The Annual Report of the Director of Public Health

Brighton and Hove City Teaching Primary Care Trust
and
Brighton and Hove City Council

2004
Executive Summary

This annual report of the Director of Public Health is the first joint report between Brighton and Hove City Council and Brighton and Hove City Teaching PCT. The report covers the key health problems facing the adult population of Brighton and Hove today.

The report uses routine morbidity and mortality data and also draws on the findings of a local health, lifestyle and social capital survey that was undertaken in 2003. The results of the survey are compared with a similar lifestyle survey conducted in 1992.

Self reported health status of the local population has remained virtually static over the past 10 years although it is worse among more deprived residents. Mortality from coronary heart disease and cancer, the two biggest killers, has decreased over the past 10 years. Mortality from accidents has remained static while the number of suicides has increased.

There is no indication that general practice provision is worse for poorer residents although they are more likely than their more affluent counterparts to seek advice from pharmacists. Residents living in more deprived parts of the city are less likely to visit the dentist or optician. The dental health of children in more deprived areas is worse than that of children in more affluent areas.

Access to the areas covered by the clinical reference groups (orthopaedics, ENT, ophthalmology, dermatology and digestive diseases) is worse for more deprived residents. Planned hospital admissions are more common in more affluent residents while emergency hospital admissions are more common in more deprived residents.

There is a clear relationship in Brighton and Hove between mental illness and deprivation.

Substance misuse constitutes a major problem in the city with high numbers of intravenous users and drug-related deaths. There are also high levels of benzodiazepine prescribing in Brighton and Hove reflecting prescribing to substance misusers.

The prevalence of smoking has decreased over the past 10 years while the prevalence of drinking unsafe amounts of alcohol has increased. Alcohol consumption is higher in areas of deprivation. A minority of the population eat a healthy diet and very few people exercise at recommended levels. Over 40% of the population are overweight, obese or morbidly obese.

Social capital is higher in less deprived areas although considerable work is in progress to build social capital in these areas. There are substantial numbers of excess winter deaths.

Despite their younger average age, lesbian, gay, bisexual and transgender residents report comparatively worse health indices in many fields, in particular emotional and mental health problems compared to the general population.

Homelessness remains a serious problem in Brighton and Hove and mental health and substance misuse needs of homeless people present a particular challenge.

There is very limited local information on the health of ethnic minority groups, refugees and asylum seekers although they are likely to have particular health problems.

Health in Brighton and Hove is inextricably linked to deprivation. And tackling the health inequalities that exist will require co-ordinated action from planners and providers across a host of statutory and non-statutory sectors.
List of figures, maps and tables

Tables

Table 1.1 Pre and post-boundary changes to wards and respective Townsend Score
Table 1.2 Population characteristics of Health Counts lifestyle survey respondents (2003) compared to Census population (2001)
Table 2.1 Brighton and Hove population by age and sex, and by deprivation cluster 2001
Table 2.2 Census classification of ethnic groupings
Table 2.3 Ethnicity in England and Wales and in Brighton and Hove by deprivation cluster 2001
Table 2.4 Employment status (persons aged 16 – 74 years) in England & Wales, Brighton and Hove City, and by deprivation cluster 2001
Table 2.6 Self-reported current health and health compared to last year: Brighton and Hove lifestyle surveys 1992 and 2003.
Table 3.2 Glossary of prescribing terms
Table 4.1 Different activities equivalent to walking at moderate intensity for 30 minutes
Table 4.2 Probable route of exposure for HIV positive people in Brighton & Hove
Table 5.1 Crime in Brighton and Hove: offences recorded by the police 2002/3
Table 6.1 Sexuality and sexual orientation in Brighton and Hove
Table 6.2 Characteristics of all LGBT respondents and total survey sample
Table 6.3 SF36 Scores for LGBT respondents compared to general population
Table 6.4 Comparison of total respondents with LGBT respondents on several health questions
Table 6.5 Comparison of total and homeless populations on several health questions
Table 6.6 Categories of asylum seekers awaiting decision by Brighton and Hove City Council
Table 6.7 Drugs used by clients in the 30 days prior to starting treatment in Brighton and Hove in 2002/2003
Table 6.8 Gender, age, employment status and recent offending history of clients beginning treatment for drug misuse in Brighton and Hove in 2002/2003

Figures

Figure 1.1 Townsend updated scores by ward
Figure 1.2 Brighton and Hove split by 3 Townsend clusters
Figure 2.1 Death rates from circulatory disease in those aged less than 75 years: Age-standardised 3 year moving averages for Brighton & Hove, England and GOSE
Figure 2.2 Death rates from cancer in those aged less than 75 years. Age-standardised 3 year moving averages for Brighton and Hove, England and GOSE
Figure 2.3 Death rates from accidents. Age-standardised 3 year moving averages for Brighton & Hove, England and GOSE
Figure 2.4 Death rate from suicide and injury of undermined intent. Age-standardised 3 year moving averages for Brighton & Hove, England and GOSE
Figure 3.1 Distribution of GP and single-handed GP surgeries in Brighton & Hove
Figure 3.2 Time since spoke to doctor about own health by sex
Figure 3.3 Distribution of dental practices in Brighton and Hove
Figure 3.4 Registrations with dentist by deprivation
Figure 3.5 Distribution of optometry practices in Brighton and Hove
Figure 3.6 Visited optician for eye test by deprivation
Figure 3.7 Distribution of pharmacies in Brighton and Hove
Figure 3.8 Received pharmacy advice in past 4 weeks and whether advice was helpful
Figure 3.9 Complementary therapists consulted by sex
Figure 3.10 Cervical screening in last 5 years by deprivation
Figure 3.11 Mammogram in last 3 years by deprivation
Figure 3.12 Percentage spend per disease system (2002/03)
Figure 3.13 Cardiovascular system: Cost per therapeutic group
Figure 3.14 Outpatient appointments per 1000 population by deprivation (2002/03)
Figure 3.15 Outpatient attendance rates per 1000 population for combined clinical reference group specialties by gender and deprivation 2002/03
Figure 3.16 Elective and emergency admissions to acute specialties per 1000 population by deprivation (2002/03)
Figure 3.17 Age-standardised admission rates for mental illness (elective and non-elective) per thousand persons by sex and deprivation (2002/03)
Figure 4.1 Prevalence of smoking, by smoking classification (1992 and 2003)
Figure 4.2 Daily cigarette smoking by age and sex in 2003
Figure 4.3 Number of cigarettes smoked by men and women per day
Figure 4.4 Residents who smoke by area of deprivation
Figure 4.5 Units of alcohol consumed by residents per week in 1992 and 2003
Figure 4.6 Units of alcohol consumed by men and women per week in 2003
Figure 4.7 Percentage of residents who drink above recommended maximum levels by area of deprivation
Figure 4.8 Exercising to recommended levels by age and gender
Figure 4.9 Body weight by deprivation cluster
Figure 4.10 National and local prevalence for obesity and overweight by gender
Figure 4.11 Number of new disease contacts at Brighton and Hove genitourinary medicine clinic
Figure 5.1 How many people in their neighbourhood respondents feel they can trust
Figure 5.2 How frequently respondents see or speak to neighbours
Figure 5.3 Percentage of people reporting stress from particular issues
Figure 5.4 Percentage of people stressed by particular issues
Figure 5.5 Percentage of households by central heating and sole use of a bath or shower and toilet (Facilities)
Figure 5.6 Number of excess winter deaths
Figure 5.7 How often people cannot keep their home warm enough
Chapter 1

Introduction and background to the report

Context

This Public Health Annual Report for 2004 is published jointly by Brighton and Hove City Teaching Primary Care Trust (PCT) and Brighton and Hove City Council. The report serves two primary functions: first as a resource document containing key health statistics for the population of Brighton and Hove and secondly as a guide to how the health of the population might be improved. The popular picture of a vibrant city by the sea with a lively, resourceful and healthy population masks some serious health and lifestyle issues and considerable inequalities within certain groups and neighbourhoods in Brighton and Hove.

This in itself is not new; the influences on and impact of lifestyle have been known for some time and health inequalities have existed for many years. In recent years local Directors of Public Health had drawn attention to these findings in their Public Health Annual Reports. We are however increasingly in a position to see what progress we are making with regard to health and health inequalities. In this annual report we reflect on what progress we have made with regard to improving the health and lifestyle of the population over the past 10 years. The report draws on the findings of a local health, lifestyle and social capital survey that was undertaken in 2003 and compares the findings with a similar lifestyle survey conducted in 1992.

Readers are encouraged to use this report as a key resource document for understanding health in Brighton and Hove, they are also urged to consider how they might better address some of the important lifestyle issues and health inequalities that persist in the city of Brighton and Hove.

The report reflects two increasing public health concerns. The first is the impact that unhealthy lifestyles are having, and will have, on the population’s health, the second is the inequalities in health that exist between different sections of our population; differences, which instead of narrowing, seem to be growing wider. These concerns are felt both locally and nationally.

Nationally, the recent report by Derek Wanless, *Securing Good Health for the Whole Population* has drawn government and public attention to issues such as increasing levels of obesity, poor diet, lack of exercise and the effects of smoking in public places. The Secretary of State for Health, John Reid, has launched a national consultation paper on improving public health: *Choosing Health? A consultation on improving people’s health*. The NHS, local government, non-governmental organisations, schools, employers, industry, the media and individuals themselves are invited to contribute to the debate on how we can create opportunities for all to enjoy health. A White Paper outlining national public health priorities is anticipated later in 2004.

With regard to inequalities in health, recent years have seen considerable focus on this issue. A 1998 *Independent Inquiry into Inequalities in Health* established that in order to tackle health inequalities action was needed right across government. A wide range of related programmes and interventions have already been introduced. *Sure Start* is designed to support the development of children from poorer families. A *Strategy for Neighbourhood Renewal* has been developed to regenerate the most deprived communities. The *UK Fuel Poverty Strategy* aims to support the most vulnerable households. The *NHS Plan* has for the first time focused the NHS on tackling health inequalities. A Treasury-led *Cross Cutting Review* has identified how government spending could be best applied to reduce health inequalities and *Tackling Health Inequalities; A Programme for Action* has laid out the government’s commitment and approach to tackling inequalities.

While national action with dedicated resources is important, the greatest contributions to improving health and reducing inequalities in health are to be made at local level. Local
strategic partnerships (LSPs) with contributions from all sections of the community have a key role to play. It is not easy to alter unhealthy lifestyles, many of which are rooted in longstanding socio-economic influences. It can be even more difficult to tackle inequalities in health. Many current interventions, although effective in tackling ill health, may, at least initially, be associated with a widening of the health inequality gap. For example anti-smoking measures, when first introduced, were adopted preferentially by the more affluent and healthy sections of the population, leading to improvements in health among a group of people who were actually healthier in the first place. Measures to reduce health inequalities therefore do not just have to be effective in improving health; they have to be targeted where improvements in health are most needed.

Aims
1. To describe the health status of the population of Brighton and Hove City;
2. To describe lifestyle changes that have occurred over the past 10 years;
3. To provide information on social capital and the health inequalities that exist in Brighton and Hove;
4. To inform policy makers of the potential to address these health inequalities;
5. To inform the setting of public health priorities for Brighton and Hove;
6. To inform an Inequalities in Health Strategy for Brighton and Hove.

Scope
The report contains health-related information from a number of sources. The latest Census (2001) has still to be fully analysed but there is still considerable information available at this stage. The public health common data set, hospital episode statistics and prescribing data provide us with most of our information on morbidity and mortality. As data from general practice improves, this will shed more light on the quality of care received by patients. Data collected by the local authority on housing, education, transport and environment provides us with a wealth of information on the wider determinants of health.

In addition, this year the PCT Public Health Directorate completed a lifestyle and social capital survey of the population of Brighton and Hove. This postal survey of a random sample of 2% of the population aged over 18 years produced a good response rate of 50%. The postal survey was supplemented with additional sampling of certain groups: residents of the EB4U area and Hollingdean, homeless people and members of the lesbian, gay, bisexual and transgender communities. We have been able to compare some of these results with results from a similar local survey conducted in 1992.

Method of Presentation
The report makes frequent use of tables, figures and maps with additional commentary. In most of the areas discussed, there is further information available, as not everything can be included. Readers interested in pursuing further information are advised to contact the Public Health Directorate of Brighton and Hove City Primary Care Trust.

Throughout the report, the population is split by ward into three clusters:

1. **Cluster A - Most Deprived:** Regency, Queens Park, Brunswick and Adelaide, East Brighton and Central Hove.
2. **Cluster B - Intermediate:** Goldsmid, South Portslade, Moulescoomb and Bevendean, Hanover and Elm Grove, Hollingbury and Stanmer, Preston Park and Westbourne.
3. **Cluster C - Most Affluent:** Hangleton and Knowle, Wish, North Portslade, Rottingdean Coastal, Withdean, Woodingdean, Patcham and Stanford.
This split has been achieved by applying the Townsend Index of Material Deprivation. The Townsend Index uses four variables derived from the Census at ward level: home ownership, car ownership, overcrowding within households and employment. Other indices of deprivation will produce slightly different results. The Townsend index was selected because it has long been established as a valid and reliable indicator of material deprivation and it has been found to be associated with many causes of morbidity and mortality. The availability of a recent census means that the variables are likely to be reasonably accurate. Because car ownership is not so widespread in Brighton and Hove, the population was also examined using just three of the Townsend variables: the results were much the same, so the split is by Townsend index.

The effect of recent boundary changes to wards within Brighton and Hove is shown in Table 1.1: twenty-six wards have now been re-configured to form twenty-one. Marina, which together with Whitehawk previously formed Marine ward, is now included with Rottingdean as Rottingdean Coastal. Whitehawk now forms part of East Brighton and Moulsecoomb in turn has now been combined with Bevendean. As can be seen from Table 1.1, these changes affect where particular wards sit in terms of relative deprivation.

**Table 1.1 Pre and post-boundary changes to wards and respective Townsend Score**

<table>
<thead>
<tr>
<th>Pre-boundary change ward</th>
<th>Townsend score</th>
<th>Post-boundary change ward</th>
<th>Townsend score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moulsecoomb</td>
<td>7.11</td>
<td>Regency</td>
<td>5.84</td>
</tr>
<tr>
<td>Regency</td>
<td>7.04</td>
<td>Queen’s Park</td>
<td>5.62</td>
</tr>
<tr>
<td>Marine</td>
<td>6.95</td>
<td>Brunswick and Adelaide</td>
<td>4.58</td>
</tr>
<tr>
<td>Queen’s Park</td>
<td>6.78</td>
<td>East Brighton</td>
<td>4.31</td>
</tr>
<tr>
<td>Vauxhall</td>
<td>5.60</td>
<td>Central Hove</td>
<td>3.54</td>
</tr>
<tr>
<td>Brunswick and Adelaide</td>
<td>5.55</td>
<td>St. Peter’s and North Laine</td>
<td>1.86</td>
</tr>
<tr>
<td>Kings Cliff</td>
<td>4.88</td>
<td>Goldsmid</td>
<td>1.43</td>
</tr>
<tr>
<td>Seven Dials</td>
<td>4.66</td>
<td>South Portslade</td>
<td>0.98</td>
</tr>
<tr>
<td>Hanover</td>
<td>3.95</td>
<td>Moulsecoomb and Bevendean</td>
<td>0.91</td>
</tr>
<tr>
<td>St. Peter’s</td>
<td>3.62</td>
<td>Hanover and Elm Grove</td>
<td>0.84</td>
</tr>
<tr>
<td>Hollingbury</td>
<td>3.30</td>
<td>Hollingbury and Stanmer</td>
<td>-0.41</td>
</tr>
<tr>
<td>Goldsmid</td>
<td>2.69</td>
<td>Preston Park</td>
<td>-0.51</td>
</tr>
<tr>
<td>Tenantry</td>
<td>1.99</td>
<td>Westbourne</td>
<td>-0.54</td>
</tr>
<tr>
<td>Westbourne</td>
<td>1.64</td>
<td>Hangleton and Knoll</td>
<td>-1.80</td>
</tr>
<tr>
<td>Stanmer</td>
<td>1.20</td>
<td>Wish</td>
<td>-2.60</td>
</tr>
<tr>
<td>Nevill</td>
<td>1.17</td>
<td>North Portslade</td>
<td>-3.26</td>
</tr>
<tr>
<td>Hangleton</td>
<td>1.06</td>
<td>Rottingdean Coastal</td>
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</tr>
<tr>
<td>Portslade South</td>
<td>0.84</td>
<td>Withdean</td>
<td>-3.84</td>
</tr>
<tr>
<td>Wish</td>
<td>0.36</td>
<td>Woodingdean</td>
<td>-3.84</td>
</tr>
<tr>
<td>Preston</td>
<td>-0.59</td>
<td>Patcham</td>
<td>-4.33</td>
</tr>
<tr>
<td>Woodingdean</td>
<td>-0.63</td>
<td>Stanford</td>
<td>-5.35</td>
</tr>
<tr>
<td>Portslade North</td>
<td>-0.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Westdene</td>
<td>-1.53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patcham</td>
<td>-2.41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rottingdean</td>
<td>-2.56</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stanford</td>
<td>-2.82</td>
<td></td>
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</tr>
</tbody>
</table>

*Source: East Sussex, Brighton and Hove Public Health Information Department 2004.*

Figure 1.1 shows the scores for each of the wards in Brighton and Hove and the split into three clusters. Those five wards which sit above the upper horizontal line have been designated as the most deprived wards while those which sit below the lower horizontal line are designated the most affluent wards. This split into three clusters has been made on the basis of face validity in terms of where incremental gaps between wards appear to be most significant.
Figure 1.2 shows where these wards sit within Brighton and Hove. In general the most deprived wards are more centrally located while the most affluent wards, with the exception of Portslade South, are located more peripherally.

**Figure 1.1 Townsend updated scores by ward**
Content and Structure
Following this introductory chapter, the demographic characteristics of the local population are explained in Chapter 2. In Chapter 3 the use of health services is discussed. Chapter 4 deals with health-related behaviour and Chapter 5 with the wider determinants of health. Chapter 6 looks at some particular groups who are known to suffer from inequalities in health. The report concludes with Chapter 7, which summarises the main conclusions and outlines recommendations for policy makers across the statutory and non-statutory sectors of Brighton and Hove.

Accuracy, validity and reliability issues
The information described in the report comes from four main sources: the 2001 census, the public health common data set, hospital admission data, and the 1992 and 2003 lifestyle surveys. Birth and mortality data drawn from the public health common data set are generally accurate, valid and reliable although there can be delays in obtaining up-to-date data. Hospital admission data is increasingly accurate although because most ill health does not require a hospital admission, its usefulness in terms of describing ill health is limited. The 2001 census is considered to be very accurate and has resulted in revisions to previous population estimates.

The 2003 local survey of lifestyle and social capital, Health Counts obtained a response rate of just under 50%. Additional sampling was undertaken of homeless people and the lesbian, gay, bisexual and transgender communities. A response rate of 50% is considered to be sufficient for this type of survey. The response rate to the 1992 survey, Healthquest was 60% although just 1% of the population was then sampled. The characteristics of those who responded to the 2003 survey, compared to the general population of Brighton and Hove as of the 2001 census, is shown in Table 1.2.
### Table 1.2  Population characteristics of Health Counts lifestyle survey respondents (2003) compared to Census population (2001)

<table>
<thead>
<tr>
<th>2003 Survey Sample</th>
<th>2001 Census Population of B&amp;H City</th>
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<tr>
<td><strong>Gender</strong></td>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>Male:</td>
<td>Male:</td>
</tr>
<tr>
<td>42.4</td>
<td>48.4</td>
</tr>
<tr>
<td>Female:</td>
<td>Female</td>
</tr>
<tr>
<td>57.6</td>
<td>51.6</td>
</tr>
<tr>
<td><strong>Age in Years</strong></td>
<td><strong>Age in Years</strong></td>
</tr>
<tr>
<td>18-24</td>
<td>20-24</td>
</tr>
<tr>
<td>8.5</td>
<td>10.4</td>
</tr>
<tr>
<td>25-34</td>
<td>25-34</td>
</tr>
<tr>
<td>17.9</td>
<td>22.9</td>
</tr>
<tr>
<td>35-44</td>
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</tr>
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<td>45-54</td>
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</tr>
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<td>15.7</td>
<td>15.0</td>
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<td>55-64</td>
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</tr>
<tr>
<td>14.4</td>
<td>11.4</td>
</tr>
<tr>
<td>65-74</td>
<td>65-74</td>
</tr>
<tr>
<td>12.7</td>
<td>9.8</td>
</tr>
<tr>
<td>75+</td>
<td>75+</td>
</tr>
<tr>
<td>10.7</td>
<td>11.0</td>
</tr>
<tr>
<td>No answer</td>
<td>Note: &lt;20years excluded for purposes of comparison</td>
</tr>
<tr>
<td><strong>Ethnic Group</strong></td>
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</tr>
<tr>
<td>White</td>
<td>White</td>
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<td>95.1</td>
<td>94.3</td>
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<td>Mixed</td>
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<td>1.9</td>
<td>2.2</td>
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<tr>
<td>Asian or Asian British</td>
<td>Asian or Asian British</td>
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<tr>
<td>1.5</td>
<td>1.8</td>
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<tr>
<td>Black or Black British</td>
<td>Black or Black British</td>
</tr>
<tr>
<td>0.6</td>
<td>0.8</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
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<tr>
<td>1.2</td>
<td>1.2</td>
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<tr>
<td><strong>Employment Status</strong></td>
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</tr>
<tr>
<td>59.4</td>
<td>60.1</td>
</tr>
<tr>
<td>Unemployed</td>
<td>Unemployed</td>
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<tr>
<td>2.5</td>
<td>4.4</td>
</tr>
<tr>
<td>Permanently sick or disabled</td>
<td>Permanently sick or disabled</td>
</tr>
<tr>
<td>4.9</td>
<td>5.5</td>
</tr>
<tr>
<td>Student (full time)</td>
<td>Student (economically inactive)</td>
</tr>
<tr>
<td>5.3</td>
<td>7.3</td>
</tr>
<tr>
<td>Retired</td>
<td>Retired</td>
</tr>
<tr>
<td>24.0</td>
<td>13.6</td>
</tr>
<tr>
<td>Carer (home/family/ dependents)</td>
<td>Carer (home/family/ dependents)</td>
</tr>
<tr>
<td>3.7</td>
<td></td>
</tr>
</tbody>
</table>


There are some differences in the characteristics of the respondents to the lifestyle survey compared to the census profile of the local population. A higher proportion of females responded to the survey, respondents to the survey were on average older and a higher proportion of them were retired. There were no substantial differences however in terms of ethnicity.

### Audience

As a health information resource and vehicle for improving public health, the report is aimed at those who have remit to deliver on improving public health in the city. Thus statutory sectors, non-statutory organisations and even local residents will find much of its content relevant. The report will be posted on the web site of Brighton and Hove City Primary Care Trust.

### Conclusions

The national emphasis on reducing health inequalities and improving public health signals an opportunity to time for those concerned with local public health to reflect on the future. The availability of a recent census and two lifestyle surveys separated by a period of just over ten years provides us with ideal information for examining the state of public health in Brighton and Hove and planning our public health priorities.

Of central importance locally is that Brighton and Hove City is aiming to become a participating member of the World Health Organisation's Phase IV Healthy Cities Network. This will bring insight and access to an extensive research evidence base of public health practice from approximately 170 designated Healthy Cities across Europe. In Brighton and Hove the City Health Partnership provides a vehicle to co-ordinate cross-sector contributions to public health goals through a healthy city approach, aiming to achieve health for all and
reduce health inequalities within the urban environment. This Annual Report therefore also represents a profile of the city's health for the purposes of informing healthy city objectives.

This report should be judged on three key outcomes:

1. As a resource document that accurately describes the health status, lifestyle, social capital and health inequalities of the population of Brighton and Hove City

2. As the platform for the establishment of a comprehensive health inequalities' strategy for Brighton and Hove that places the reduction of health inequalities as central to the work of all local statutory and non-statutory organisations that have a remit for improving public health.

3. As the conduit that brings the representatives of the people of Brighton and Hove City in statutory and non-statutory organisations together to better address the public health priorities for Brighton and Hove City for the coming years.
Chapter 2

Population characteristics and progress on disease related targets

Summary
The city of Brighton and Hove has a relatively higher proportion of young adults and a lower proportion of children compared to the national population. The model used for this report to split the population of Brighton and Hove City into three deprivation clusters suggests that in deprived areas there are fewer children and more unemployed people. There are more elderly people but fewer people from ethnic minority backgrounds living in the more affluent parts of the city.

There does not appear to have been any change in the self-reported health of local residents as assessed by respondents to the lifestyle surveys of 1992 and 2003. However residents who live in more deprived areas report poorer health.

Progress towards the targets outlined in ‘Saving Lives: Our Healthier Nation’ (DH, 1999) has been mixed. There continues to be good progress towards achieving the circulatory disease target. Progress towards the cancer target has recently tailed off. It is not clear whether the accident target will be met and predicting future trends accurately is hampered by the relatively small numbers. There has been no progress towards achieving the suicide target.

Introduction
The first part of this chapter describes the population of Brighton and Hove using the statistics from the 2001 census and includes analysis of the three deprivation clusters outlined in chapter 1. The second part of the chapter assesses progress with regard to the four key public health targets described in the Department of Health White Paper Saving Lives: Our Healthier Nation (DH, 1999). These targets specify reductions in mortality from cancer, circulatory disease, accidents and suicides and take as a baseline mortality rates from 1995 to 1997.

1. Population structure
   Age and sex
The resident population for Brighton and Hove City in 2001 was recorded as 247,817 with 51.6% of the population female and 48.4% male. The age structure differs slightly from the national picture. There is a higher proportion of young adults (aged 16 to 44 years) and elderly (over 75 years) compared to England and Wales and relatively fewer children (under 16 years) and older working age adults (aged 45 to 64 years). There has been a 3% increase in the size of the population compared to figures in 1991, but at the time of writing there are no reliable estimates of the future population projections.
Table 2.1  Brighton and Hove population by age and sex, and by deprivation cluster 2001

<table>
<thead>
<tr>
<th>Age Group</th>
<th>England and Wales</th>
<th>Brighton &amp; Hove population (N= 247817)</th>
<th>Cluster A (N= 52363)</th>
<th>Cluster B (N= 103110)</th>
<th>Cluster C (N= 92344)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(% of total pop)</td>
<td>Males</td>
<td>Females</td>
<td>All persons</td>
<td>Number</td>
</tr>
<tr>
<td>0-16</td>
<td>16.6</td>
<td>9926</td>
<td>10931</td>
<td>20857</td>
<td>5938</td>
</tr>
<tr>
<td>17-24</td>
<td>12.9</td>
<td>6576</td>
<td>6576</td>
<td>14861</td>
<td>21701</td>
</tr>
<tr>
<td>25-44</td>
<td>20.8</td>
<td>9863</td>
<td>9863</td>
<td>25796</td>
<td>51507</td>
</tr>
<tr>
<td>45-64</td>
<td>7.7</td>
<td>3756</td>
<td>3756</td>
<td>8553</td>
<td>19025</td>
</tr>
<tr>
<td>75 - 84</td>
<td>6.0</td>
<td>3122</td>
<td>3122</td>
<td>5733</td>
<td>14924</td>
</tr>
<tr>
<td>85+</td>
<td>2.6</td>
<td>1407</td>
<td>1407</td>
<td>1765</td>
<td>6501</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics Census 2001

The number of people in each deprivation cluster varies. The most affluent group (C) consists of 92,344 residents, the intermediate group (B) is the largest group with 103,110 residents and the most deprived group (A) is the smallest 52,363. Within deprivation clusters there is a difference in the age structure. The most deprived group has a lower proportion of children and a higher proportion of 25 to 44 year-olds compared to the rest of the local population and the most affluent cluster has a higher proportion of over 65 year olds.

Ethnicity
Certain minority ethnic groups may be at increased risk of various health-related conditions. A fuller discussion is included in Chapter 6. A question on ethnicity has been included in the last two censuses, five main groupings are described; White, Mixed race, Asian, Black and Chinese and other groups. More specific ethnic sub-groupings are contained within these five general headings. A full breakdown of these subgroups is included in Table 2.2.

Table 2.2  Census classification of ethnic groupings

<table>
<thead>
<tr>
<th>Ethnic Grouping</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>White British, White Irish and White Other White</td>
</tr>
<tr>
<td>Mixed race</td>
<td>Mixed White and Black Caribbean, Mixed White and Black African, Mixed White and Asian and Mixed Other Mixed</td>
</tr>
<tr>
<td>Asian</td>
<td>Asian or Asian British Indian, Asian or Asian British Pakistani, Asian or Asian British Bangladeshi and Asian or Asian British Other Asian</td>
</tr>
<tr>
<td>Black</td>
<td>Black or Black British Black Caribbean, Black or Black British Black African and Black or Black British Other Black</td>
</tr>
<tr>
<td>Chinese and other groups</td>
<td>Chinese or other ethnic group Chinese, Chinese or other ethnic group, Other Ethnic Group</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics Census 2001

Table 2.3 shows the ethnic breakdown of the population of England and Wales compared to Brighton and Hove City and includes a breakdown by deprivation cluster. Brighton and Hove City has a relatively low proportion of non-white ethnic groupings: 5.7% of the population compared to 8.7% in England and Wales. The wards with the higher deprivation scores have a slightly higher proportion of non-white ethnic groups: 6.4% in Cluster A compared to 4.9% in Cluster C.
Table 2.3  
**Ethnicity in England and Wales and in Brighton and Hove by deprivation cluster 2001**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>England and Wales</th>
<th>Brighton &amp; Hove Total N= 247817</th>
<th>Cluster A Most Deprived N= 52363</th>
<th>Cluster B Intermediate N= 103110</th>
<th>Cluster C Most Affluent N= 92344</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>(%)</td>
<td>Number</td>
<td>(%)</td>
<td>Number</td>
<td>(%)</td>
</tr>
<tr>
<td>91.3</td>
<td>233582</td>
<td>94.3</td>
<td>49012</td>
<td>96707</td>
<td>93.8</td>
</tr>
<tr>
<td>Mixed</td>
<td>1.3</td>
<td>4799</td>
<td>1.9</td>
<td>1111</td>
<td>2.1</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>4.4</td>
<td>4539</td>
<td>1.8</td>
<td>983</td>
<td>1.9</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>2.2</td>
<td>1989</td>
<td>0.8</td>
<td>539</td>
<td>1.0</td>
</tr>
<tr>
<td>Chinese &amp; other ethnic groups</td>
<td>0.9</td>
<td>2905</td>
<td>1.2</td>
<td>718</td>
<td>1.4</td>
</tr>
</tbody>
</table>

*Source: Office for National Statistics Census 2001*

**Employment status**

Unemployment has been shown to be associated with a number of adverse psychological, social and physical outcomes. Unemployed people have higher levels of psychological problems for example depression, anxiety, self-harm and suicide. There are also increased rates of morbidity such as limiting long-term illness and higher rates of premature mortality, in particular from coronary heart disease, injuries and poisoning. Policies that increase levels of employment and improve work opportunities are therefore likely to benefit individuals and the community. Work opportunities can be enhanced through training and education. Family friendly work policies enable more people to remain in employment (London Health Observatory, 2003).

Table 2.4 shows the employment status of people aged 16 to 74 years in Brighton and Hove compared to England and Wales. At the time of the 2001 Census there were 185,131 people aged 16 to 74 years in Brighton and Hove 6,725 (3.6%) of whom were unemployed. This is a slightly higher unemployment rate than the national average. There is also a higher proportion of students, both economically active and inactive, but a lower proportion of people looking after home or family and retired people compared to national figures (in this age group). A further 5.3% of the population were permanently sick or disabled and 2.8% were economically inactive for other reasons.

Unemployment varies within the three deprivation clusters, with over double the rate of unemployment in the most deprived group compared to the most affluent group (5.3% compared to 2.5%). This is as expected as one of the variables that make up the Townsend deprivation score is unemployment. There are also higher proportions of permanently sick and disabled people in the most deprived group.
Table 2.4 Employment status (persons aged 16 – 74 years) in England and Wales, Brighton and Hove City, and by deprivation cluster 2001

<table>
<thead>
<tr>
<th>Status (all people 16-74)</th>
<th>England and Wales</th>
<th>Brighton &amp; Hove Total</th>
<th>Cluster A (Most Deprived)</th>
<th>Cluster B (Intermediate)</th>
<th>Cluster C (Most Affluent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(%)</td>
<td>Number (%)</td>
<td>Number (%)</td>
<td>Number (%)</td>
<td>Number (%)</td>
</tr>
<tr>
<td>Employed</td>
<td>60.6</td>
<td>111318</td>
<td>60.1</td>
<td>25337</td>
<td>60.5</td>
</tr>
<tr>
<td>Unemployed</td>
<td>3.4</td>
<td>6725</td>
<td>3.6</td>
<td>2238</td>
<td>5.3</td>
</tr>
<tr>
<td>Long-term unemployed</td>
<td>1</td>
<td>2363</td>
<td>1.3</td>
<td>804</td>
<td>1.9</td>
</tr>
<tr>
<td>Student (economically active)</td>
<td>2.6</td>
<td>7425</td>
<td>4.0</td>
<td>1368</td>
<td>3.3</td>
</tr>
<tr>
<td>Student (economically inactive)</td>
<td>4.7</td>
<td>13148</td>
<td>7.1</td>
<td>2495</td>
<td>6.0</td>
</tr>
<tr>
<td>Retired</td>
<td>13.6</td>
<td>21082</td>
<td>11.4</td>
<td>4093</td>
<td>9.8</td>
</tr>
<tr>
<td>Looking after home or family (economically inactive)</td>
<td>6.5</td>
<td>10534</td>
<td>5.7</td>
<td>1965</td>
<td>4.7</td>
</tr>
<tr>
<td>Permanently sick or disabled</td>
<td>5.5</td>
<td>9752</td>
<td>5.3</td>
<td>2871</td>
<td>6.9</td>
</tr>
<tr>
<td>Economically inactive (other)</td>
<td>3.1</td>
<td>5147</td>
<td>2.8</td>
<td>1529</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics Census 2001

Indicators of health

A question on self-reported health status over the previous year was included in the census. In England and Wales 68.9% of the population reported ‘good’ health in the previous year, 9% reported ‘not good’ health and 18.2% of the population reported a limiting long-term illness (LLTI), a health problem or disability that limited their daily activities or the work they were able to perform. This latter figure makes up more than 1 in 8 of the working age group and has increased since the 1991 census. One in 10 of the population of England and Wales provide unpaid care to family members, friends, neighbours or others, because of long-term physical or mental ill health or disability and problems related to old age.

These England and Wales figures are similar to those for Brighton and Hove. Among the three deprivation clusters in Brighton and Hove there is a higher proportion of people with limiting long-term illness and health reported as ‘not good’ in the most deprived group. This is consistent with the association between deprivation and poor health.
Table 2.5  Health status in England and Wales, Brighton and Hove City, and by deprivation cluster

<table>
<thead>
<tr>
<th></th>
<th>England and Wales</th>
<th>Brighton &amp; Hove Total N= 247817</th>
<th>Grouping A Most deprived N= 52363</th>
<th>Grouping B Intermediate N= 103110</th>
<th>Grouping C Most affluent N= 92344</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limiting long-term illness</td>
<td>18.2%</td>
<td>44925 (18.1%)</td>
<td>10608 (20.3%)</td>
<td>18020 (17.5%)</td>
<td>16297 (17.6%)</td>
</tr>
<tr>
<td>General health 'not good'</td>
<td>9.0%</td>
<td>22415 (9.0%)</td>
<td>5755 (11.0%)</td>
<td>9092 (8.8%)</td>
<td>7568 (8.2%)</td>
</tr>
<tr>
<td>General health 'fairly good'</td>
<td>22.1%</td>
<td>56752 (22.9%)</td>
<td>12614 (24.1%)</td>
<td>23604 (22.9%)</td>
<td>20534 (22.2%)</td>
</tr>
<tr>
<td>General health 'good'</td>
<td>68.9%</td>
<td>168650 (68.1%)</td>
<td>33994 (64.9%)</td>
<td>70414 (68.3%)</td>
<td>64242 (69.6%)</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics Census 2001

The Health Counts lifestyle survey of 2003 described in chapter 1 included questions on general health perceptions, functional status and wellbeing. Compared to the census, a higher proportion of people in the lifestyle survey reported a LLTI (33% compared to 18.2%). This may in part reflect the higher proportion of elderly people who responded to the lifestyle survey. There were no obvious differences in LLTI between the deprivation clusters of lifestyle survey responders.

Table 2.6 compares the results from the 2003 lifestyle survey with the results from the lifestyle survey of 1992. There has been little change in self-reported health both currently and compared to the previous year in the two surveys. The largest proportion of people reported that their general health was either good or very good. A question assessing those who are at risk of major depression also showed little change, with 37% and 38% of responders at risk of depression in both surveys. As was the case for LLTI, there were no substantial differences between the three deprivation clusters for self-reported health in the 2003 survey.

Table 2.6 Self-reported current health and health compared to last year: Brighton and Hove lifestyle surveys 1992 and 2003.

<table>
<thead>
<tr>
<th></th>
<th>Self reported current health</th>
<th>Health compared to last year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Very good</td>
<td>35%</td>
<td>33%</td>
</tr>
<tr>
<td>Good</td>
<td>34%</td>
<td>35%</td>
</tr>
<tr>
<td>Fair</td>
<td>15%</td>
<td>17%</td>
</tr>
<tr>
<td>Poor</td>
<td>3%</td>
<td>5%</td>
</tr>
</tbody>
</table>


SF 36 results from the lifestyle survey

The Short Form 36 (SF 36) is a validated set of questions developed in the USA, which is now a widely used measure of health status. It is designed to measure physical and mental health and scores health in 8 different areas including bodily pain, general health and vitality. Each of the areas is measured on a scale, which ranges from 0-100. Zero represents the worst state whilst 100 represents the best possible state. The SF36 questionnaire was included in both the 1992 and 2003 lifestyle surveys. There has been no real change in health status as assessed by the SF36 among those surveyed in 1992 and 2003 and there were no consistent differences between deprivation groupings.
2. Progress towards the Our Healthier Nation targets

_Saving Lives: Our Healthier Nation_ (OHN) (DH, 1999) is a comprehensive Government wide public health strategy for England. It was published as a White Paper in July 1999 with the twin goals of improving health and reducing health inequalities. The strategy aims to prevent up to 300,000 untimely and unnecessary deaths by the year 2010.

Specific targets were set to reduce mortality rates in four areas: circulatory disease, cancers, accidents and suicides. Progress towards the four targets in Brighton and Hove is described below. Mortality rates in the four target areas are represented graphically over several years. There is however discontinuity in the estimate of the size of the population associated with the census in 2001, this makes the more recent trend data difficult to interpret. The projected progression of the mortality rates from the 1995 to 1997 baseline required to achieve the 2005 target is included in the graphs. This helps to assess the progress towards the target. The mortality rates in England and the south east of England (Government Office for the South East (GOSE)) are included for comparison.

**Circulatory disease**

Coronary heart disease (CHD), stroke and related conditions are a major cause of early death, accounting for a third of all deaths and one fifth of all deaths respectively in men and women aged under 65 years of age. There are inequalities in mortality rates from circulatory disease within the population, for example the South Asian population has higher rates of coronary heart disease and hypertension whereas stroke rates are higher among African-Caribbean populations. Men in the lower social classes are at greater risk of dying from coronary heart disease than men in higher social classes.

A _National Service Framework (NSF) for Coronary Heart Disease_ (DH, 2000) has been produced to set standards and service models for the prevention, diagnosis and treatment of coronary heart disease. The OHN target for circulatory disease is ‘to reduce the death rate from circulatory disease in people aged under 75 years by 40% between 1995-97 and 2010 with an interim target reduction of 25% by 2005. Current trends in Brighton and Hove suggest that the 2005 interim and the 2010 final targets will be achieved if the current trend continues.

![Figure 2.1](image-url) **Figure 2.1** Death rates from circulatory disease in those aged less than 75 years. Age-standardised 3 year moving averages for Brighton & Hove, England and GOSE

TARGETS based on 1995/6/7 figures

_Source: Brighton and Hove City PCT Public Health Information Dept and ONS_
Cancer
Cancer is the cause of just over a quarter of all deaths in the UK. Lung cancer accounts for over one fifth of the cancer deaths and a further quarter of the cancer deaths are due to cancers of the large bowel, breast and prostate combined (Cancer Research UK, 2000).

The mortality rate from all cancers is decreasing in Brighton and Hove, with a total of 686 deaths from all cancers in all age groups in Brighton and Hove in 2001 (315 deaths in the under 75 age group). It is not clear from current projections whether or not the OHN target ‘to reduce the death rate from cancer in people aged under 75 years by 20% between 1995-97 and 2010 (and by 12% by 2005)’ will be reached. Although mortality from the individual cancers of lung, breast and colon has declined in the past ten years, in recent years this decline has slowed or even been reversed. Data on individual cancers however, reflects small numbers of deaths and makes trends difficult to interpret.

Figure 2.2 Death rates from cancer in those aged less than 75 years. Age-standardised 3 year moving averages for Brighton and Hove, England and GOSE
TARGETS based on 1995/6/7 figures

Source: Brighton and Hove City Teaching PCT Public Health Information Dept and ONS

Accidents
Accidents are responsible for 10,000 deaths per year across England and represent the greatest single cause of death in children and young people. Accidents, particularly falls, are a major cause of death and disability in older people. Children from poorer backgrounds are more likely to die as the result of an accident compared to children from better off families. Current Government policies aimed at reducing accidents, target in particular three groups: children up to 15 years; young people aged 16-24 years (at particular risk from road traffic accidents); and older people (at risk of falling). Strategies to reduce the number of deaths from accidents require a multi-agency approach.

The mortality rate from accidents in Brighton and Hove has been roughly static since the early 1990s. As the numbers are relatively small, the data has been amalgamated to produce 5 year rolling averages. It is not clear from current projections whether or not the OHN target to reduce the ‘death rate from accidents by 20% between 1995-97 and 2010 (and by 12% by 2005)’ will be achieved.
Suicide and Undetermined injury
Death from suicide is a rare event and it can be difficult to determine if death was intentional. Hence when analysing suicide statistics death certifications of ‘suicides’ are combined with ‘undetermined deaths’. The rate of suicide and undetermined death (Figure 2.4) has been high in Brighton and Hove since the 1980s. The most recent suicide audit conducted in Brighton and Hove in 2003 reported 34 deaths from suicide (a further three deaths are still under consideration) and 48 in total from suicide and undetermined injury.

These persistent high rates are worrying although there are local initiatives underway to address this problem guided by the National Suicide Prevention Strategy for England (DH, 2002). The target to ‘reduce the death rate from suicide by 20% between 1995-97 and 2010 (and by 12% by 2005)’ is unlikely to be met. In terms of numbers this equates with a target reduction of 8 suicides per year by the year 2010 from a baseline of 42 in 1995-97.

Local audits show that the mortality rate from suicide and undetermined deaths is higher in all age groups in Brighton and Hove compared to the England and Wales average in 2000-2002. Among men, suicide rates are particularly high in younger and older males however in females the suicide rate is highest in the 45-69 year age group. The 2003 suicide audit showed that only one fifth of people committing suicide were born in Brighton. Eighty percent of people who committed suicide were single, divorced or widowed, and a large proportion of these were unemployed or living alone. These are all recognised risk factors for suicide. These high suicide rates continue to be a real concern.
Figure 2.4  Death rate from suicide and injury of undermined intent. Age-standardised 3 year moving averages for Brighton and Hove, England and GOSE TARGETS based on 1995/6/7 figures

Source: Brighton and Hove City Teaching PCT Public Health Information Dept and ONS

Conclusions
The population of Brighton and Hove City differs from the national population by having a higher proportion of young adults and fewer children. This is particularly the case among the more deprived parts of the city.

Self-reported health as assessed in the lifestyle surveys of 1992 and 2003 has not changed significantly.

There has been good progress towards achieving the circulatory disease target outlined in the Government white paper Saving Lives: Our Healthier Nation (DH, 1999).

There has been some progress towards the target to reduce mortality from cancer in Brighton and Hove.

It is less clear whether the accident target will be met. Predicting future trends accurately is hampered by the relatively small numbers.

There has been no progress towards achieving the suicide target; although it is not clear what the figure would be were action under the current suicide prevention strategy not taking place. These deaths do reflect small numbers but they also occur in a relatively young age group.

References


Chapter 3

Use of Health Services

Summary

Primary care
Brighton and Hove City Teaching PCT has a higher proportion of GPs working part-time than the national average. Eighty two percent of respondents to the 2003 lifestyle survey had seen their GP in the previous year, and sixty five percent in the previous 6 months. Residents living in more affluent areas are less likely to be served by a single-handed GP practice. Primary care prescribing costs are higher in Brighton and Hove compared to the rest of Sussex and Surrey and national equivalents although high proportions of generic drugs are used. Drugs prescribed for the cardiovascular system make up almost 25% of the total primary care prescribing costs. Prescribing of antibacterial drugs is favourable (lower) compared to other parts of the country, however there are high levels of prescribing of benzodiazepines across the city.

Dental health in 5 year olds has improved little in the past five years. Residents from more deprived areas were less likely to be registered with a dentist and less likely to have visited their dentist in the last two years. Use of optometry services increases with affluence. Residents living in more deprived areas are more likely to use a pharmacist for health advice. Women are more likely than men to consult complementary therapists. There was no demonstrated relationship between use of complementary therapists and levels of deprivation.

Secondary care
Admission to hospital appears to be influenced by levels of deprivation. Residents living in more affluent areas are more likely to have elective (planned) admissions to acute specialties. Those residents living in more deprived areas are more likely to have an emergency admission. Admissions for mental illness increase with the level of deprivation.

Introduction
This chapter covers a wide range of health services in both primary and secondary care. It uses referral data, prescribing data and data from the 2003 Health Counts lifestyle survey to build up a picture of primary and secondary care services. Where possible, these are analysed with reference to the three deprivation clusters described in Chapter 1.

Primary Care

General practice services
A new GP contract came into force in April 2004. The new contract focuses on quality of care and changes in practice are anticipated as the contract becomes operational. The new contract:
- makes it mandatory for practices to deliver a defined range of services to their patients unless they can demonstrate there are clear reasons why they should be allowed to ‘opt out’;
- rewards practices which can demonstrate the achievement of a variety of quality standards;
- gives primary care trusts (PCTs) the opportunity to commission enhanced services from some practices where the right skills exist;
- sets new standards for premises including branch surgeries.

General practitioners
There are 149 principal GPs (excluding retainers) working in the 51 practices in Brighton and Hove, 14 of whom work alone (single handed general practitioners). Because of recruitment difficulties, locum general practitioners currently staff four single-handed practices and there are 4 additional vacancies. Thirty eight percent of GPs (57) are women and 62% (92) are men. This mirrors the national picture where women make up 37% of all GPs (DH, 2003).
There are a total of 59 surgeries, as some practices have branch surgeries. Figure 3.1 shows the distribution of these practices by the three deprivation clusters. Fourteen practices are in the most deprived cluster A (population 51,363). Cluster B (intermediate), which has the largest population (103,110), has 32 practices and cluster C (most affluent) with a population of 92,344 has 15 practices. Five years ago there were 16 single-handed surgeries in Brighton and Hove, now there are 15 single-handed surgeries: eight are in the intermediate area; four are in the most deprived; and three in the most affluent area.

**Figure 3.1**

Distribution of GP and Single Handed GP Surgeries in Brighton & Hove

Seventy five percent (112) of GPs work full-time and 25% (37) work part-time. This equates with 135.25 whole time equivalent (WTE) general practitioners and is slightly higher than the national rate of 21% part-time general practitioners (RCGP, 2003). Of those who work part-time, 76% (28) are women and 24% (9) are men. This equates with national figures (DH, 2003). Sixty five percent (33) of practices have female GPs and 35% (18) do not. Of those without a female GP, 13 are single-handed practices.

The largest practice has a list size of 17,100 with 4 WTE partners, and the smallest, a single-handed practice, has a list size of 778. There has been a reduction in average list size both nationally and locally although local list sizes remain higher. Five years ago in Brighton and Hove the average list size was 2,149, now it is 1,965 (median). Five years ago the national (England and Wales) average list size was 1,866, now it is 1,802 (DH, 2003).

**GP registrations**

At the end of March 2003, GP list sizes indicated that 293, 954 people were registered with a GP, yet the 2001 census estimates the total size of the population in Brighton and Hove to be 247,870. It is likely that registrations are inflated due to ‘ghost’ patients (e.g. patients who have died or no longer live in Brighton and Hove, but who remained registered with Brighton and Hove GPs). It is also likely that more patients who live outside of Brighton and Hove are registered with Brighton and Hove GPs than vice versa. It is unlikely however that these factors completely account for a discrepancy of this size.
**GP consultations**

Of those who responded to the 2003 lifestyle survey, just over a third (32.6%) had talked to their GP about their own health in the past 3 months. Sixty-five percent had spoken to their GP in the past 6 months and 85% in the past year. The survey did not specify face-to-face contact, so it is likely that these figures include those who spoke to their doctor by telephone. It is well established that women consult their doctor more frequently than men (Cleary et al 1982; Kandrack et al 1991; Gijsber van Wijk et al 1992, 1995; Williams et al 1986; Verhaak 1995; Fylkesnes et al 1992; Sayer and Britt 1996). Similarly, locally 12.8% of male residents and 17.9% of female residents had consulted their GP about their health in the last two weeks. Of these men, 44% were 65 years and over; of these women 52% were 65 years and over (Figure 3.2). A total of 78% of males and 84% of females had consulted their doctor in the previous year. There were no substantial differences by deprivation.

**Figure 3.2 Time since spoke to doctor about own health by sex**

![Graph showing time since spoke to doctor about own health by sex](image)

**Source:** Health Counts Survey 2003

**Practice Nurses**

A survey of local practice nurses is undertaken annually. Forty-two of the 51 local practices responded to the 2003 practice nurse survey. At these 42 practices, there were 80 practice nurses (equivalent to 50.2 full-time posts) mostly working part-time. Practice nursing levels locally have remained unchanged since 1999 at 0.4 WTE practice nurses per WTE GP, slightly below the national average of 0.46, and 0.18 practice nurses per thousand population, again below the national average of 0.23 (ESBHHA, 1999; DH, 2004).

**Dental practice services**

Modernising NHS dentistry: implementing the NHS Plan (DH 2000) and NHS dentistry: options for change (DH 2002) both emphasise the need to reduce inequalities in health and provide access to high quality, patient-centred healthcare. A draft oral health strategy for East Sussex, Brighton and Hove has been developed. It is hoped this will inform the development of locally sensitive, high quality, oral health improvement programmes, which reduce inequalities and enable better access to NHS dental services (Jones and Allen, 2003).

**Dental practitioners**

There are 61 general dental practices in Brighton and Hove, one of which is an access centre. The latter is open to people who have been unable to register with a dentist. It was set up to improve access to NHS treatment. The distribution of dental practices is shown in Figure 3.3. Twenty (33%) are in cluster A with the smallest, although most deprived population; 26 (43%) are in cluster B (intermediate) which has the largest population; and 15 (25%) are in cluster C. Practices are concentrated in the centre and around main roads. Three wards: Portslade North, Hangleton and Knowle and Rottingdean Coastal have no dental practices.
Dental registrations
The Dental Practice Board (DPB) estimates that 45% of the adult population in England and Wales is registered with a dentist who has a contract to provide NHS treatment (DPB, December 2003). In the 2003 lifestyle survey, 80% of respondents were registered with a dentist, and of these 70% were NHS patients and 30% private (Figure 3.4). Residents from more affluent areas were more likely to be registered with a dentist privately. The DPB however estimate that just 46% of the local population are registered with a dentist. Not all DPB registrations are Brighton and Hove residents as the data collected is based on practice postcodes rather than patient postcodes, however the reasons for the wide discrepancy between the two figures are not clear. The DPB estimate that 71% of local children are registered with a dentist: this compares well with the national figure of 61% (DPB, December 2003).

Figure 3.4 Registrations by deprivation

Source: Health Counts Survey 2003
The average NHS list size for a dentist in Brighton and Hove is 722, the range being from under 500 to over 2000 (Jones and Allen, 2003). In England and Wales the average is 1,443 (DPB, 2003). Locally 59% of dentists registered for NHS work had list sizes of under 500, 9% had list sizes of over 2000. Smaller NHS list sizes probably reflect a larger private component.

**Dental consultations**
Over 50% of respondents to the 2003 lifestyle survey had visited their dentist in the previous 6 months and over 70% in the past year; 17% had not visited their dentist for over 2 years. The proportion that had not visited their dentist in two years increased with deprivation: 14% of most affluent cluster, 17% of average cluster, 20% of most deprived cluster. Those respondents who had not visited their dentist for over a year were asked to indicate why this was the case. Eighteen percent stated that they found treatment too expensive and 8% were unable to find a NHS dentist. There did not appear to be any relationship between reasons given for not visiting a dentist for over a year and deprivation. Women (76%) were more likely than men (67%) to have visited their dentist in the previous year.

**Dental health**
The two main dental diseases are dental caries (tooth decay) and chronic inflammatory periodontal disease (gum disease). Dental decay tends to be a problem in the younger population and periodontal disease is more prevalent in the older population; both can lead to loss of teeth and both are preventable. An indicator of the level of dental decay is obtained by calculating the number of decayed, missing and filled teeth (DMFT score). In 5 year olds this score is for deciduous or milk teeth (dmft), in 12 year olds it is for permanent teeth (DMFT).

In 2001/02, 67% of 5 year-old children in Brighton and Hove had no experience of dental caries compared to 60% in England and Wales (Jones and Allen 2003). In the one third of children with dental decay, an average of 3.08 teeth per child were affected, compared to an average of 3.83 in England and Wales (BASCD 2004). Data is not available on a PCT basis prior to this time; the data for the next BASCD survey is currently being collected and should be available in July 2004 (Pers. Comm. Sarah Crosbie, South Downs Health NHS Trust 2004).

Local screening data on 5 year old children collected by South Downs Health NHS Trust suggest that dental health improved little between 1996 and 2002 (Sarah Crosbie, 2004). Recent data are available for 36 of the 44 schools. The mean dmf for 5 years old children ranges from 0.04 at St Bernadette’s to 2.96 at Whitehawk Infant School. The percentage of all screened children in reception to year 2, who have ‘naturally sound teeth’ (i.e. no experience of dental decay), ranges from 90% at St Bernadette’s to 37% at Whitehawk Infant’s. The percentage of children requiring treatment ranges from 7% at St Bernadette’s to 51% at Goldstone Infants (South Downs Health NHS Trust, 2004).

The data collected to monitor the dental health of children aged 12 years and 14 years, and adults are not yet available at a PCT level.

**Optician services**
*Optometrists and ophthalmic medical practitioners*
There are 79 optometrists and 9 ophthalmic medical practitioners (OMP) in Brighton and Hove of whom 53 are men and 35 are women. Both of these professional groups conduct eye tests. There are 24 practices; seven of which are owned by three ‘multiples’: Boots, Dolland and Aitchison, and Specsavers. As Optometrists and OMPs are based within optician’s shops they are concentrated in central Brighton and Hove along the seafront strip, where the major concentration of retail outlets exists (Figure 3.5). Recently in Brighton and Hove work has been going on to develop clinical governance in optometry services and to build on the expertise within optometry services, for example by considering what role they might play in monitoring diabetic retinopathy.
Vision testing

In 2002/03 in Brighton and Hove a total of 46,181 NHS sight tests were conducted, giving a rate of 1,863 per 10,000 population, which is a little lower than the rate for England and Wales (1,950 per 10,000 population). A total of 16,152 vouchers were reimbursed, the rate per 10,000 population being 651: again a little below the nation rate, which was 710 in the same period. Twenty eight percent (4548) of the vouchers issued were for children under 16 years. Vouchers generally equate with glasses although a proportion will relate to repairs.

In the 2003 lifestyle survey 80% of men and 77% of women wore glasses or contact lenses at some time. Eighty-six percent of men and 89% of women had taken a vision test. Forty two percent of males and 45% of females had taken a test within the last year. Twenty-three percent had not had an eye test for over two years; the majority of this group (52%) stated that this was because their vision was fine, although cost represented a barrier for 14%. People from more deprived areas were less likely to have an eye test (Figure 3.6) although this will be influenced by the fact that affluent areas have higher proportions of old people living there.
Figure 3.6 Visited optician for eye test by deprivation

Source: Health Counts Survey 2003

Pharmacy services

A Vision for Pharmacy in the new NHS was published in July 2003 and will form the basis for the new Community Pharmacy Contract to be implemented in October 2004. It includes recognition of key roles for pharmacists:

- To be a first point of healthcare contact;
- To provide health promotion, health improvement and harm reduction services;
- To prescribe medicines and monitor clinical outcomes.

These are in addition to the roles currently associated with pharmacists such as advice, dispensing of prescribed medicines, and provision of support to patients in managing their medicines.

The PCT published its Community Pharmacy Strategy in February 2003 which outlines plans for developing pharmacy services locally, including improvements to repeat prescribing and dispensing services, greater assistance to older people in medicines taking and review, and access to some services traditionally provided by GPs through a community pharmacy.

Community pharmacists

There are 59 pharmacies in Brighton and Hove of which 22 are owned by five multiples: Asda 2; Co-op 3, Boots 5; Lloyds 5 and Moss 7.
Pharmacies are generally located near to GP surgeries or in town centres and this appears to be the case in Brighton and Hove (Figure 3.7). However, there is no pharmacy in Moulescoomb and Bevendean ward.

**Use of pharmacy services**
In the 2003 lifestyle survey just 11% of men and 16% of women had received advice from their pharmacy/chemist in relation to their health in the previous 4 weeks. Of those who had received advice, 75% had found this advice helpful (Figure 3.8).

**Figure 3.8 Received pharmacy advice in past 4 weeks and whether advice was helpful**

![Graph showing the percentage of men and women who received pharmacy advice and whether it was helpful, categorized by deprivedness status.]

Source: Health Counts Survey 2003
During the previous four weeks, 31% of respondents had purchased some form of non-prescribed medicine, of which 82% had found this helpful. Forty-five percent of respondents were on regular medication prescribed by their doctor.

**Complementary Therapies**

Twenty five percent of men and 32% of women had consulted a complementary therapist in the previous 3 months. The highest numbers of consultations were to osteopaths, followed by chiropractors (Figure 3.9). Women were more likely than men to consult complementary therapists. There was no apparent relationship between using a complementary practitioner and level of deprivation.

**Figure 3.9 Complementary therapists consulted by sex**

![Chart showing the percentage of men and women consulting different types of complementary therapists](chart.png)

*Source: Health Counts Survey 2003*

**Screening**

**Cervical screening**

In the 2003 lifestyle survey 94% of women aged 25-64 years had had a cervical smear test; of these 90% had had this within the last 3 years. There were no clear findings in relation to deprivation.
Breast screening
In the 2003 lifestyle survey 93% of women aged 50-69 years had received an invite for a mammogram. Of those who had had a mammogram, 89% had had this in the previous 3 years. As with cervical screening there were no clear findings in relation to deprivation.

Primary care prescribing and medicines management
Prescribing costs
In 2002/03, Brighton and Hove GPs prescribed a total of 2,829,254 items at a cost of £33,039,317; this equates to 9.56 items and a cost of £111.70 per patient. This compares with the Strategic Health Authority (SHA) average spend (£35, 907,943) and the national average (£34,706,734). The cost per ASTRO-PU (see Table 3.2 for glossary) for Brighton and Hove City Teaching PCT (£27.57) is however higher than that of the SHA (£26.81) and nationally (£27.44).
The five most costly disease areas in terms of total prescribing costs are cardiovascular system; central nervous system (including mental health); endocrine system; respiratory system; gastrointestinal system (Figure 3.11).

**Figure 3.12 Percentage spend per disease system (2002/’03)**

![Bar chart showing percentage spend per disease system](chart)

**Disease system**

- Cardiovascular
- Central nervous
- Endocrine
- Respiratory
- Gastrointestinal
- Musculoskeletal & joints
- Gynaecology & Urinary tract
- Malignant disease & immunosuppr...
- Infections

**Source:** Medicines Management Team, Brighton and Hove City Teaching PCT

In recent years, total prescribing costs have increased, as have number of items prescribed; however the proportion of drugs prescribed by their generic as opposed to their trade name has also increased from 70.86% in 2001 to 75.46% in 2003 (Table 3.1). There have been particular increases in the prescribing of cardiovascular drugs in line with national guidance on the treatment and prevention of coronary heart disease (Figure 3.12).

**Table 3.1 Primary care prescribing trends (cost and volume) in Brighton and Hove**

<table>
<thead>
<tr>
<th>Year</th>
<th>Items</th>
<th>% Generic</th>
<th>Cost (£)</th>
<th>List size</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>2,673,116</td>
<td>70.9</td>
<td>29,063,587</td>
<td>291,886</td>
</tr>
<tr>
<td>2002</td>
<td>2,794,033</td>
<td>72.5</td>
<td>32,316,946</td>
<td>294,800</td>
</tr>
<tr>
<td>2003</td>
<td>2,927,104</td>
<td>75.5</td>
<td>34,834,665</td>
<td>297,487</td>
</tr>
</tbody>
</table>

**Source:** Medicines Management Team, Brighton and Hove City Teaching PCT
Source: Medicines Management Team, Brighton and Hove City Teaching PCT

**CHI indicators for primary care trusts**

The Commission for Health Improvement (CHI) assesses the performance of primary care trusts against a range of indicators, four of which relate to prescribing. The CHI indicators allow comparison with PCTs in the same strategic health authority (SHA) and with a cluster of similar PCTs identified by the Prescribing Support Unit; these are examined below (PPA Toolkit, 2004).

**Indicator 1: To increase the proportion of generic items prescribed**

Generic prescribing locally has increased over the past three years. However Brighton and Hove City Teaching PCT is ranked ninth out of the 15 PCTs in Surrey and Sussex, with 75.8% of items being prescribed generically, and just 10th out of the 11 matched-cluster PCTs; the range for the latter being 74.6-84.8%. Brighton and Hove City Teaching PCT score (75.8%) is just below the strategic health authority average (75.9%) but several points below the average for England (77.7%).

**Indicator 2: To reduce prescribing of antibacterial drugs**

Although prescribing of antibacterial drugs locally has changed little between 2000/01 and 2002/03, Brighton and Hove City Teaching PCT has performed well in 2002/03. It ranked first out of the 15 PCTs in Surrey and Sussex, with an indicator (Items/STAR-PU) of 0.842, (range 0.842–1.198), and first in the 11 matched-cluster PCTs in England (range 0.842 – 1.414). Brighton and Hove City Teaching PCT also scored below both the SHA (0.988) and National (1.06) averages.

**Indicator 3: To reduce prescribing of benzodiazepines**

Whilst the trend in benzodiazepine prescribing locally is downwards, Brighton and Hove City Teaching PCT was one of the highest prescribers in 2002/03, ranking 14th amongst the 15 PCTs in Surrey and Sussex, and 10th out of the 11 matched-cluster PCTs in England. Brighton and Hove City Teaching PCT has an ADQ/STAR-PU score of 16.055; the SHA average is 9.688 (range 6.776 to 16.709) and the national average is 8.851. The high level of prescribing in Brighton and Hove is accounted for by prescribing to patients with substance misuse problems.
Indicator 4: To increase the prescribing of atypical antipsychotic drugs
These drugs have fewer side effects than traditional antipsychotic treatment. The prescribing of these drugs in Brighton and Hove has increased over the last three years; the proportion of atypicals in relation to all anti-psychotics being 32.7% in 2000/01, 46% in 2001/02 and 54.6% in 2002/03. In 2002/03, Brighton and Hove City Teaching PCT ranked third amongst the other PCTs in the local strategic health authority with a score of 54% (range 61.2% - 33.8%), and third among matched-cluster PCTs (range 66% - 37.4%). The average figure for Brighton and Hove (54.6%) is higher than the SHA average (48.6%) and national average (49%).

Table 3.2 Glossary of prescribing terms

<table>
<thead>
<tr>
<th>Glossary</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADQ</td>
</tr>
<tr>
<td>Average Daily Quantity (ADQ) is a way of standardising drugs within a therapeutic class to enable aggregation of data for comparing prescribing.</td>
</tr>
<tr>
<td>ASTRO-PU</td>
</tr>
<tr>
<td>These are designed to weight the prescribing needs of practice populations for age, sex and temporary residents. The ASTRO-PU values are based either on drug cost or the number of items.</td>
</tr>
<tr>
<td>PU</td>
</tr>
<tr>
<td>Prescribing Units: Patients aged 65 years and over are counted as three prescribing units and patients under 65 years and temporary residents are counted as one.</td>
</tr>
<tr>
<td>STAR-PU</td>
</tr>
<tr>
<td>STAR-Pus have been developed using a similar methodology to the ASTRO-PU but are weighted based on costs within different therapeutic groups for specific age-sex bands.</td>
</tr>
</tbody>
</table>

Secondary care
Outpatient attendance
In 2002/03 there were 255,299 outpatient appointments made for Brighton and Hove residents, giving a rate of 1030 per 1000 population. An analysis by the three deprivation clusters (Figure 3.13) shows that the age-standardised rates for both males and females increase with the level of deprivation, although there is considerable variation within clusters. Rates are highest in East Brighton and Queens Park wards. The proportion of appointments kept decreases with increasing deprivation, from 84% in the most affluent to 78% in the most deprived cluster.

Figure 3.13 Out-patient appointments per 1000 population by deprivation (2002/03)

Source: Public Health Information Department, Brighton and Hove City Teaching PCT
Brighton and Hove City Teaching PCT is currently examining trends in five clinical areas referred to as clinical reference groups (orthopaedics, ENT, ophthalmology, gastroenterology and dermatology). Examination of each area (Figure 3.14) suggests a possible inverse relationship between outpatient attendance and affluence for three of the five areas: orthopaedics, ENT and ophthalmology, but the opposite with respect to gastroenterology. However these data are not age standardised as some of the numbers are very small. Further analysis of the combined clinical reference groups data standardised for age revealed that attendance was lowest in the most deprived group in both males and females (Figure 3.15).

*Figure 3.14* Outpatient attendance in clinical reference group specialties per 1000 population by deprivation (2002/03)

*Figure 3.15* Outpatient attendance rates per 1000 population for combined clinical reference group specialties by gender and deprivation 2002/03

*Source: Public health information department, Brighton and Hove City Teaching PCT*
In the lifestyle survey (2003) 25% of respondents had attended hospital as an outpatient in the previous three months. Here too, attendance was lowest amongst the most deprived.

**In-patient admission**

In 2002/03 there were a total of 23,225 elective hospital admissions, including day cases, and 15,146 emergency admissions (excluding maternities, new-born babies and transfers). The majority of elective admissions (97.6%) and emergency admissions (94%) were to acute specialties (mental illness specialties excluded). Of the elective admissions, 49.5% were men and 50.5% were women; of the emergency admissions, 48% were men and 52% were women.

As in the case of outpatients, there appears to be a relationship between deprivation and hospital admission in Brighton and Hove (Figure 3.16). Age-standardised emergency admission rates to acute specialties suggest that emergency admission rates are higher in the most deprived cluster compared to the rest of the population for males and females. Age-standardised elective (planned) admission rates to acute specialties suggest something of the reverse. The relationship between deprivation and elective admissions to the clinical reference group specialties is not clear. These data are not age-standardised, as the number of emergency admissions in some specialties is too small.

**Figure 3.16 Elective and emergency admissions to acute specialties per 1000 population by deprivation (2002/03)**

![Elective and emergency admissions per 1000 population by deprivation](image)

**Source:** Public Health Information Department, Brighton and Hove City Teaching PCT

Mental illness is known to be associated with deprivation. There were 938 elective and emergency hospital admissions for mental illness in 15-65 year olds in 2002/03. Analysis of age-standardised admission rates by deprivation cluster reveals a clear relationship between hospital admission as a result of mental illness and levels of deprivation in both males and females (Figure 3.17). The wards with the highest rates were Queens Park and East Brighton.
Conclusions
There appears to be a clear relationship between much of primary care service provision and uptake and deprivation in Brighton and Hove.

Residents from more deprived areas are less likely to be registered with a dentist less likely to have seen their dentist recently. Use of optometry services also increases with affluence. Residents living in more deprived areas are more likely to use a pharmacist for health advice. There does not appear to be any relationship between using complementary therapists and levels of deprivation.

There has been an increase in the prescribing of drugs, particularly for coronary heart disease, in recent years. There are high levels of benzodiazepine prescribing across the city.

Admission to hospital appears to be influenced by levels of deprivation. Residents living in more affluent areas are more likely than those in more deprived areas to have an elective (planned) hospital admission. Residents living in more deprived areas are more likely than those living in more affluent areas to have an emergency hospital admission.

Hospital admissions as a result of mental illness increase with the levels of deprivation.

While many of these findings may confirm what is known from the published literature, they do quantify the extent of the task facing health care commissioners and providers across Brighton and Hove if health inequalities are to be reduced.

References


BASCD. British Association for the Study of Community Dentistry. Dental Health Services Research Unit Website, Dundee University (accessed 3rd March 2004) 5 year old in England and Wales, 2001 In Dental Caries Experience of 5, 12 and 14 year old children in Great Britain, BASCD.


Chapter 4

Health related behaviour

Summary
There has been a substantial reduction in the prevalence of smokers in Brighton and Hove from 27% in 1992 to 20% in 2003. Of those who now smoke, 58% say that they would like to give up.

The proportion of male and female residents drinking above safe limits has increased by just fewer than 50% in the last 10 years. Residents living in more deprived areas are more likely to be heavy drinkers.

Just 44% of adults eat the recommended five or more portions of fruit and vegetables each day. Only 15% of adults take the nationally recommended levels of exercise. A high proportion of the population is overweight: 32% of adults are overweight, 7% are obese and 3% are grossly obese.

Sexually transmitted diseases have increased steadily over recent years. Between 2001 and 2002, 113 new cases of HIV infection were diagnosed.

Introduction
This chapter considers health-related behaviour, particularly smoking, alcohol, exercise, diet and sexual behaviour. It briefly describes the impact of these behaviours on health. Findings from the Health Counts Lifestyle Survey 2003 are considered and compared, where possible, with findings from the Health Quest Lifestyle Survey of 1992. Where possible, further national comparisons are made.

Smoking
Smoking is the main cause of preventable illness and premature death. It is a major cause of cancer, heart disease and chronic obstructive lung disease, three common fatal diseases. Smoking in pregnancy has been shown to cause increased risk of miscarriage, stillbirth and low birth weight. Passive smoking is also known to be linked to Sudden Infant Death Syndrome (SIDS / cot death) and childhood respiratory disease (DH, 2002).

Smoking kills over 120,000 people each year in the UK. Nationally, men living in households in the unemployed manual group are more than twice as likely to smoke as those who live in professional households (39% compared to 17%) (General Household Survey 2000). Around 1200 people are estimated to die each year in the UK as a result of breathing in other people’s smoke (CMO, Annual Report 2002).

There is a continuing fall in the number of people in Great Britain who smoke, the General Household Survey statistics show that smoking prevalence amongst adults aged 16 and over has dropped from 28% in 1998, to 26% in 2002 (ONS, 2004). Smoking prevalence amongst manual groups decreased from 33% in 1998 to 31% in 2002.

Figure 4.1 compares data on smoking from the Health Counts Lifestyle Survey 2003 with results from the Health Quest Lifestyle Survey undertaken in 1992. In Brighton and Hove, there has been a significant decrease in the number of people who smoke daily, from 27% in 1992 to 20% in 2003.
A total of 21.4% of men smoked compared to 18.9% of women. Across virtually all age bands, men were more likely than women to smoke daily (Figure 4.2). Smoking seems to decrease steadily from a peak in the 18-24 year old age group (the result for females in the 45-54 years age group is likely to be unrepresentative). Nationally smoking among 16-19 year olds is reported to be 22% in males and 29% in females (ONS). The 2003 Health Counts lifestyle survey was however sent to those aged 18 years and over and so a direct comparison with 16-19 year olds is not possible.
smokers who wanted to stop smoking in 1992. One third of smokers have seriously tried to give up smoking in the last 12 months and 89% of smokers believed that they could give up smoking if they tried. Forty-three percent of smokers were aware of local smoking cessation services but just 11% of these had tried to use these services.

Figure 4.3 shows that a greater percentage of women smoke up to 20 cigarettes per day compared to men. Conversely, more men smoke 20 or more cigarettes per day compared to women. So of those who smoke men are the heavier smokers.

**Figure 4.3 Number of cigarettes smoked by men and women per day**

![Chart showing number of cigarettes smoked by men and women per day]

*Source: Health Counts Survey 2003*

In Brighton and Hove a greater proportion of unemployed respondents smoke - 51.5%, compared to 32% of employed and smoking prevalence is highest in the most deprived areas (Figure 4.4). Smoking also varies between the wards categorised as “most deprived”. A recent household survey by MORI undertaken in the East Brighton area confirmed that almost 50% of the adult population in East Brighton smoke (MORI/NOP, 2002).

**Figure 4.4 Residents who smoke by area of deprivation**

![Chart showing smoking prevalence by area of deprivation]

*Source: Health Counts Survey 2003*
Alcohol
Alcohol causes certain types of cancer and liver disease (Seitz & Homann, 2001). Heavy drinking constitutes a severe risk to the development of cardiovascular disease (DH, 1999). Low levels of alcohol consumption can have a protective effect against coronary heart disease (DH, 1999). Alcohol is closely linked with mental illness, suicides, accidents, violence and crime; it affects individual’s families and communities, and incurs considerable social costs (Alcohol Concern, 1999).

Alcohol is implicated in up to 40,000 deaths per year in England and Wales, and is directly responsible for 5,000 (DH, 2001). Drinking at levels that cause harm have risen in recent times and now 29% of men and 17% of women in England and Wales risk health or social problems (Walker, et al 2001). In Great Britain, in 2001, 39% of men aged 16 and over drank more than 4 units of alcohol on at least one day in the last week and 22% of women drank more than 3 units on at least one day in the last week (ONS 2003). 27% of men and 15% of women now exceed the 1992 guidelines of 21 and 14 units per week respectively. The proportion of women who drink more than the recommended weekly guidelines has increased since 1986. In men, the prevalence has been relatively constant.

The current daily maximum recommended levels of alcohol consumption are 4 units and 3 units a day respectively for men and women, with two alcohol-free days per week. For the purposes of comparison with 1992 we have had to use 21 units for men and 14 units for women, which were the maximum recommended weekly levels at that time. In Brighton and Hove the percentage of men drinking more than the maximum recommended weekly levels (21 units) increased from 15.6% in 1992 to 27% in 2003. The percentage of women exceeding maximum recommended weekly levels (14 units) in the city has also risen by a similar proportion from 8.2% in 1992 to 17% in 2003.

The 2003 survey results are consistent with the national General Household Survey (GHS), which found that the proportion of men and women drinking over the 21/14 units level decreases with age. The GHS found that adults aged 16-24 years are most likely to drink over 21 units per week. In Brighton and Hove in 2003 the peak age-range for exceeding maximum recommended drinking limits is 18-24 for both sexes. The 2003 survey was also consistent with GHS results in that the proportion of abstainers increases with age, especially among women.

Figure 4.5 compares units of alcohol consumed on average per week in the city between 1992 and 2003. There has been a decrease in low alcohol consumption (0-6 units) from 60% in 1992 to 47% in 2003 and a corresponding increase in alcohol consumption over 21 units compared to 1992. The percentage of people drinking above 51 units per week has increased from 2% to 6%. The proportion of people who have tried to cut down the on the amount of alcohol they drink has remained stable in the city over the past decade at around 17%.
Figure 4.5 Units of alcohol consumed by residents per week in 1992 and 2003


Figure 4.6 shows that in Brighton and Hove, men are more likely than women to be heavy drinkers.

Figure 4.6 Units of alcohol consumed by men and women per week in 2003

Source: Health Counts Survey 2003

In Brighton and Hove, patterns of drinking also vary with levels of deprivation. In the most deprived areas 27% of residents drink above maximum recommended levels, compared to 20% in intermediate areas and 17% in the most affluent areas. This trend is present in both sexes (Figure 4.7). Analysis by age showed that men and women in the 18-29 years age group were most likely to be heavy drinkers.
Figure 4.7  Percentage of residents who drink above recommended maximum levels by area of deprivation.

Source: Health Counts Survey 2003

Further information on alcohol and other substance misuse is reported in Chapter 6.

Diet
Diet plays a fundamental role in the development of coronary heart disease. The type and amount of dietary fat consumed has been recognised for some time as being particularly influential. It is well recognised that dietary salt intake affects blood pressure. More recently, increased consumption of fruit and vegetables has been identified as an important factor in reducing the rates of both heart disease and some cancers (DH 1994, 1998). The promotion of healthy eating is therefore important in reducing the risk of CHD, obesity and diet related cancers.

In 2000-01, 13% of men and 15% of women aged 19-64 in Great Britain consumed the recommended healthy diet of 5 portions of fruit and vegetables per day (ONS, 2004). Nationally, there are wide social class differences in fruit and vegetable consumption, with those in lower class groups consuming about 50% less than those in professional groups. Consumption is also found to increase with age. None (0%) of the young men (aged 19-24) interviewed for the National Diet and Nutrition Survey had consumed an average of 5 or more portions of fruit and vegetables per day and only 4% of young women had done so (National Diet and Nutrition Survey 2001).

According to the 2003 lifestyle survey, in Brighton and Hove 44% of adults eat the recommended five or more portions of fruit and vegetables each day. A greater proportion of women than men eat five or more portions of fruit and vegetables each day: 48% women compared to 37% men. Of those aged 18-64 years, 33% of men and 47% of women ate the recommended healthy daily diet; this is considerably better than the national average for the same age group. Unexpectedly, a similar proportion of respondents from each deprivation cluster reported eating the recommended five portions of fruit and vegetables each day. However, analysis by employment status showed that unemployed residents (70%) eat fewer than five portions of fruit and vegetables each day, compared to employed residents (58%). It is likely therefore that the difference in diet between the different deprivation groups is greater than demonstrated by the survey.

Physical Activity
Physical activity has been shown to have several benefits. Regular physical activity reduces mortality from cardiovascular disease in general and coronary heart disease mortality in particular. The level of decreased risk from coronary heart disease attributable to regular
Physical activity is similar to that of not smoking. Regular physical activity prevents or delays the development of high blood pressure, and exercise lowers blood pressure in people with established hypertension. Physical activity is also important in controlling diabetes, regulating weight and reducing the risks of osteoporosis and colon cancer (HDA, 2000).

The national recommendation is to achieve 30 minutes of moderate intensity activity (such as brisk walking, heavy gardening and heavy housework) on at least five days of the week (DH 1996). Walking and cycling are frequently cited as useful means of achieving this recommendation (WHO/Federation of Sports Medicine 1995; US Department of Health and Human Services 1996). Table 4.1 outlines a range of physical activities that are equivalent to walking at a moderate intensity for 30 minutes.

Table 4.1 Different activities equivalent to walking at moderate intensity for 30 minutes

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time (minutes)</th>
<th>Less vigorous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washing and waxing a car</td>
<td>45-60</td>
<td>More time</td>
</tr>
<tr>
<td>Washing windows and floors</td>
<td>45-60</td>
<td></td>
</tr>
<tr>
<td>Playing volleyball</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Playing touch football</td>
<td>30-45</td>
<td></td>
</tr>
<tr>
<td>Gardening</td>
<td>30-45</td>
<td></td>
</tr>
<tr>
<td>Walking 3 km</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Cycling 8 km</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Dancing fast</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Pushing a pushchair for 2.5km</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Raking leaves</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Walking 3.5 km</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Water aerobics</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Swimming laps</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Cycling 6.5 km</td>
<td>15</td>
<td>More vigorous</td>
</tr>
<tr>
<td>Skipping</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Running</td>
<td>15</td>
<td>Less time</td>
</tr>
<tr>
<td>Stair walking</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

Source: British Heart Foundation.

The number of hours spent watching TV has increased since the 1960s and a more automated lifestyle (domestic appliances, use of a motor car) has eliminated the amount of physical activity incorporated into daily life. The population has become more sedentary with the result that the amount of energy expended has reduced. Data from the 1998 Health Survey for England (Joint Surveys Unit 1999) showed that just 37% of men and 25% of women met the guidelines for activity. Physical activity levels drop with age and participation in exercise is lower among many black and minority ethnic groups.

According to the 2003 lifestyle survey, just 15% of residents take the nationally recommended level of a minimum of 30 minutes physical activity five times a week. This finding is not attributable simply to the higher numbers of older respondents. Figure 4.8 shows the percentage of men and women, by age, who take more than the recommended levels of physical activity. More men (19%) than women (12%) exercise to the recommended level. This is significantly lower than the national average. There is a general trend for men and women to become less active as they grow older and 44% of men and 40% of women over 75 years of age never, or have less than, 30 minutes exercise in a given month. Exercise levels however are particularly low among females and, in the survey; the 18-24 age group for men (27%) and the 55-64 age group for women (15%) were is the most active age groups.
According to the survey the reasons that prevent respondents from taking more exercise are: lack of leisure time – 33%, lack of incentive - 21%, illness or disability - 16.5 %, and lack of money – 14%. With the exception of illness or disability (men 19% and women 15%), more women report barriers to taking more exercise than men: lack of leisure time (36% women, 33% men); lack of incentive (23% women, 19% men); lack of money (16% women, 10 % men).

There is no significant difference in levels of physical activity reported by deprivation cluster, however, as in the case of diet, a greater proportion of unemployed people had infrequent exercise (54%) compared to employed people (31%).

**Overweight and Obesity**

There is a graded, increased risk of cardiovascular and total mortality in people with a body mass index (BMI) over 25 kg/m² (Nutrition and Physical Activity Task Forces 1995). Approximately 75% of non-insulin dependent diabetic patients are overweight (Jung 1997). In women, a weight gain of about 10kg can lead to a threefold increase in the risk of developing diabetes (Jung 1997). Compared to those with a BMI of 22 kg/m², women with a BMI over 35kg/m² have a 93 times higher risk of diabetes and men with a BMI over 35kg/m² have a 42-fold increased risk (Jung, 1997). The incidence of CHD is highest in obese men and women, especially in those under 50 years old.

Childhood obesity predicts adolescent obesity and adult obesity (Parsons *et al.* 1999). Adolescent obesity is associated with an increased risk of adult mortality and morbidity (Epstein 1995). Children are more likely to be obese and are at greater risk of developing childhood diabetes type II if they have an obese parent.

The prevalence of overweight and obesity has increased in the United Kingdom in recent decades. In 2001, 24% of women and 21% of men were obese compared to 8% of women and 6% of men in 1980 (Health Survey for England 2001, Mulivill and Quigley 2003). This is due largely to changes in dietary habits and exercise patterns. Even although for many people total energy intake has decreased, much less active lifestyles have reduced the opportunities for energy expenditure, and the prevalence of overweight and obesity increases, despite decreased energy intake (Barlow and Dietz 1998). In 2001 in England, 47 percent of men and 33 percent of women were overweight (BMI 25-30).
Based on Body Mass Index calculations, 44% of Brighton and Hove 2003 lifestyle survey respondents have a normal weight. 32% are overweight, 7% are obese, 3% are grossly obese, and 8% are underweight. More women (47%) have a normal weight compared to men (40%). More men than women are overweight (40% compared to 26%). However similar proportions of men and women are obese and grossly obese. More women than men are underweight (11% compared to 5%). Surprisingly, analysis by deprivation cluster (Figure 4.9) suggested that those from more deprived areas were more likely to be underweight than overweight.

*Figure 4.9 Body weight by deprivation cluster*

![Graph showing body weight by deprivation cluster](image)

*Source: Health Counts Survey 2003*

Figure 4.10 shows 2001 national prevalence data for overweight and obesity in men and women compared to local data from the Health Counts Lifestyle Survey 2003. These findings illustrate that although local figures are concerning, there are fewer overweight and obese men and women in Brighton and Hove compared to the national average.

*Figure 4.10 National and local prevalence for obesity and overweight by gender*

![Graph showing national and local prevalence for obesity and overweight by gender](image)

*Source: Health Survey for England 2001, Health Counts Survey 2003*
**BMI**

The healthy weight range is based on the Body Mass Index (BMI) measurement. This is calculated by dividing an individual's weight by their height squared. BMI scores < 20 represent underweight, 20-25 normal, >25–30 overweight, >30-35 obese, >40 (or >35 with comorbidities) morbidly obese.

---

**Sexually transmitted diseases**

Nationally, sexually transmitted diseases have been increasing, particularly among adults aged between 15 and 24 years. HIV infection is also increasing nationally. No information on sexually transmitted disease was collected through the lifestyle survey. Data is collected by local genitourinary medicine clinics although the individuals attending these clinics may not always be local residents. It is difficult therefore to calculate local population rates of disease and rather “new disease contacts” are recorded. As of January 2003 these figures will include those who attend for general sexual health screening and who are subsequently diagnosed with a sexually transmitted disease.

Figure 4.11 shows how the number of “new disease contacts” in Brighton and Hove has increased in recent years. Preliminary figures from 2003 suggest that the slight reduction seen in 2002 has not continued.

*Figure 4.11 Number of new disease contacts at Brighton and Hove genitourinary medicine clinic*

Source: KC60 statistics. Brighton and Hove City Teaching PCT Public Health Information Resource 2004

**HIV infection**

Between 2001 and 2002 the number of people diagnosed as HIV positive increased from 633 to 746. The number of people in each of the probable exposure groups increased although the proportions in each group remained roughly the same. Some of the data cannot be published because of the confidentiality issues around the use of small numbers, however the figures for the three main routes of exposure are shown in Table 4.2.
**Table 4.2 Probable route of exposure for HIV positive people in Brighton and Hove**

<table>
<thead>
<tr>
<th>Probable route of exposure</th>
<th>2001 Percentage</th>
<th>2002 Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex between men</td>
<td>525</td>
<td>609</td>
</tr>
<tr>
<td>Sex between man and woman</td>
<td>48</td>
<td>60</td>
</tr>
<tr>
<td>Intravenous drug usage</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>Other</td>
<td>40</td>
<td>55</td>
</tr>
<tr>
<td>Total*</td>
<td>633</td>
<td>746</td>
</tr>
</tbody>
</table>

*Source: SOPHID. Note: * excludes some children*

**Conclusions**

Smoking has decreased in Brighton and Hove over the last 10 years. It is a greater problem in less affluent areas where levels of smoking exceed the general population level 10 years ago. Smoking interventions need to be targeted at less affluent areas.

The number of male and female residents drinking above safe limits has substantially over the last 10 years. There is heavier drinking in the more deprived areas of the city. Interventions to reduce excessive alcohol consumption need to be targeted to less affluent areas.

The information on diet, exercise and obesity is not encouraging. More than half the population could be described as having a poor diet in terms of fruit and vegetable consumption. Just 15% take the nationally recommended level of a minimum of 30 minutes physical activity five times a week. Over 40% of the population are overweight, obese or severely obese although these figures are lower than national equivalents. More work is required to explore the relationship that exists locally between diet, weight, exercise and deprivation.

Sexually transmitted diseases appear to have increased dramatically over recent years. To date only limited information has been available but further local research should be undertaken to help target those most at risk.

**References**


Department of Health, Nutritional Aspect of the Development of Cancer: report of the working group on diet and cancer of the Committee on Medical Aspects of Food and Nutrition Policy, 1998


MORI/NOP. National Evaluation of New Deal For Communities: Topline Results, East Brighton, NDC, 2002.


Chapter 5

The wider determinants of health

Summary
The more deprived areas of Brighton and Hove appear to have lower levels of social capital than the more affluent areas.

People living in deprived areas appear more likely to suffer stress because of concern about violence against themselves or against their friends and family.

There is a well-educated adult population in Brighton and Hove but educational achievement varies widely across local schools.

Keeping the home warm in winter is likely to be a problem for 1 in 15 people living in the more deprived areas of the city.

Introduction
Better off people live longer healthier lives than poorer people, even in the wealthiest of countries. Research aimed at exploring the reasons for these differences has resulted in a greater understanding of the broader influences on health (Wilkinson and Marmot 2003). This chapter considers some of these broader determinants of health. Where appropriate information from the local 2003 Health Counts Lifestyle Survey is presented by the three deprivation clusters as described in Chapter 1.

Social Capital
The World Bank defines social capital as the institutions, relationships and norms that shape the quality and quantity of a society’s social interactions (World Bank Group). It has also been described it as the “invisible glue” which holds a community together. The main indicators of social capital are social relationships and support, formal and informal social networks, group memberships, community and civic engagement, norms and values and levels of trust. There is ongoing debate about the effects of social capital on health and whether evidence supporting the benefits to individuals can be extrapolated to larger communities or populations. It has been suggested however that good social support structures act as a buffer against the adverse health effects of stress (Berkman 1995, Glass 1999).

The 2000 national General Household Survey (GHS) included questions on social capital. The local 2003 lifestyle survey included some of the same GHS questions on social capital.

In Brighton and Hove, when asked how long local people had lived in the area the average length of time was 12 years for those in the most deprived areas and 19 years from the most affluent areas. One third of people living in the most deprived areas had lived there for 3 or less years.

There was little difference between the three areas as to whether or not people had been involved in any local organisations in the past 3 years (range 28-32%), however women (34%) were more likely than men (25%) to have been involved. In the national General Household Survey (GHS) just 21% of respondents had been involved in a local organisation during the previous 3 years.

Figures 5.1 and 5.2 show the results for neighbourhood trust and speaking to neighbours. The findings suggest that people living in more deprived areas are less likely to trust people living in their neighbourhood, and are less likely to have seen or spoken with their neighbours than those living in more affluent areas.
In the national GHS 58% of people felt that they could trust most or many of the people in their neighbourhood: in the 2003 lifestyle survey the comparable percentage for Brighton and Hove was 59%. In Brighton and Hove 50% of people spoke with their neighbours 3-6 days per week or more frequently: this too was comparable with the national GHS survey figure.

The 2003 local lifestyle survey asked people if they had been anxious or stressed by various factors during the previous 3 months. Figure 5.3 shows the percentage of people who replied that they had been stressed all, most or some of the time by a particular issue.
Figure 5.3 Percentage of people reporting stress from particular issues

![Stress issue chart]

Source: Health Counts Survey 2003

The above figure has to be interpreted cautiously as it combines a wide range of responses. However, it suggests that people living in the more deprived areas are more likely to experience stress and anxiety as a result of their environment than are people living in more affluent wards.

Crime
The effects of crime on the health of a population are not restricted to the victims of crime: fear of crime can raise anxiety in the whole community. The Acheson Report on inequalities in health (Acheson 1998) reported that fear of crime can be a cause of mental distress and social exclusion, particularly among women and older people, and that people’s fear of being a victim of crime may be in excess of the actual risks. It has been suggested that the causes of crime and the causes of ill health are similar, and that of these, poverty is the most important (Middleton 1998). Unemployment and overall social deprivation are both associated with crime.

The 2003 lifestyle survey suggested that people living in deprived areas were more anxious and stressed about the possibility of violence against themselves or their friends and family than were people living in the most affluent areas. There was no such pattern however for burglary or car theft. Figure 5.4 shows the percentage of respondents who replied that during the previous three months they had been stressed all, most or some of the time by a particular issue.
Table 5.1 compares the rates of recorded crime in Brighton and Hove for 6 key offences with the national rates. In 2002/3 in Brighton and Hove there were 4591 offences of violence against the person recorded by the police, an increase of 1.9% on the previous year. Sexual offences notified to the police fell by 3.2% to 214, robbery increased by 7.4% to 464, burglary increased 6% to 1946 and car theft increased 12.2% to 1679.

**Table 5.1. Crime in Brighton and Hove: offences recorded by the police 2002/3**

<table>
<thead>
<tr>
<th></th>
<th>Violence against the person</th>
<th>Sexual offences</th>
<th>Robbery</th>
<th>Burglary from a dwelling</th>
<th>Theft of a motor vehicle</th>
<th>Theft from a motor vehicle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of offences recorded Brighton and Hove</td>
<td>4591</td>
<td>214</td>
<td>464</td>
<td>1946</td>
<td>1679</td>
<td>3119</td>
</tr>
<tr>
<td>Rate per 1,000 population in Brighton and Hove</td>
<td>19</td>
<td>1</td>
<td>2</td>
<td>17</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Rate per 1,000 population in England and Wales</td>
<td>16</td>
<td>1</td>
<td>2</td>
<td>20</td>
<td>6</td>
<td>13</td>
</tr>
</tbody>
</table>

*Source: Home Office 2004*

The incidence of violent crime is a major national and local concern. In Brighton and Hove in 2001/2 there were 2880 reported cases of domestic violence, 419 racially motivated crimes and 145 homophobic crimes/incidents.

**Transport**

A healthy transport system should support and encourage people who wish to walk or cycle as well as provide good public transport. A lack of transport may damage people’s health by denying them access to people, goods and services.

The findings of a national report on transport and social exclusion (Social Exclusion Unit 2003) included:
• Two out of five job seekers said that lack of transport was a barrier to getting a job;
• 6% of all 16-24 year olds reported turning down further education opportunities because of problems with transport;
• Over 1.4 million people reported that they had missed, turned down, or chosen not to seek medical help over the last 12 months because of transport problems.

National policy aims to improve mainstream public transport, give greater weight to accessibility in decisions about planning, tackle the concentration of road casualties in disadvantaged areas and tackle crime and fear of crime around transport sites. With specific regards to health services the Social Exclusion Report (2003) proposed that specialist travel should be more organised around the patient. Initially this will be through widening of the criteria for eligibility to patient transport services.

The 1991 census found that 42% of households in B&H had no car, but by 2001 this had fallen to 37% compared with 19% in the Southeast and 27% in England and Wales. Car ownership in B&H is the lowest in the Southeast region, and the 38th lowest out of 376 local authority areas nationally.

The 2003 lifestyle survey found that across the city the car/motorcycle/moped were the main form of transport for 57% of males and 48% of females. However just 33% of people in the most deprived cluster said their main form of transport was the car/motorcycle/moped compared with 64% of people from the most affluent cluster. By contrast 26% of people from the most deprived cluster said that walking was their main form of transport compared with 7% from the most affluent cluster. There was little difference between the deprivation clusters as to whether or not residents felt that there was good local transport.

Education

Education both contributes to health inequalities and is a traditional route out of poverty for those living in disadvantage (Acheson 1998). Education helps determine an individual’s socio-economic position through its effects on employment, which in turn influences income, housing and other material resources. Children excluded from school or those who are frequent truants are more likely to have increased involvement with crime, substance misuse and other dangerous activities. In the longer term they are more likely to be unemployed, imprisoned and homeless and the girls are also more likely to become pregnant whilst teenagers.

The 2001 census found that Brighton and Hove had a well-educated population compared with the local region and the country. Of people aged 16-74 years, 29% had qualifications at degree level or above compared with 22% for the region and 20% for the country. Similarly the city had a higher percentage of people who had reached A level standard. However, although nationally in 2003, 53% of pupil’s aged 15 achieved at least 5 GCSEs at grades A*-C, for Brighton and Hove the figure was just 48%. The results of the ten local mainstream state schools ranged from 12 to 66%.

In 2002 in Brighton and Hove secondary schools the percentage of half days missed was 8.1% due to authorised absence and 1.2% for unauthorised absence. This compares with 7.5% and 1.1% respectively for England. Again there was a wide variation across the city. For most schools the unauthorised absence rate was less than 1%. However, one school had an unauthorised rate of 11.3%. In 2002/3 there were 24 permanent exclusions from primary, secondary and special schools within the local education authority. This figure is similar to that for the last two years. Most of the children excluded were from secondary schools and were male. The main reasons for exclusion were either physical aggression towards staff or other pupils or unacceptable behaviour. In 2002/3 there were 1449 fixed term exclusions. Again the majority were male and from secondary schools. The most common reasons for exclusion were unacceptable or disruptive behaviour and physical aggression towards other pupils. The number of exclusions related to illegal drugs was approximately 30. The total number of days lost through fixed term exclusions was 1205 days for primary schools and 4452 days for secondary schools. The latter was almost a 50% increase compared with the
totals for the two previous years for secondary schools. The reasons for this increase are being investigated.

Housing and fuel poverty
The *Acheson Report* (Acheson 1998) highlighted the relationship between damp homes and asthma and stated that cold housing leads directly to hypothermia, which may contribute to the excess of winter deaths seen in older people.

Poor people tend to suffer from poor quality housing but may also have difficulty finding and keeping permanent accommodation. The report recommended the development of policies that increase the availability of social housing and improve the quality of housing, including reducing the prevalence of fuel poverty.

Cold temperatures are known to have physiological effects. Resistance to respiratory infections decreases below 16°C, and below 12°C the body may respond to cold by short-term increases in blood pressure and increased fibrinogen levels and hence blood viscosity. This is one postulated mechanism linking cold room temperatures to excess cardiovascular deaths.

The UK *Fuel Poverty strategy* (2001) described a fuel poor household as being one that could not afford to keep adequately warm at a reasonable cost. Households that contain older people, children and people with disabilities or who are suffering from a long-term illness are especially vulnerable. The widely used definition of fuel poverty is a household that has to spend more than 10% of income on all fuel use to heat the home to an adequate standard. An 'adequate standard' has been recommended by the World Health Organisation as being 21°C in the living room and 18°C in the other occupied rooms. The target set for the UK by the strategy is that by 2010 all vulnerable households will no longer suffer from fuel poverty.

An analysis of deaths from cardiovascular diseases, linked to findings from the *English House Condition Survey*, found there were over 20% more deaths from cardiovascular disease during the winter months than in other months of the year (Wilkinson 2001). The excess increased with age but not with decreasing social class. The older a property is and the poorer its thermal rating, the greater the number of excess deaths. The coldest homes had a risk 20% greater than the warmest ones.

The 2001 census demonstrated that within Brighton and Hove a greater percentage of the households had no central heating (11%) or had to share a bath, shower or toilet (1.4%) than the national average (8.5% and 0.5% respectively).

Figure 5.5 shows the percentage of households in each of the three deprivation clusters that have central heating as well as sole use of a bath/shower and toilet. In the most deprived areas 2.1% households lacked sole use of all these facilities compared with 0.1% of the most affluent households.
Excess winter deaths are defined as the difference between the number of deaths that occur in winter (December to March) and the average number of deaths during the preceding four months and the subsequent four months. Between 1990/91 and 1999/00 the number of excess winter deaths in England ranged between 25,000 and 45,000. These levels are far above the average for other European countries. One of the proposed explanations is the quality of the housing stock in England.

Figure 5.6 shows the number of excess winter deaths in Brighton and Hove between 1995 and 2001.
In the 2003 lifestyle survey people were asked if there were times in the winter when they could not keep the home warm enough. Of those who answered 10.5% of males and 13.5% of females responded ‘yes’, either as ‘quite often’ or ‘most of the time’. Figure 5.7 gives the percentage responses by deprivation cluster. It suggests that keeping the home warm in winter is a problem for one in every fifteen people living in the most deprived wards. But also shows that in the more affluent areas there are still many people who cannot keep their home warm in winter.

**Figure 5.6 Number of excess winter deaths**

![Graph showing number of excess winter deaths](image)

*Source: Public Health Information Department, Brighton and Hove City Teaching PCT 2002.*

**Conclusions**

The findings from the 2003 Brighton and Hove *Health Counts* lifestyle survey suggest that neighbourhood of residence affects health status. This supports the need to build social capital in deprived areas with initiatives such as the neighbourhood renewal programme.

Reducing crime has a part to play in reducing inequalities and also in improving the health of the community through reducing stress and anxiety from fear of crime, particularly for people living in more deprived areas.
Education and employment make a large contribution to improving the health of a community. There are inequalities locally in terms of educational performance and addressing these will help reduce the health inequalities within the city over the longer term.

Across the city there are significant numbers of people who find it difficult to keep their homes warm during the winter. In addition many people in the city still have to share a bath, shower or toilet.

References


Chapter 6

Special Groups

Summary
Members of the lesbian, gay, bisexual and transgender community who took part in the Health Counts and Count Me In surveys report less healthy lifestyles compared to the general population.

Homeless people who took part in the Health Counts lifestyle survey report increased levels of severe health problems including mental illness and substance misuse. They also report higher levels of smoking, untreated dental problems and fear of violence compared to the general population.

There is a lower proportion of residents from black and ethnic minority groups in Brighton and Hove compared to England as a whole. Ethnic minority groups are more likely to live in the more deprived parts of the city. There is very limited information on refugees, asylum seekers and illegal immigrants in Brighton and Hove although these groups are likely to have particular health needs.

Alcohol use is increasing in Brighton and Hove and is implicated in over 200 deaths a year. The estimated prevalence of injecting drug use in Brighton and Hove is 2%, which is similar to the prevalence estimated for Liverpool, and for 8 inner London boroughs. Two recent national reports have found that Brighton and Hove had the highest rates of drug-related deaths in the country. Drug use in the local neighbourhood is considered to be a big problem for over a quarter of residents of Brighton and Hove overall, but for almost half of residents in the most deprived areas of the city.

Introduction
This chapter presents data on specific health problems, risk factors and needs of certain minority groups living in Brighton and Hove. These groups have differing needs from the general population, which can result in very different health outcomes. For example, there are higher rates of coronary heart disease and diabetes among South Asians living in the UK and higher levels of untreated severe mental illness among homeless people. Many of these issues are complex in their causation. The following groups are examined: the lesbian, gay, bisexual and transgender (LGBT) communities, homeless people, black and ethnic minority groups, refugees and asylum seekers, and people with substance misuse problems.

Lesbian, Gay, Bisexual and Transgender (LGBT) communities
The National Strategy for Sexual Health and HIV (DH 2001) states that there is an unequal impact of HIV on gay men and certain ethnic minority groups. In 2001 a local Count Me In Survey analysed 1145 questionnaire responses from LGBT people who live or socialise in Brighton and Hove. This led to development of the Brighton and Hove Lesbian, Gay, Bisexual & Transgender Community Strategy 2001-2006. In addition the 2003 lifestyle and social capital survey Health Counts described in Chapter 1 collected data from 116 members of the LGBT group by random sampling and a further 86 responses by specific targeting.

Estimates of a population’s sexuality are notoriously difficult. The Count Me In survey estimated the number of lesbians and gay men in Brighton to range from 20,000 to 35,000 (Wright 1999) i.e. approximately 10% of the population. The 2003 Health Counts survey included a question on sexuality and recorded a lower prevalence than did the Count Me In survey although in the Health Counts survey 6.7% did not answer this question (Figure 6.1).
### Table 6.1  Sexuality and sexual orientation in Brighton and Hove

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight / heterosexual</td>
<td>1709</td>
<td>86.5</td>
</tr>
<tr>
<td>Gay</td>
<td>68</td>
<td>3.4</td>
</tr>
<tr>
<td>Lesbian</td>
<td>29</td>
<td>1.5</td>
</tr>
<tr>
<td>Bisexual</td>
<td>19</td>
<td>1.0</td>
</tr>
<tr>
<td>Transgender</td>
<td>2</td>
<td>0.1</td>
</tr>
<tr>
<td>Unsure</td>
<td>8</td>
<td>0.4</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>0.4</td>
</tr>
<tr>
<td>No answer</td>
<td>133</td>
<td>6.7</td>
</tr>
<tr>
<td>Total</td>
<td>1976</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Source: Health Counts Survey 2003*

*Note: The above table includes only to those who answered the Health Counts survey sent by random postal sampling and not the additional 86 LGBT respondents who responded following specific targeting.*

The age / sex distribution of LGBT respondents also differed from the total population who responded to the survey (Figure 6.2). There were more males in this group and more adults particularly in the 35-44 years age group. There were considerably fewer LGBT respondents who were aged 65 years and over. This should be borne in mind with regard to interpretation of any findings.

### Table 6.2  Characteristics of all LGBT respondents and total survey sample

<table>
<thead>
<tr>
<th>2003 Total Survey Sample</th>
<th>2003 LGBT Survey Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>%</td>
</tr>
<tr>
<td>Male:</td>
<td>42.4</td>
</tr>
<tr>
<td>Female</td>
<td>57.6</td>
</tr>
<tr>
<td>Age in Years</td>
<td>%</td>
</tr>
<tr>
<td>18-24</td>
<td>8.5</td>
</tr>
<tr>
<td>25-34</td>
<td>17.9</td>
</tr>
<tr>
<td>35-44</td>
<td>19.7</td>
</tr>
<tr>
<td>45-54</td>
<td>15.7</td>
</tr>
<tr>
<td>55-64</td>
<td>14.4</td>
</tr>
<tr>
<td>65-74</td>
<td>12.7</td>
</tr>
<tr>
<td>75+</td>
<td>10.7</td>
</tr>
<tr>
<td>No answer</td>
<td>0.4</td>
</tr>
</tbody>
</table>

*Source: Health Counts Survey 2003*

Using the SF36 questionnaire (Chapter 2) the 2003 lifestyle survey measured self-reported general health and wellbeing. Compared to the population as a whole, LGBT respondents reported better physical functioning. However, despite their younger age, LGBT respondents reported comparatively worse scores for general health, vitality, social functioning, problems with work or other daily activities as a result of emotional problems and mental health (Table 6.3).

### Table 6.3  SF36 Scores for LGBT respondents compared to general population

<table>
<thead>
<tr>
<th>SF36 Category</th>
<th>General population</th>
<th>LGBT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Functioning</td>
<td>80.35</td>
<td>83.41</td>
</tr>
<tr>
<td>Role-physical</td>
<td>75.18</td>
<td>75.35</td>
</tr>
<tr>
<td>Bodily Pain</td>
<td>71.55</td>
<td>73.81</td>
</tr>
<tr>
<td>General Health</td>
<td>66.84</td>
<td>62.88</td>
</tr>
<tr>
<td>Vitality</td>
<td>57.16</td>
<td>53.84</td>
</tr>
<tr>
<td>Social functioning</td>
<td>79.18</td>
<td>71.88</td>
</tr>
<tr>
<td>Role-emotional</td>
<td>79.08</td>
<td>66.84</td>
</tr>
<tr>
<td>Mental Health</td>
<td>72.51</td>
<td>66.27</td>
</tr>
</tbody>
</table>

*Source: Health Counts Survey 2003*
The 2003 lifestyle survey recorded some striking differences between the results of the general population when compared to those of the LGBT group (Table 6.4) although some of this may reflect the different age and sex structure of the LGBT community. Members of the LGBT communities were more likely to drink in excess of 21 units (males) or 14 units (female) per week, to be at risk for major depression, to be overweight or obese, to smoke daily and to report a long term limiting illness. A larger proportion of men in this group was unaware of smoking cessation services compared to men in the general population. Because these findings are based on a population with a higher proportion of young males, further analysis is currently underway to determine whether the findings for the LGBT communities do differ significantly from the general population in the same age, sex and socio-economic group.

These findings are however largely consistent with the Count Me In survey which also reported that 49% of the LGBT community used recreational drugs: drug use varied from 70% among those aged less than 25 years to 8.3% among those aged over 65 years. The mental health findings too are consistent with the Count Me In survey where more than a third (37%) of respondents said they had been prescribed medication for a mental health problem and 19% stated that they had attempted suicide.

### Table 6.4  Comparison of total respondents with LGBT respondents on several health questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Total Respondents</th>
<th>LGBT Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long term limiting illness</td>
<td>33%</td>
<td>38%</td>
</tr>
<tr>
<td>Major depression risk</td>
<td>38%</td>
<td>54%</td>
</tr>
<tr>
<td>Smoke daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>21%</td>
<td>33%</td>
</tr>
<tr>
<td>Females</td>
<td>19%</td>
<td>24%</td>
</tr>
<tr>
<td>Aware of local smoking cessation services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>44%</td>
<td>33%</td>
</tr>
<tr>
<td>Females</td>
<td>41%</td>
<td>53%</td>
</tr>
<tr>
<td>Body Mass Index – overweight or obese</td>
<td>42%</td>
<td>43%</td>
</tr>
<tr>
<td>Drinking more than recommended limits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males (&gt;21units)</td>
<td>27%</td>
<td>28%</td>
</tr>
<tr>
<td>Females (&gt;14units)</td>
<td>17%</td>
<td>38%</td>
</tr>
</tbody>
</table>

*Source: Health Counts Survey 2003*

The lifestyle survey did not include any specific questions regarding HIV, however in the 2001 Count Me In survey, 66% of men reported that they had taken an HIV test and 17% of those tested had been diagnosed with HIV. By comparison the 1999 National Gay Men Sex Survey recorded that 58% of men report to have ever had an HIV antibody test, and 9% report that they have been diagnosed HIV positive (Weatherburn 2000). Table 4.2 in Chapter 4 of this report shows the probable route of HIV exposure for patients with HIV in NHS care in Brighton and Hove PCT for 2001 and 2002. Although there was an increase in the overall numbers exposed, the proportion in each category did not change significantly.

### Homeless people

Mental health problems, substance misuse, ‘dual diagnosis’ (mental illness and substance misuse) and chronic physical illness are all more common, and frequently untreated, among homeless people. Psychosis is over represented by a factor of 20 or 30 in hostel populations. Both anxiety and depression are common. Alcohol and substance misuse have often been found to be associated with homelessness but in most British studies psychosis is at least as common as alcoholism. Alcohol or drug misuse and mental illness in the same individual (‘dual diagnosis’) can multiply the disruptive effect of each problem. Such patients are difficult to treat and often fall between mainstream alcohol and psychiatric services. Compared with
the general population, homeless people also suffer considerably more from untreated physical disease: chronic chest, skin and dental problems predominate and may exacerbate anxiety and depression (Timms 1997).

Following the Children (Leaving Care) Act 2001 and Homelessness Act (implemented July 2002), local authorities are now obliged to improve support and accommodation for young people leaving care. The Brighton and Hove City Council Homelessness Strategy and the Single Homeless and Rough Sleeper Strategy set out the local programme to address the challenge of homelessness (Brighton and Hove City Council 2003a).

Homelessness has constituted a significant problem in Brighton and Hove in recent years with on average, more than eight households presenting themselves as homeless every day of the year. However between 2000/01 and 2002/03 homelessness applications reduced by 17%. In 2002/03 there were 2943 homelessness applications 851 of which were accepted as homeless. Almost two thirds of homelessness results from either loss of private rented accommodation and eviction by family or friends. Homelessness following a short period of residency in Brighton and Hove tends to be due to other causes such as discharge from supported accommodation and domestic violence. Families with dependant children and people with mental health problems are more likely to become homeless than other city residents (Brighton and Hove City Council 2003a).

The Morley Street GP Practice in Brighton has registered only homeless people for the last 3 years. The number of registered patients has remained fairly constant (currently around 850) although there is a very high turnover, with approximately 150 people registering and de-registering every quarter. A small sample of 27 homeless people who attended the Morley Street GP practice during one week took part in the 2003 Health Counts lifestyle survey. Because those who took part constituted a small sample and were attending a doctor’s surgery, some caution is required in interpretation. In addition most were men (21 of 27) and 25 were between the ages of 18 and 54 years. The mean length of time lived in the area was 1.5 years. The results for this group compared to the general population are shown in Table 6.5.

<table>
<thead>
<tr>
<th>Question</th>
<th>General population</th>
<th>Homeless people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long term limiting illness</td>
<td>33%</td>
<td>70%</td>
</tr>
<tr>
<td>Moderate or severe bodily pain in the past 4 weeks</td>
<td>31%</td>
<td>67%</td>
</tr>
<tr>
<td>At risk for major depression</td>
<td>38%</td>
<td>82%</td>
</tr>
<tr>
<td>Felt anxious or stressed by fear of violence ‘almost all of the time’ in last 3 months</td>
<td>3%</td>
<td>26%</td>
</tr>
<tr>
<td>Smoke Daily</td>
<td>21%</td>
<td>93%</td>
</tr>
<tr>
<td>Aware of local smoking cessation services</td>
<td>42%</td>
<td>27%</td>
</tr>
<tr>
<td>Registered with a dentist</td>
<td>80%</td>
<td>45%</td>
</tr>
<tr>
<td>Seriously tried to cut down on alcohol in last 12 months</td>
<td>18%</td>
<td>50%</td>
</tr>
<tr>
<td>Regularly care for family, friends or neighbours</td>
<td>17%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Source: Health Counts Survey 2003

Almost all of the homeless people sampled smoked daily. Less than a third were aware of local smoking cessation services. Although the majority of homeless people surveyed were not registered with a dentist, over three-quarters (78%) thought they needed dental treatment. Over 60% had experienced toothache or pain caused by teeth/dentures over the previous 12 months. Five of the 27, a similar proportion to that in the general population, were regular carers for family friends or neighbours needing care due to ill health, old age or disability.

A local report on drug-related deaths in Brighton and Hove (see below) reported that a third of the people who died were living either in hostel accommodation or on the streets.
**Black and Minority Ethnic (BME) Groups**

Black and Minority Ethnic groups face different risks of various health related conditions compared to the general population, depending on multiple interacting factors such as early life outside of the UK, diet, lifestyle, experience of racism, cultural attitudes to illness or to seeking help and language barriers. The NHS Plan (DH 2000) and other government policy documents have drawn attention to the specific health needs of different minority groups including minority ethnic groups and their importance in tackling health inequalities. National service frameworks for diabetes and coronary heart disease have also described particular needs of different ethnic minority groups.

A comparison of the ethnic status of the census population and those responding to the 2003 lifestyle survey is shown in Chapter 1: the figures are broadly comparable. Innovative quality assurance methodology was used to ensure the accuracy of the 2001 census, and this is considered to have been very successful (Diamond *et. al.* 2003). However it has been suggested that the census may still underestimate the numbers from some ethnic minority communities (including refugees, asylum seekers and illegal immigrants (Munro *et al.* 2001).

The percentage of residents identifying themselves in the 2001 Census as from ‘any group other than white British’ varies considerably across Brighton and Hove. This group includes white ethnic minorities such as Irish and other EU nationals, but also immigrants and refugees from Balkan and former Eastern block countries. There are 6 wards where over 15% of residents are from this latter group: Brunswick and Adelaide, Central Hove, Goldsmid, Queens Park, Regency and St Peter’s and North Laine. Together with East Brighton, these are the most deprived wards in the city.

The Sussex Interpreting Service (SIS) employs 126 community interpreters speaking 59 languages, which illustrates the diversity of ethnic minority groups in the area. On average SIS deals with 100 GP appointments each month. Other main areas of work for interpreters are mental health and housing support. The most frequent language requested is Arabic (40%). In the 15 months from July 2002 to September 2003 service activity increased by 51% (SIS 2003).

Among ‘looked-after children’, in 2002/2003, 11.1% were from non-white ethnic groups compared to 5.7% of the general population (Brighton and Hove City Council, 2003b). Further work is currently underway to determine whether or not the *Health Counts* lifestyle survey can be meaningfully analysed by ethnicity.

**Refugees and Asylum seekers**

A 2002 study of 40 organisations in England and Scotland working with asylum seekers found that 85% of organisations reported that their clients experience hunger; 95% of organisations reported that their clients cannot afford to buy clothes or shoes; and 80% of organisations reported that their clients are unable to maintain good health. It was also found that it is often the most vulnerable who suffer from lack of additional support. Disabled asylum seekers struggle to receive the extra help they need or receive no additional help at all. The report concluded that asylum seekers are forced to live at a level of poverty that is unacceptable. (Penrose, 2002)

Table 6.6 shows the numbers of asylum seekers that Brighton and Hove City Council was supporting in January 2004. These people were waiting to receive decisions on their claims for asylum or waiting for the results of appeals. People in these categories are no longer allowed to apply for work.
Table 6.6  Categories of asylum seekers supported by Brighton and Hove City Council

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>44</td>
</tr>
<tr>
<td>Families</td>
<td>25 (39 Adults and 46 Children)</td>
</tr>
<tr>
<td>Unaccompanied Minors aged 16-17 years</td>
<td>12</td>
</tr>
<tr>
<td>Unaccompanied Minors aged under 16</td>
<td>7</td>
</tr>
</tbody>
</table>

*Source: Brighton and Hove City Council (Jan 2004)*

The National Asylum Support Service (NASS) separately finances and/or accommodates other asylum seekers in the city. In September 2003 there were 55 people in NASS accommodation and 100 in receipt of subsistence-only support from NASS (Home Office 2003). Asylum seekers whose claims are accepted are given refugee status. It is difficult to accurately determine the total numbers of refugees who live in Brighton and Hove, as some are likely to be unrecorded illegal immigrants. Those seeking asylum may have particular health needs however, in Brighton and Hove the nature of any specific health needs remains to be determined.

**Alcohol and substance misuse**

Chapter 4 describes patterns of alcohol consumption in Brighton and Hove and the impact such consumption has on health. Drug use is also known to be prejudicial to health. There is some evidence that inpatient and residential rehabilitation is beneficial for some patients and that different types of intervention including the use of injectable diamorphine can help certain patients as part of a package of care however further studies are needed.

The profile of alcohol and substance misuse as a key health policy area has increased in recent years and the Department of Health has established a number of targets (Chapter 7).

The 2003 lifestyle survey reported that overall, 27% of people in Brighton and Hove feel drug use in their neighbourhood to be a ‘very big’ or ‘fairly big’ problem. This percentage however varies from 46% for people living in the most deprived areas of the city to 16% of those living in the most affluent areas.

Substance misuse is also associated with violence both as a victim and perpetrator. Since February 2004 primary care trusts have been under legal obligation to commission services for violent patients (DH 2004). In Brighton and Hove one practice has provided GP services to all patients referred through the Violent Patients Scheme (VPS) from other practices since January 2002. Preliminary results of an audit of 50 patients on the scheme revealed that the overwhelming majority of patients on the scheme have substance misuse or alcohol problems.

In 2000/2001 using capture-recapture methods, the number of injecting drug users in the 15-44 age group in Brighton and Hove was estimated to be 2304 (95% CI 1514-3737). This equated to a prevalence of around 2.0% (Hickman 2003). This prevalence is similar to those estimated for Liverpool and inner London boroughs placing Brighton as one of the worst affected areas in the country. Provision of needle exchange in Brighton and Hove, as measured by syringes distributed, was 186 syringes per injector per annum in 2000/2001. This was equivalent to one clean syringe per injector every two days (or 25% of all injections).

Hepatitis C is a slowly progressive liver disease. The most important risk factor for hepatitis C is a history of current or past IV drug use. After exposure to the virus about 20% of patients develop acute hepatitis. Up to 85% of those exposed fail to clear the virus and develop chronic hepatitis. Of those initially infected about 30% develop cirrhosis within 20 years. Three to 5 percent develop hepatocellular carcinoma. Thirty-three percent may never progress to cirrhosis or may not progress for 50 years (O’Dea 2001).

An unlinked anonymous survey of hepatitis C in IV drug users using specialist and community drug services revealed a prevalence of 52% in the London area and 31% outside London in
1999 (Public Health Laboratory Service 1999, quoted in O’Dea 2001). Given the estimate of 2300 injecting drug users in Brighton and Hove, the number infected with hepatitis C may be 700. This estimate does not include those infected through other routes (e.g. blood products, accidental injury with clinical sharps).

Crack cocaine use can lead to serious health (mental and physical) and social problems and can result in harm to the wider community through violence and crime. The use of crack and the combined use of crack and heroin are increasing among drug-using populations. There is limited evidence for what works for crack cocaine misuse with only short-term outcome studies published in the UK to date. The main interventions are brief and highly intensive. Rapid easy access to specially trained staff and prompt access to residential rehabilitation have shown benefits (Bennett 2004).

Data from the Sussex Treatment Outcomes Research Study (STORS) is shown in Tables 6.7 and 6.8. Approximately a third of clients presenting to substance misuse treatment agencies in Brighton and Hove are using crack cocaine. Approximately one quarter of urine toxicology specimens analysed at RSCH laboratory from all sources was positive for cocaine in 2003, compared to just over a tenth in 1999. Cocaine use is now regularly associated with drug-related deaths in Brighton and Hove (4 deaths in 2002 or 8% of all deaths). Heroin and benzodiazepines are the most commonly used substances prior to starting treatment, followed by alcohol and crack cocaine. In 2002/2003, 11% of clients had suffered an overdose in the 90 days preceding the start of their treatment (Brighton and Hove DAAT 2003).

Table 6.7  Drugs used by clients in the 30 days prior to starting treatment in Brighton and Hove in 2002/2003

<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>Number</th>
<th>Percent</th>
<th>% Prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>169</td>
<td>37</td>
<td>-</td>
</tr>
<tr>
<td>Heroin</td>
<td>318</td>
<td>70</td>
<td>2</td>
</tr>
<tr>
<td>Methadone</td>
<td>113</td>
<td>25</td>
<td>19</td>
</tr>
<tr>
<td>DF118 (dihydrocodeine)</td>
<td>100</td>
<td>22</td>
<td>13</td>
</tr>
<tr>
<td>Other Opiates</td>
<td>22</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>187</td>
<td>41</td>
<td>23</td>
</tr>
<tr>
<td>Crack</td>
<td>146</td>
<td>32</td>
<td>-</td>
</tr>
<tr>
<td>Cocaine</td>
<td>36</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>13</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Cannabis</td>
<td>117</td>
<td>26</td>
<td>-</td>
</tr>
<tr>
<td>LSD</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>19</td>
<td>4</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Sussex Treatment Outcomes Research Study (STORS)

Table 6.8  Gender, age, employment status and recent offending history of clients beginning treatment for drug misuse in Brighton and Hove in 2002/2003

<table>
<thead>
<tr>
<th></th>
<th>Number (Total = 449)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex: Male</td>
<td>337</td>
<td>75</td>
</tr>
<tr>
<td>Age 19-24 years</td>
<td>49</td>
<td>11</td>
</tr>
<tr>
<td>Age 25-44 years</td>
<td>356</td>
<td>79</td>
</tr>
<tr>
<td>Unemployed</td>
<td>328</td>
<td>73</td>
</tr>
<tr>
<td>Committed an offence in the 30 days before assessment (including possession of drugs)</td>
<td>180</td>
<td>40</td>
</tr>
</tbody>
</table>

Source: Sussex Treatment Outcomes Research Study (STORS)

Local data suggest that between 10 and 20 percent of patients on the caseload of community mental health teams in Brighton and Hove have a dual diagnosis of mental illness and substance misuse. This is in keeping with rates elsewhere. Those who work with homeless people report higher levels of dual diagnosis among their clients. Studies have suggested that
patients with dual diagnosis may fall between services for mental illness and substance misuse and consequently receive poor care. Since 2002, the Department of Health has advocated “mainstreaming” care for people with dual diagnosis within mental health services (Nicholls 2002).

In 1999 two national reports found that Brighton and Hove had the highest rates of drug-related deaths in the country (npSRD 2000). In response to this a local group was established to investigate these deaths and to make recommendations on how to reduce further deaths. The group reported on 87 drug-related deaths that occurred in Brighton and Hove between April 1997 and December 1999. Heroin was implicated in 4 out of every 5 deaths, usually in combination with either alcohol or benzodiazepines. Those who died were aged from 18 to 57 years (average age 32) and most were males. Of the 87 people who died, 76 (87%) were unemployed and 79 (91%) had lived locally for at least 3 months. A third of the people who died were either on the streets or in hostel accommodation.

A further local confidential inquiry looked more closely into the 36 drug-related deaths that occurred in 1999. The inquiry sought to identify ways in which local care could be improved to prevent such deaths. The following risk factors for drug-related deaths were identified: being a known intravenous drug user; being homeless; having mental health problems; using heroin in combination with alcohol and/or benzodiazepines; and using heroin after a period of abstinence. Three of those who died were not known to any of the 22 organisations contacted. Nine were not known to be drug users. Missed opportunities for referrals and communications between different agencies and professionals and problems in clinical care were also identified.

The report of the confidential inquiry made several recommendations (Chapter 7) many of which have now been enacted.

Conclusions
Among the LGBT community local data suggest a high risk of depression. Drug use is more common in this group. Being overweight, and smoking and drinking alcohol in excess of recommended weekly limits are more common in this group than in the general population although the LGBT community is younger than the population as a whole.

Little is known about the health of ethnic minority groups, and in particular asylum seekers and refugees living in Brighton and Hove. More work needs to be done to ascertain the health of a difficult to reach groups.

There has been a recent fall in the number of homeless applications and acceptances in Brighton and Hove although the number of homeless people attending a local specialist GP service has remained constant. Problems of mental and physical health, and substance misuse including dual diagnosis are more common among homeless people than in the general population. Compared to the general population, local homeless people surveyed reported a very high risk of major depression, increased long term limiting illness/disability, high levels of untreated dental problems, bodily pain, and fear of violence. There are high rates of mental illness, substance misuse, smoking and disability in this group. Homelessness remains a sizeable problem in Brighton and Hove.

Brighton and Hove City has a high prevalence of substance misuse including injecting drug use. Drug-related deaths have been very high in recent years. Crack cocaine use is a growing problem and is associated with some drug-related deaths.

References:
Bennett, J. (2004) Developing services to deal with the consequences of using crack-cocaine and cocaine (Draft) Brighton & Hove City PCT

Brighton and Hove City Council (2003b) Matching needs and services audit of looked after children, RTB Associates


Munro, A.J., Chambers, M. and Marwaha, A. (2001) Some patients seem not to have been included in census. *British Medical Journal* (323) 343


Chapter 7

Conclusions and recommendations

This chapter considers some of the key findings of the report and briefly explores how these are being addressed and what in addition might be done to improve the population’s health. This chapter has been written following presentation of the main findings of the report to senior managers in the PCT and City Council, local councillors in the City Council and representatives of the Local Strategic Partnership who sit in the City Health Partnership.

Key findings from Chapter 2 and action required

Population characteristics

The lack of accurate population projections hampers the planning of health care and health related services. The continuous feature over the last 10 years of relatively larger proportions of young adults and elderly people compared to national figures does however provide some focus for local service planners.

Although the black and ethnic minority communities form a small proportion of the local population they are more likely to be found living in the more deprived parts of the city. There is also an increasing part of the population that originates from other parts of the European Union and former Eastern Block countries who are also concentrated in the more deprived parts of the city. The lack of accurate information on the health of immigrants and refugees is something that the PCT in partnership with the City Council should seek to address at an early stage.

It is interesting to reflect that despite the efforts and hard work of health care planners and providers over the past ten years, the self reported health status of the local population has remained virtually static. Self reported health status is however poorer among more deprived residents. These findings highlight not just the magnitude of the task but also the multiplicity of influences on self reported health status.

Disease related targets

The national service framework for coronary heart disease has focussed much attention on this area. Progress in terms of reducing mortality has been good and further reductions are anticipated. The disease does however along with cancer, remain the main cause of premature mortality in Brighton and Hove. What is not clear is whether this progress is evenly spread across the population. The PCT is therefore currently undertaking a health equity audit in coronary heart disease to determine how future action might be best targeted.

Progress on cancer mortality may be levelling off and so this is an area that requires close monitoring. Brighton and Hove is part of a cancer network that covers a large part of the south east of England and links have been forged with cancer care planners and providers in northern France. There are an increasing number of new drugs and treatments available while at the same time evidence for the links to diet, exercise and smoking are becoming ever clearer. Planners in this area will have to balance investment in short-term gains against a longer-term strategy.

Mortality from accidents has been roughly static since 1990 and it is not clear whether the Government target will be met. Accidents occur more often in those from more deprived backgrounds. Effective action to prevent accidents needs to involve not just health services but the many departments within the council, the police, voluntary organisations and private companies. While there is considerable co-ordinated activity in some areas, such as addressing falls in the elderly, this has to be viewed against the lack of progress on the overall mortality from accidents. The City Health Partnership, a subcommittee of the Local Strategic Partnership is best placed to ensure that effective action to tackle accidents in a co-ordinated way takes place.
The continued high suicide rate in Brighton and Hove remains a concern. The Brighton and Hove Suicide Prevention Group co-ordinates local initiatives and suicide audits continue to provide important information. There is work within primary care to improve recognition and treatment of depression, an important risk factor for suicide. There are initiatives with local older people’s agencies on suicide prevention and further local initiatives are planned to raise awareness of suicide and deliberate self-harm and. There is also a local internet-based resource aimed at promoting the mental health of young men that can be found at http://www.fmhsussex.co.uk.

A Brighton and Hove suicide prevention strategy guided by the National Suicide Prevention Strategy will be published this year to provide a better co-ordinated uniform approach to suicide prevention across Brighton and Hove.

Key findings from Chapter 3 and action required

**General Practice**

A new contract for general practitioners was launched on April 1st 2004. A key aim of the new contract is to reward providers of good clinical practice, and in particular the appropriate management of patients with chronic illness. The new contract calls for more multi-disciplinary working and it is likely that individual general practices will have to work more co-operatively with other practices. Already some practices are identifying larger premises where they can expand their services and work more closely with other practices and other professionals who have a role in delivering primary care. This reconfiguration of general practice is an opportunity to address some of the inequalities that lie therein.

For example, the new contract offers general practitioners the opportunity to be remunerated for providing what are termed ‘local enhanced services’ (LES). These LES are services beyond what might normally be expected of a general practitioner such as additional minor surgery services, enhanced contraceptive care or additional child protection services. The advent of LES provides the PCT with an opportunity to commission enhanced services that will reduce health inequalities. The PCT should therefore ensure its criteria for selecting enhanced services includes consideration of what impact the enhanced service will have on health inequalities.

Similarly, the construction of several new primary care premises, which will inevitably accompany the implementation of the new contract, offers the PCT a unique opportunity and challenge. The PCT must ensure that all sections of the population have access to comprehensive high quality primary care services delivered from high quality premises. It will clearly not be possible to provide such premises in all areas of the city and some residents may have to travel further than they do now for primary care services. It is essential therefore that in developing and delivering its primary care premises strategy, the PCT liaises with the local authority, community groups and most importantly the residents who live and work in these areas.

**Prescribing**

The PCT works closely with GP practices to promote good quality prescribing and also to achieve cost savings where appropriate. For example, an initiative on dose-optimisation in cardiovascular disease, where patients were switched from twice-daily doses to an equivalent once-daily dose, helped improve patient concordance and in 2003 realised £150,000 of savings that was invested in other health care. A PCT prescribing support team monitors prescribing practice and promotes clinically and cost-effective prescribing.

The high level of benzodiazepine prescribing in Brighton and Hove reflects prescribing to substance misusers. Recently improved working with the Substance Misuse Service has led to some progress being made. Twenty-five practices have completed a detailed audit and the Substance Misuse Service is working more closely with practices that have large numbers of patients with substance misuse problems.

**Dental health**

There does seem to be a problem with access to dentists in Brighton and Hove. Of the 30% of lifestyle survey respondents who had not visited a dentist in the last year, 18% stated that they found treatment too expensive and 8% were unable to find a NHS dentist. This equates
with over 5% of the population who say they cannot afford to visit a dentist and over 2% who say they cannot find a dentist to treat them. Local screening data suggests that dental health in children has not improved between 1996 and 2002 and that children attending schools based in more deprived areas are more likely to have dental caries. There is scope for more integration of dental health issues with ongoing work on food in schools. There is a clear need for an ‘inequalities in health’ focus to this work.

The PCT Directorate of Public Health is engaged in collating information on the effects of fluoridation and dental health and in mapping better the dental health of children and adults across the city. Further debate on the merits and disadvantages of water fluoridation should be conducted in the light of the best local, national and international evidence.

**Optometry**
As in the case of dentistry there appears to be a minority of the population who do not seek vision testing because of the cost involved. Of the 21% of lifestyle survey respondents who had not had an eye test in the previous two years, cost represented a barrier for 14%. This equates with 3% of the population who say they cannot afford to have their vision tested. While eligibility to free vision testing is set nationally, it is important that local residents are aware of visual symptoms that might seriously compromise their health and require prompt assessment and treatment.

**Optometry**
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**Community Pharmacy**
Although in the lifestyle survey three quarters of people who sought pharmacy advice found it helpful, just 11% of men and 16% of women had actually received advice from their pharmacy/chemist in relation to their health in the previous 4 weeks. Given the high GP consulting rates in this country it would appear that pharmacists represent an underused health advisory resource. The PCT is actively promoting an extended role for the community pharmacist. It would be helpful to evaluate such programmes also in the context of their impact on general practice.

**Clinical reference groups**
The clinical reference groups working on orthopaedics, ENT, ophthalmology, dermatology and digestive diseases have among their aims better access for local residents to these services. The analysis in this report suggests a relationship between access and deprivation. The various clinical reference groups should therefore seek to improve access proportionately more for those living in more deprived areas. They should work closely with the Directorate of Public Health in the PCT to monitor progress on this.

**In-patients and out-patients**
This report has demonstrated that residents from more affluent parts of the city are more likely to have an elective or planned admission than their more deprived counterparts, while the situation is reversed for emergency admissions. Presentation at hospital can represent a stage in a process that might include: impact of social deprivation (e.g. poor housing, unemployment), health related behaviour, knowledge and understanding of the seriousness of symptoms, advice from family and friends, access to primary care and level of care provided in primary care. Measures to address this inequality in secondary care access therefore need to be focussed not just on referral behaviour, but on all levels of this journey. While much good work is going on at the moment, this report demonstrates that the PCT Public Health Directorate needs to work with all sections of the PCT and City Council to ensure that consideration of the need to address health inequalities is a pre-requisite of all service planning. To this end, a health inequality strategy will be published later this year.

**Mental health**
As anticipated, there was a clear relationship between mental illness and deprivation. However accommodation for adult service users with severe and enduring mental illness is not necessarily to be found in the same areas where mental illness is most prevalent. With an increasing focus on community based mental health services, consideration should be given in new service developments as to the most appropriate location of services.
Key findings from Chapter 4 and action required

The Local Strategic Partnership and in particular the City Health Partnership represent the key forums for progressing much of the work needed to address the health and lifestyle issues that have been raised in this report. Success in achieving WHO Healthy City Status will also provide further opportunities to improve the health of the local population and reduce many of the health inequalities that persist.

Smoking

The decreasing prevalence of smoking is a measure of some success in addressing this issue both locally and nationally. However there has also been a fall in the number of smokers who would like to quit, suggesting that further reductions in the number of smokers will be harder to achieve. Further improvements can still be made and the PCT works with many partners to raise general public awareness through promotional campaigns, advertising and media debate and the provision of smoking cessation services. Furthermore the PCT Public Health Directorate and health promotion team, working within the City Health Partnership will this year undertake an integrated health impact assessment of the effect of becoming a smoke-free city. The results will be shared with colleagues in the local authority in the first instance. As part of a national consultation exercise on Public Health, the Public Health Directorate has urged the government to legislate for local authorities to have legal powers to restrict smoking in public places if they deem it to be in the interest of the public’s health.

Alcohol

Alcohol consumption in Brighton and Hove has continued to rise and drinking above safe limits is more common among those living in areas of deprivation. Measures to reduce alcohol consumption include: education programmes as part of the Healthy Schools and Extended Schools programmes, early assessment and brief interventions in primary care, adoption of national enhanced services in primary care, adoption of national enhanced services in primary care, improved awareness and assessment in hospitals and referral to the specialist Substance Misuse Services. It is essential that such measures are targeted preferentially at areas of deprivation.

Diet, exercise and weight management.

The findings in the report with regard to diet, exercise and obesity, although in many instances better than national equivalents, are not encouraging. Just 44% of adults in Brighton and Hove eat the recommended proportions of fresh fruit and vegetables. Nationally a clear relationship has been demonstrated between deprivation and diet: although this was not evident in Brighton and Hove from the survey it is likely to be the case. The City Council and PCT have together developed a joint Food Strategy. Measures include: promoting better awareness of the importance of diet, developing cookery skills groups in community settings, promoting fruit and vegetable taster sessions in schools, community and commercial settings (supermarket tours) and cross-sector strategic action to support access to affordable healthy foods in deprived areas.

Similarly, very few people exercise to the recommended levels in Brighton and Hove, females exercise less than males and exercise levels drop dramatically as teenagers become young adults. Exercise need not be expensive and there are many ways that increased physical activity can be integrated into working and home life. Some work has been undertaken by the PCT and City Council on this but it is evident that much more is required. An Active Living Strategy is in development and measures will include: increased awareness of the benefits of exercise, promotion of access to green space, promotion of regular walking and stair use as practical means of increasing physical activity, more affordable opportunities to participate in exercise activities, specific programmes targeted at different age groups, ability and sensitive to cultural needs.

The findings regarding weight and levels of obesity in the city are not encouraging. A Weight Management Strategy is in development to reduce the high levels of overweight and obesity within the city. The strategy will include: promotion of healthy eating, physical activity and weight management through the Healthy Schools scheme, better access to healthy affordable foods, increased opportunities for habitual physical activity, better management of weight problems in primary care.
Key findings from Chapter 5 and action required

Social capital
The findings of the lifestyle survey confirm that a whole range of diverse factors can influence the health of the local population. Local agencies need to fully understand the contribution that they can make to improving health by tackling the inequalities that exist within their own field, and the benefits that working with health services to improve health can bring to them. To reinforce this the PCT should contribute to joint investment in programmes aimed at tackling inequalities and the broader determinants of health, such as supporting schemes aimed at tackling fuel poverty and cold homes. Neighbourhood based initiatives involving local communities are already an integral part of local action to reduce health inequalities.

In January 2001 the Social Exclusion Unit published “A New Commitment to Neighbourhood renewal: national strategy action plan”, to “tackle the unacceptably bad conditions in poor neighbourhoods”. The strategy proposed ‘Local Strategic Partnerships’ (LSPs), a single local body that aims to bring together the various parts of the public sector with the private, voluntary and community sectors to allow different initiatives to supplement each other. The strategy also proposed ‘Neighbourhood Management’ in which a single person, team or organisation in charge of the services provided to a neighbourhood.

Following this publication, a local Neighbourhood Renewal Strategy was published setting out an agreed vision for improving neighbourhoods in Brighton and Hove. The local strategy identified 27 neighbourhoods that could be defined as deprived and then prioritised 9 of these and the eb4U neighbourhoods. The eb4U area was part of the New Deal for Communities initiative. Two neighbourhoods, Hollingdean and Tamer, have already had one years funding, and the other neighbourhoods have now received funding to develop Neighbourhood Action Plans. As well as health related targets the local strategy focuses on community participation, community safety, education and family support, employment and housing.

Crime
Crime and fear of violent crime in particular is more of a problem in more deprived parts of the city. The Acheson Report on inequalities in health (Acheson 1998) stated, “the most effective approaches to crime prevention are likely to be those which are integrated with wider social and economic policies for reducing health inequalities.” Addressing crime and fear of crime are therefore integral to initiatives such as neighbourhood renewal.

A local example of good practice

The eb4U Community Safety Team is the lead project delivering a Safer East Brighton as part of the East Brighton New Deal for Communities Community Partnership. The team aims to take effective action to reduce anti-social behaviour and crime across East Brighton and to develop the response of local services to one of the main priorities of local residents. The team has not taken over the responsibilities of the main service providers to tackle anti-social behaviour, but supports those services to produce a more co-ordinated response.

The Community Safety Team works in a multi-agency environment, that promotes a holistic approach to problem solving, and has a broad role in tackling anti-social behaviour and its causes. The range of support, intervention and enforcement measures used by the Team include: housing management tenancy action; dedicated legal support; youth inclusion work with young people at risk of offending; neighbourhood wardens; a neighbourhood policing team; restorative justice and victim support; domestic violence; and parenting support. The Team has developed innovations viewed as a model of best practice, for example the introduction of tools such as Acceptable Behaviour Contracts and Victim Support Services for people involved in civil cases. The East Brighton area has seen a fall in recorded crime of 23% from 2185 crimes in 1999 to 1673 in 2003. Independent evaluation attributes this fall overwhelmingly to the work of the Team.

Transport
Healthy transport systems reduce the need for people to travel by car (without being anti-car), increase levels of physical exercise, reduce fatal accidents, increase social contact and reduce air pollution. A lack of transport may damage people’s health by denying them access to people, goods and services. The lifestyle survey found that residents living in more
deprived parts of the city were more likely to require access to public transport systems. Much work has been done in recent years in developing better public transport systems in Brighton and Hove, the effects of these changes on different sections of the population should be monitored.

**Housing and fuel poverty**

Increased deaths in winter remain a problem in the UK and in Brighton and Hove. A substantial proportion of the population state that they cannot afford to heat their home properly. Brighton and Hove City Council Environment and Housing Department Home Energy Efficiency strategy aims to reduce the incidence of illness and early deaths by eliminating fuel poverty, to provide affordable warmth and promote energy saving in households and to raise awareness of the benefits of energy conservation. The impact of this policy is being monitored.

**Key findings from Chapter 6 and action required**

**Lesbian, gay, bisexual and transgender community (LGBT)**

Despite their younger average age, LGBT residents report comparatively worse general health, vitality, social functioning, problems with work or other daily activities as a result of emotional problems and mental health compared to the general population.

There is a need for ensure awareness of the risk of mental health problems and suicide in the LGBT group among mental health professionals and service planners.

Although the lifestyle data collected require further analysis, there may also be a need for specifically targeted LGBT health promotion activities on smoking, drinking, substance misuse and obesity.

**Homelessness**

Homelessness remains a serious problem in Brighton and Hove. The health issues faced by local homeless people appear to mirror those in national studies with higher levels of substance misuse and mental health problems. A quarter of those surveyed stated that they lived in constant fear of violence. The findings of the local drug-related death enquiries confirm that the mental health and substance misuse needs of homeless people present a particular challenge to local services.

Almost all of those homeless people surveyed smoked, but homeless people are less likely to be aware of smoking services. The Health Development Agency has pointed out the importance of affording smoking cessation services to homeless people, who often have adopted more damaging smoking habits than the general smoking population, making them even more susceptible to infection and disease.

The Morley Street GP Practice in Brighton provides health services specifically tailored to the needs of homeless people. There is likely to be a relocation of this service in the near future. It will be important to ensure continuity of access to care during and following this move. Brighton and Hove City Council no longer houses families with dependent children in Band B accommodation. The Council also now focuses more on families and people with mental health problems. The PCT and council need to work closely together to better determine and address the needs of homeless people.

**Ethnic minority groups, refugees and asylum seekers**

There is very limited local information on the health of these groups. There is a need for the PCT and Council to work closely together to share any available information in order to plan services appropriately. There is a clear need for health data on local refugees and asylum seekers.

**Substance Misuse**

Substance misuse in Brighton and Hove remains a very serious issue resulting in considerable health and social problems. Problematic drug usage is on a par with Liverpool and inner London and drug-related deaths are very high.
There is a considerable body of local work in progress to address these issues. There is a need to ensure co-ordination of prevention and treatment services across both health and social care. There are specific needs such as an increase in needle exchange provision and improved access to services. More work is required on how better to address the problems faced by increased use of crack cocaine.

Brighton and Hove is likely to face a real challenge in meeting the targets set out by the Department of Health:

- Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008;
- Increase year-on-year the proportion of users successfully sustaining or completing treatment programmes;
- Provide local services in support of the home office PSA target to reduce the proportion of people under the age of 25 reporting the use of Class A drugs;
- Reduce frequent use of any illicit drug among young people, especially the most vulnerable young people;
- Deliver the NHS Plan targets to reduce levels of drug-related death by 20% by 2004.

**Conclusions**

This report has detailed how the work of those engaged in the public health agenda over the last 10 years has reaped some benefits: improvements in coronary heart disease and cancer, reductions in smoking, better and more integrated policies to tackle the wider determinants of health, clearer structures and processes such as the Local Strategic Partnership for coordinating effort. However, much remains to be done. In Brighton and Hove the problems of mental health, substance misuse, homelessness, social exclusion and adverse lifestyles present major challenges to service planners and providers.

Most of public health problems in Brighton and Hove take the biggest toll on the poor. People living in the more deprived parts of the city generally have the poorest health. The health inequality profiling in this report will provide a baseline against which the success of future interventions can be measured. It is clear that if the health of the population is to be improved interventions need to be targeted, more than ever, at the city’s most deprived residents. A Health Inequalities Strategy to be published later in the year will cover in detail what specific actions are being taken, and what more needs to be done to reduce these inequalities.

The issue of lifestyle is particularly to the fore in the nation’s consciousness at the moment, backed by a series of government consultations and reports. There is a danger in seeking to address this agenda that blame is laid at the feet of those who, for whatever reason, find it more difficult to adopt a healthy lifestyle. While individuals have a responsibility for their own health and lifestyle the onus on service planners and providers is to see that everyone has the same opportunity to remedy adverse behaviour. This again means targeting interventions at those who have the steepest hill to climb.

Health in Brighton and Hove remains inextricably linked to deprivation. Tackling health and health inequalities requires co-ordinated action from planners and providers across a host of statutory and non-statutory sectors. In 2004, a network of public health practitioners will be established across the city to bring together and support people from different agencies working to reduce the adverse effects of social determinants on health.

The challenge is enormous but not insurmountable, and for those who seek to engage in the public health agenda, the rewards are more than worth the effort.

**Recommendations**

1. The PCT and City Council should work together to collect and collate better information on the health of particular groups such as refugees and asylum seekers. Data that has
already been collected, such as the *Health Counts* survey, should be analysed with a view to better determining the health needs of particular groups such as black and minority ethnic communities and the lesbian, gay, bisexual and transgender communities.

2. Current joint PCT and City Council approaches to preventing accidents, improving mental health and reducing suicides should be reviewed with the aim of meeting current national targets.

3. Primary and secondary care service provision should be more focused on reducing inequalities. Populations with relatively poor dental health should be targeted to ensure better access to dental services. The PCT approach to developing enhanced primary care services and new primary care premises should include a health inequalities focus. The work of the clinical reference groups should have a health inequalities focus.

4. The PCT and City Council should make tackling the problems that result from alcohol and substance misuse a greater priority than is currently the case.

5. The proposed local strategies to tackle weight, exercise and diet should be published and monitored for impact by the Local Strategic Partnership.

6. The PCT and City Council should review the health impact of the city adopting a smoking ban in public places policy.

7. There should be greater joint PCT and City Council investment to tackle the problems that result in reduced social capital.

8. The Local Strategic Partnership should adopt a Health Inequalities Strategy that includes specific health equity audits. The Public Health Directorate should lead on developing this strategy.

9. Healthy City status should be seen as a catalyst for more action to tackle health inequalities within the city.

10. A local public health network, which draws together public health specialists and practitioners across the city, should be developed to tackle the key public health priorities that the city faces.