hollingdean and Stanmer fare very well. These three wards have the highest spaces in hectares classed as amenity green space. However, some of the land audited as amenity green space is grassed areas around blocks of flats or grass verges. These areas may not readily provide usable open space, for example due to privacy and traffic. It is therefore important to consider the quantity and the quality of open spaces when we explore the reasons behind people's use of these spaces.

Figure 12.2 Percentage of population who DO NOT use parks and open spaces at least once a week by quintile of deprivation in Brighton & Hove, 2012



Source: Health Counts Survey 2012

Quality of open spaces

In fact, in the city council Audit (2007) none of the sites were ranked as very good, just over 50 were ranked good or above average, and 100 sites were ranked as average. Just under half the sites in the audit are still considered as having a poor offer as open space.

One observation was that many sites consisted of very small areas of grass verge, or small amenity green spaces in private residential areas. These sites offer very little in terms of open space, providing little other than a small mown grass area. If the audit were applied to open spaces within the control of the city council, a very different set of results might be found and a greater proportion might achieve higher ranks.

Use of parks and open spaces

Whilst there is no inequality in the availability of open spaces across the city, albeit tempered by the quality of that space, according to the 2012 Health Counts survey, there are considerable inequalities in the use of open space. The absolute inequality gap between the most and least deprived individual in terms of use of green space is 10 percentage points (Figure 12.2). In relative terms the most deprived person is 1.2 times more likely than the least deprived person NOT to use a park or open space at least once a week. This question was not asked in previous Health Counts surveys and so we cannot make comparisons over time.

The reasons for this difference may relate to the quality of the space, or, as the national evidence suggests, it could reflect a relative lack of connection with local communities in the design and management of initiatives to improve participation in the living environment. Understanding the reasons behind this finding is likely to be an important step in reducing inequalities in the living environment.

12.3 What can we conclude?

The living environment has enormous potential to improve physical and mental wellbeing as well as develop social capital. Nationally, more deprived people have less access to open spaces and are less likely to use them. Initiatives that promote the use of open spaces run the risk of increasing inequalities, as often the people who most take them up are those who are already using open spaces.

In Brighton & Hove, the geographical availability of green space does not reflect deprivation levels and some of the more deprived parts of the city have more green space, although there are some questions as to the quality of some of these spaces. Despite this potential availability, information on participation in the living environment shows that locally, more deprived people are still less likely to use open, green spaces.

The reasons behind the relative inequality in use of the living environment are not clear, however what is clear is the considerable potential to address inequalities by fostering a 'more equal' engagement in the living environment. It is essential therefore that planners, developers and service providers work to involve local communities more in the design and operation of living environment initiatives, if these inequalities are to be reduced.

There might also be a role for increasing knowledge within deprived communities in terms of where the spaces are, what activities they can offer and the health benefits of regular visits and activity. GP's could provide information leaflets and prescribe 'green gyms', schools and play bus could provide info and/or active campaigns could take place.

Conclusions and Recommendations

1 In order to tackle inequalities, we need a strategy with a life course approach that covers the full gamut of deprivation. So for example, strategies to improve inequalities in young people need to include actions on education, employment for families, health, welfare benefits, housing, crime and the environment.

2 There needs to be a special focus on certain groups, this includes those in multiple deprivation, and groups where inequalities seem to be widening, such as disabled people. Although mental ill health inequalities are reducing both in absolute and relative terms, they are still substantial. Mental illness will require particular attention across the life course beginning even before birth with support for pregnant women as well as the needs of particularly vulnerable groups such as homeless people.

3 Poverty in older people has been moving in the right direction compared to poverty in many other groups. However, the city has a higher proportion of older people living alone (41%) than is found in the country as a whole (31%). Many of the problems older people face are due to isolation, lack of confidence and some who do live with a partner, find that their role is now one of carer. Strategies to reduce inequalities in older people need to include a focus on social issues, and some of this could be done through a more city-wide active citizenship or volunteer strategy.

4 We need to improve the routine monitoring of inequalities. In some areas, like sexually transmitted infections, the impact on inequalities could be examined further. There are more data already available, and routine monitoring of inequalities should be built into service models and care pathways.

5 The way that inequalities manifest themselves means that sometimes there is a risk they may be viewed by some people as a problem to be got rid of, rather than a concern to be addressed. Child poverty rates for example are much higher in certain ethnic groups, including Gypsies and Travellers.

6 Health inequalities are common and some of them have been around for decades. The national initiative of 'Making Every Contact Count' should be linked to a programme to reduce inequalities as it has the potential to affect inequalities for better and worse. Health trainers are a low cost and effective intervention and we should use them more.

7 There is a good evidence base on how to address some inequalities. We should use it. For example, Sure Start Children's Centres are based on a solid body of evidence and there are local data that show that more deprived families use them more. With increasing public sector financial pressure, we need to ensure that the impact on inequalities is, if anything at least neutral. Local children's centres have a higher proportion of children attending from areas of deprivation. Further work should be undertaken to understand the full impact of local children's centres on families attending.

8 Interventions like food banks are required in the short-term but they are not a long-term solution. Initiatives like these need to be tied to a more comprehensive approach which includes dealing with financial pressures, ensuring appropriate and prompt access to benefits, employment support, as well as achieving a healthy diet, on what might be a restricted range of foodstuffs.

9 The education challenges of the city in terms of secondary school exam results are well documented. Whole school approaches that deal with bullying, mental wellbeing, diet, exercise, social skills, risk taking behaviours and attitudes to other groups can all improve wellbeing, academic achievement and reduce inequalities. We should also consider local, more informed measures of school success.

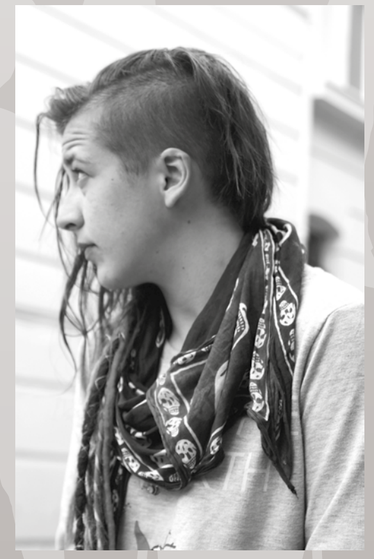
10 Income and employment are the biggest influencers on inequalities and increasing the number of people in work, earning a living wage, as opposed to a minimum wage, has the potential to reduce poverty and inequalities. The city council is already pursuing this path in its procurement. It is not however, mandatory and social care providers and the leisure industry often pay below the living wage. There should be a city-wide goal for the statutory and business sector to increase the proportion of workers in receipt of at least a living wage.

11 Welfare reform, which is set to expand is already having a significant impact on the lives of some of the poorest residents of Brighton & Hove. Households with disabled residents, headed by women or where people struggle with digital systems are likely to struggle most. The city council, clinical commissioning group (CCG) and third sector partners are already working together but, residents most at risk need to be identified so they can be supported more. Benefits advisers should be trained in motivational skills to help steer people into employment.

12 Housing is a major barrier to reducing inequality in Brighton & Hove. Residents renting from housing associations and the council have poorer health than home owners. Homelessness is an expression of inequality at its most unequal and it requires a solution hitherto unimagined.

13 Crime is linked to deprivation, and like other facets of inequalities, effective approaches need to cross education, employment, health - especially mental health, social care and the criminal justice system.

14 The environment is a good example of how easy it is to increase inequalities by opening initiatives to all. Whilst there is more green space in more deprived areas there are some questions as to the quality of some of these spaces, so the focus needs to be on engaging local people in designing the solutions to reducing inequalities.



If there is one over-riding recommendation from this report, it is the need to establish a city wide, coordinated approach to reducing inequalities. For as well as the many gaps in addressing inequalities, there is also potential for much duplication. A new approach will require better routine monitoring, new levels of engagement with partners, as well as with the people most affected by inequalities. It will require clear governance and a commitment across the city over a significant time. For as this report shows, inequalities have been with us for decades, some of them for centuries. That does not mean that we just have to accept them. Inequalities can be reduced and doing so is in all our interests, for they are not just bad for those who are most deprived, they are bad for all of us.

Link to references

www.brighton-hove.gov.uk/phannualreport14-15

Photos taken at First Base Day Centre

Notes