Joint Strategic Needs Assessment (JSNA)

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

JSNA has been described as

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

It intends to identify “the big picture” in terms of the current and future health and wellbeing needs of the local population.

For several years in Brighton and Hove the Primary Care Trust and City Council have developed a joint approach to planning and delivering services. This has been helped by a geographically coterritorial unitary authority and primary care trust, a series of jointly appointed posts across health and social care and a lot of good will to do things better together.

Since 2004 the Annual Report of the Director of Public Health has been produced jointly by the Primary Care Trust and City Council. Extending this approach, a joint steering group was established in 2009 to oversee the development of JSNA in the city.

An ongoing rolling programme of themed JSNA chapters is now being taken forward. These chapters will form part of a JSNA portfolio of needs assessment resources.

Chapters may relate to health needs, e.g. mental health and wellbeing, or population groups, e.g. children and young people. JSNA chapters will include recommendations to inform service commissioning and will be produced typically every three years. A complementary data profile will also be produced that will be updated as new data become available.

Each year, a JSNA summary setting out the main health and wellbeing needs of the city will be published. It is intended to inform the development of strategic planning (for example, the PCT Strategic Commissioning Plan) and identification of local priorities (for example, to influence the Local Area Agreement and Children and Young People’s Plan).

Throughout this summary Brighton and Hove Local Area Agreement targets relating to the needs identified in this document are highlighted (LAA).

An online JSNA resource is being launched within the Brighton and Hove Local Information Service (BHLIS) (available at www.bhlis.org from early 2010) and will be expanded as the JSNA portfolio develops.
Local people, local health needs

Brighton and Hove city is located between the sea and the South Downs. It is known for its easy-going approach to life, quirky shopping, restaurants, festivals and beautiful architecture. Many people choose to come and live in the city for the opportunities it offers.\(^1\)

However, there are significant health and health inequality issues within the city.

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

This summary gives an overview of Brighton and Hove’s population, its health needs and where we are in relation to the health and health inequality priorities for the city.

The information is primarily drawn from the Joint Strategic Needs Assessment (JSNA) portfolio which includes the last five Annual Reports of the Director of Public Health, the Local Area Agreement, along with specific Joint Strategic Needs Assessments such as the Children and Young People’s JSNA 2008\(^2\) as well as the Children and Young People’s Plan (2009-12), the Community Strategy and the Housing Strategy.

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

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\(^1\) Community Strategy


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On average, every day in Brighton and Hove:
Nine babies are born;
Around 3,400 people visit their GP;
69 people are admitted to hospital as an emergency and;
Six people die
Population demographics and health need

Brighton and Hove is one of the most deprived areas in the South East. This, together with a relatively large proportion of younger adults, results in a population with significant health needs and inequalities.

Particular challenges are high teenage pregnancy rates, high rates of sexually transmitted infections, high levels of alcohol and drug related morbidity and mortality, high levels of mental health problems, widening inequalities in life expectancy and cancer and cardiovascular diseases.

Encouraging healthy lifestyles through reducing smoking and hazardous and harmful drinking together with promoting exercise and healthy eating will help to address some of these issues.

It has been estimated that the NHS can only contribute 8% to any increase in life expectancy and that other factors; the broader determinants of health, such as education, employment and housing have a greater impact. Some of the major socio-economic problems in the city are the levels of young people not in education, employment or training, sections of the population with low skills, the number of people claiming incapacity benefit and high numbers of children in households with no working adults.

Local demographic trends

Brighton and Hove has an unusual population distribution compared with the national picture. There are relatively large numbers of people aged 20 to 44 years, with relatively fewer children aged less than 15 years and older people. However, it is important to note that there are relatively more very elderly people (aged 85 years or over), particularly women, who are likely to have increased needs for services.

Total population

The resident population of Brighton and Hove has risen from 248,300 people in 2003 to 256,600 in 2008 (an increase of 3%) according to the Office for National Statistics (ONS) mid-year estimates.

Age

The 2008 mid-year estimates showed that Brighton and Hove has 21.1% of the population aged 19 years or under, 64.6% of the population aged between 20 and 64 and 14.2% of the population aged 65 years or over. This compares to 24.2%, 59.0% and 16.7% respectively in the South East and England figures of 24.0%, 59.9% and 16.1%.

The population of Brighton and Hove is therefore younger than in the South East and England.

Ward level population

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

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3 South East Coast SHA Health Inequality Strategy
5 ONS mid year estimates.
6 Office for National Statistics from ChiMat (Child and Maternal Health Observatory)
Older people (aged 65 years or over) live across all areas of the city however, a larger percentage of older people reside in Westbourne (23.8%), Central Hove (21.8%) and Rottingdean Coastal (25.3%), Wish (21.2%) and Goldsmid (20.6%).

Fertile female population

Data from the Office for National Statistics (ONS) shows that there were 62,600 women of child bearing age (15 - 44 years) in Brighton and Hove in 2008, representing 48% of the total female population. This compares to 40% in England and 39% in the South East.

LGBT

The city is known for its lesbian, gay, bisexual and transgender (LGBT) community, estimated to be about 1 in 6 people in the city. Sections of the LGBT communities are at increased risk of mental illness and sexually transmitted infections, including HIV, and are more likely to be smokers and to drink above the recommended “safe levels” of alcohol.

Students

With two Universities, the city hosts approximately 32,000 students, many of whom stay on after university.

Migration

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

Ethnic groups

At the time of the 2001 Census 94% of the Brighton and Hove population were from White groups compared with 91% nationally. More recent estimates produced for 2007 suggest that the local picture is changing with decreases in the White British and White Irish population but increases in all other ethnic groups.

These changes are important as different ethnic groups experience different disease patterns. For example Asian as well as Black African and Caribbean populations are at increased risk of cardiovascular disease and diabetes.

The age structure of the Black and Minority Ethnic (BME) population is considerably younger than the White British population; 26.3% of the BME population in Brighton and Hove is aged 0-19 years and 21.2% of the White British population.

In 2005, using the ONS mid year estimates, people from BME groups made up 8% of the entire population of Brighton & Hove. There were 826 people from BME groups aged 50 years and over compared with 670 in 2001.

General fertility rate

The general fertility rate (GFR) is the number of live births per 1,000 females aged 15-44 years. The general fertility rate in Brighton and Hove is lower than that of England.

In 2008 Brighton and Hove had a general fertility rate of 53.6 live births per 1,000 women aged 15-44, an increase from 2007 (50.6 per 1,000). This is compared to the national figure of 63.6 per 1,000 in 2008 and 62.5 across the South East.

Table 1 shows the trend in the GFR in Brighton and Hove from 2004 to 2008.

Table 1: Change in fertility rates (rate per 1000 15-44 female population)

<table>
<thead>
<tr>
<th>Year</th>
<th>Brighton and Hove</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>47.7</td>
</tr>
<tr>
<td>2005</td>
<td>49.0</td>
</tr>
<tr>
<td>2006</td>
<td>52.1</td>
</tr>
<tr>
<td>2007</td>
<td>50.6</td>
</tr>
<tr>
<td>2008</td>
<td>53.6</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics

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7 Older People’s Profile & Needs Assessment (A Part of the Joint Strategic Needs Assessment 2008)

Rates are lower in the younger age groups and higher in the older age groups (particularly the 35-39 year old band) than in the South East and nationally.

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

**Births**

In England and Wales the number of live births has been increasing since 2001 and is now at the highest level since 1972 (725,440 live births in 2008).

Births have also been increasing over recent years in Brighton and Hove from 3,035 births to resident mothers in 2005 to 3,303 in 2008 – almost 300 more births per year in the city.

Nationally, there was a continued rise in the proportion of births to mothers born outside the UK: 24 per cent in 2008 compared with 23 per cent in 2007. In 1998, 14 per cent of births were to non-UK born mothers.  

Between 2000 and 2007, the number of births per year varied from ward to ward. Consistent increases were seen predominantly in the wards along the coastal strip in the west of the city: Regency, Brunswick and Adelaide, Central Hove, Goldsmid and Wish. In 2007 the ward with the lowest number of births was Rottingdean Coastal (100) and the highest was Preston Park (225). Other wards with high rates were Goldsmid (210), Hanover and Elm Grove (199), St Peters and North Laine (202).

**Population projections**

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

The resident population is predicted to increase from 256,600 in 2008 to 259,500 in five years and 265,700 in ten years (a 3.5% increase).  

The greatest predicted increase will be seen in the 45 to 54 year age group. The population of younger adults will continue to increase, but there will also be increased numbers of younger children. The number of people aged 75 years or over is expected to fall (Figure 1).

Understanding the likely changes in birth rates is important in understanding population change and for anticipating the future need for maternity and child health services. Important factors determining the number of births in an area include the fertile female population and general fertility rates.

**Fertile female population projections**

The fertile female population is projected to rise over the next decade by 5.0%, compared to a fall of 2.3% in England and a 2.6% fall in the South East.

**Projected births**

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

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9 Office for National Statistics  
http://www.statistics.gov.uk/cci/nugget.asp?id=369

10 ONS Sub national population projections, 2006 based.
Table 2 shows the estimated number of births for Brighton and Hove from 2008 to 2031, alongside the percentage change over the period for the South East and England.

Table 2: Projected number of births Brighton and Hove 2008 - 2031

<table>
<thead>
<tr>
<th>Year</th>
<th>Projected number of births</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>3,300</td>
</tr>
<tr>
<td>2011</td>
<td>3,300</td>
</tr>
<tr>
<td>2021</td>
<td>3,300</td>
</tr>
<tr>
<td>2031</td>
<td>3,300</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics

In Brighton and Hove the number of births per year is projected to remain stable at 3,300 births per year, this is compared to a projected 3.3% increase in the South East and a 3.8% increase in England by 2011.

However the trend for women to postpone having their first child until later appears to be particularly marked in Brighton and Hove. A third of all births are to women aged 30-34 years and a quarter to those aged 35-39 years. Over the next ten years, the proportion of 20-34 year old females is predicted to increase whilst the proportion of 35-44 year old, and also 15-19 year old, females is predicted to decrease. Hence the recent increases seen in the number of births may slow down without continued internal or external migration.

Figure 1: Population pyramid for Brighton and Hove - 2008 mid-year estimate and 2018 population projection

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

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

The Index of Multiple Deprivation 2007 identifies Brighton and Hove as the 79th most deprived authority in England (out of 354).

The distribution of the most deprived the city is very similar to England; 9% of all Lower Super Output Areas (LSOAs) in the city fall within the 10% most deprived LSOAs in England and 5% of LSOAs (eight of 164 in the city) fall in the 5% most deprived in England. Map 1 shows that most of the deprived areas are in the east of the city.

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

The published Child Wellbeing rankings show the rank of 1 as the least deprived – for comparability with IMD and ease of understanding the ranking has been reversed here so that 1 is the most deprived area.

In February 2009 the Department of Communities and Local Government released the Child Wellbeing Index (CWI) at local authority and lower super output area (LSOA) level.

The index uses the methodology and approach applied in the Indices of Multiple Deprivation (IMD). It is an index of child wellbeing rather than an index of deprivation, mainly because it contains variables that are not strictly related to deprivation. Child wellbeing is generally represented by how children are doing in a number of different domains of their life including material well-being, health, education, crime, housing, environment and children in need.

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

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11 Department for Communities and Local Government, 2007
http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/

12 Department for Communities and Local Government, 2009

13 The published Child Wellbeing rankings show the rank of 1 as the least deprived – for comparability with IMD and ease of understanding the ranking has been reversed here so that 1 is the most deprived area.
Map 1: Brighton and Hove Index of Multiple Deprivation 2007 Super Output Areas ranking in England

Source: Department for Communities and Local Government (DCLG), 2007
Map 2: Brighton and Hove Child Wellbeing Index 2009 Super Output Areas ranking in England

Note: The Child Wellbeing Index (CWI) is made up from 7 'domains', one being Health, all given an equal weight. In this map quintile 1 shows the SOAs in BH which fall within those that have the lowest level of wellbeing in England.

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

Analysis of the MOSAIC Public Sector dataset\textsuperscript{14} reveals that there are a number of dominant groups in Brighton and Hove – in particular:

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

These four groups comprise over 70% of households in Brighton and Hove; 34%, 15%, 13% and 10% respectively (Table 3, see Appendix 1 for full breakdown). This is considerably different to the profile for England.

The dominant groups are located within particular areas of the city with Groups E and F being concentrated centrally within the city; Group C has concentrations around Portslade, Patcham, Woodingdean, Preston Park, Hangleton and Knoll, and Wish; whilst Group J is more spread but with clusters in Rottingdean Coastal, Central, Hangleton and Knoll and Westbourne wards. Appendix 2 contains maps for each MOSAIC group with the exception of Group K (people living in rural areas far from urbanisation) to which only 0.02% of Brighton and Hove’s households belong.

\textsuperscript{14} MOSAIC Public Sector is a geodemographic dataset describing the UK population in terms of demographic, social, economic, lifestyle and behaviour factors. [http://publicsector.experian.co.uk/Products/~/media/Brochures/MosaicPublicSector_Brochure_051109A.ashx](http://publicsector.experian.co.uk/Products/~/media/Brochures/MosaicPublicSector_Brochure_051109A.ashx)

HealthAcorn\textsuperscript{15} is a classification of Census output areas using indicators of existing health, lifestyle and food consumption which relate to current and future health. The classification segments the population into four major groups:

- **Existing problems** - High levels of serious illness and poor diet and consumption patterns.
- **Future problems** - High levels of severely unhealthy lifestyles likely to lead to serious illness.
- **Possible future concerns** - Generally good health but with some potentially unhealthy lifestyle traits.
- **Healthy** - Good health with few lifestyle issues.

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

\textsuperscript{15} Health Acorn [http://www.caci.co.uk/ACORN/healthacorn.asp](http://www.caci.co.uk/ACORN/healthacorn.asp)
<table>
<thead>
<tr>
<th>Mosaic Profile</th>
<th>Brighton and Hove</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of households</td>
<td>% of households</td>
</tr>
<tr>
<td>Career professionals living in sought after locations</td>
<td>7,817</td>
<td>6.4</td>
</tr>
<tr>
<td>Younger families living in newer homes</td>
<td>3,184</td>
<td>2.6</td>
</tr>
<tr>
<td>Older families living in suburbia</td>
<td>15,412</td>
<td>12.7</td>
</tr>
<tr>
<td>Close-knit, inner city and manufacturing town communities</td>
<td>7,630</td>
<td>6.3</td>
</tr>
<tr>
<td>Educated, young, single people living in areas of transient populations</td>
<td>41,575</td>
<td>34.2</td>
</tr>
<tr>
<td>People living in social housing with uncertain employment in deprived areas</td>
<td>12,244</td>
<td>10.1</td>
</tr>
<tr>
<td>Low income families living in estate based social housing</td>
<td>3,955</td>
<td>3.3</td>
</tr>
<tr>
<td>Upwardly mobile families living in homes bought from social landlords</td>
<td>8,493</td>
<td>7.0</td>
</tr>
<tr>
<td>Older people living in social housing with high care needs</td>
<td>2,982</td>
<td>2.5</td>
</tr>
<tr>
<td>Independent older people with relatively active lifestyles</td>
<td>18,121</td>
<td>14.9</td>
</tr>
<tr>
<td>People living in rural areas far from urbanisation</td>
<td>23</td>
<td>0.02</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>121,436</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: MOSAIC

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

![HealthAcorn groups for Brighton and Hove](image)

Source: HealthAcorn
Wider determinants of health

Employment

The employment rate in Brighton and Hove between April 2008 and March 2009 was 73.7% of people of working age, similar to the national rate of 73.9% but lower than in the South East 78.6% (Figure 3). The large university population is likely to deflate the overall employment rate. Employment rates by gender are similar in the city; 74% for males and 73% for females. The gender split is much more pronounced in the South East with 83% of males and 74% of females in employment. The female employment rate in Brighton and Hove is higher than nationally (70%), but the male rate is lower (78%).

There were 27,350 people of working age in the city claiming one or more Department for Work and Pensions benefits in May 2009. This was 13% higher than in May 2008, with the majority of the increase explained by more people receiving Job Seekers Allowance (JSA). A quarter of all working age benefits recipients in May 2009 were for Job Seekers Allowance (JSA) and 48% were for Employment and Support Allowance (ESA) or Incapacity Benefit. An overall rate of 8% of the working age population in Brighton and Hove compared with 5% in the South East and 7% in Great Britain.

The number of long-term JSA claimants has also increased.

The number of individuals receiving JSA for more than 12 months fell between 2006 and 2008. However this trend has now reversed and the number of long term claimants increased from 820 in July 2008 to 1205 in October 2009.

There were 3,050 lone parents claiming Income Support in Brighton and Hove in May 2009; 1.8% of the working-age population, similar to the South East and Great Britain. There has been a small decline in the last year (3,250 in May 2008) and a larger decline from 4,000 in May 2002.

In Brighton and Hove, 11,000 (23%) of children live in households where all adults are not in paid employment, compared to 15% in the South East and 20% in England. In seven Lower Super Output Areas (LSOAs) across Brighton and Hove more than half of all children live in families with all adults out of work. In the LSOAs which are among the 20% most deprived in England, over 45% of children live in families where both parents and carers are out of work; all of these LSOAs are located in the east of the city in East Brighton, Moulsecoomb, Bevendean, Hollingbury, Stanmer Park and Queen’s Park wards.

Income

In 2008 the gross median weekly pay for full time resident workers in the city was £514.30, which was lower than in the South East (£523.20) but higher than Great Britain (£479.30). Gross weekly pay has risen consistently in recent years (Table 4).

Just under a quarter of all children in Brighton and Hove live in low income households.

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16 ONS annual population survey available at https://www.nomisweb.co.uk/reports/lmp/l a/2038431760/report.aspx?town=brighton
17 DWP benefit claimants - working age client group
18 Employment and Support Allowance replaced Incapacity Benefit and Income Support, paid because of an illness or disability, for new claims from 27 October 2008.
19 ONS claimant count - age and duration
20 OSCI, 2007
21 ONS annual survey of hours and earnings - resident analysis
22 OCSI, 2007
Figure 3: Employment rate (moving average) in Brighton and Hove, South East and Great Britain, January-December 2005 to April 2008-March 2009

All people - Economically active - In employment Brighton and Hove, South East and Great Britain
Jan-Dec 05 to Apr 08-Mar 09

Source: ONS annual population survey

Table 4: Gross Weekly Pay - All Full Time Workers, Brighton and Hove 2002-2008

<table>
<thead>
<tr>
<th>Year</th>
<th>Brighton and Hove (£)</th>
<th>South East (£)</th>
<th>Great Britain (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>410.5</td>
<td>435.1</td>
<td>392.7</td>
</tr>
<tr>
<td>2003</td>
<td>420.6</td>
<td>451.0</td>
<td>406.2</td>
</tr>
<tr>
<td>2004</td>
<td>425.4</td>
<td>461.8</td>
<td>421.3</td>
</tr>
<tr>
<td>2005</td>
<td>421.6</td>
<td>468.9</td>
<td>432.8</td>
</tr>
<tr>
<td>2006</td>
<td>459.5</td>
<td>486.5</td>
<td>445.9</td>
</tr>
<tr>
<td>2007</td>
<td>481.0</td>
<td>502.3</td>
<td>460.0</td>
</tr>
<tr>
<td>2008</td>
<td>514.3</td>
<td>523.2</td>
<td>479.3</td>
</tr>
</tbody>
</table>

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

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

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

Residents of the city live in 120,000 homes. Brighton and Hove has a lower proportion of owner occupied dwellings (62% compared to 71% for England) but a significantly higher proportion in the privately rented sector (23% compared to 11% in England). This is the 6th largest privately rented sector in the country and it is estimated that around 22% of dwellings in the city are privately rented, double the proportion found across the South East region and nationally.

There are 18,800 social housing dwellings in the city, making up 15% of all dwellings (Table 5).

A study by the Oxford Consultants for Social Inclusion (OSCI) in 2007 found Brighton and Hove to be the 11th most deprived district in the country in relation to access to owner occupation due to insufficient income.

Overall, around 36% of the city’s housing stock is considered to be non-decent. The highest proportion of non-decent housing is in the council housing stock. However, 85% of non-decent homes are in the private sector, outnumbering non-decent council homes by five to one (Figure 4).

The result of this is that many more vulnerable people, particularly those on lower incomes are privately renting. 42.5% of all vulnerable households in the private sector are living in non-decent accommodation according to the 2008 Private Sector Stock Condition Survey.

Table 5: Housing tenure, Brighton and Hove

<table>
<thead>
<tr>
<th>Tenure</th>
<th>Dwellings</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owner occupied</td>
<td>75,800</td>
<td>62%</td>
</tr>
<tr>
<td>Privately Rented</td>
<td>28,300</td>
<td>23%</td>
</tr>
<tr>
<td><strong>Private Sector Stock</strong></td>
<td><strong>104,100</strong></td>
<td><strong>85%</strong></td>
</tr>
<tr>
<td>Housing</td>
<td>6,300</td>
<td>5%</td>
</tr>
<tr>
<td>Association (RSL)</td>
<td>12,500</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Social Housing</strong></td>
<td><strong>18,800</strong></td>
<td><strong>15%</strong></td>
</tr>
<tr>
<td><strong>All Tenures</strong></td>
<td><strong>122,900</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: 2007 House Condition Survey

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23 Most of this section of the JSNA summary is taken from the Brighton and Hove Housing Strategy 2009-2014 www.brighton-hove.gov.uk/housingstrategy


Homelessness

In Brighton and Hove more than half of all homelessness acceptances involve families with children or a member of the household who is pregnant, although levels in these groups are lower than the national average. A large proportion of homeless young people are not in education, employment or training (NEET) and care leavers are over-represented in the homeless population.

Not in education, employment or training (NEET)

Being NEET between the ages of 16–18 is a major predictor of later unemployment, low income, teenage motherhood, depression and poor physical health. At 5.2%, the proportion of 16 year olds NEET is at its lowest level for more than a decade. The proportion of 18 year olds NEET rose by 2.4 percentage points to 16.6%. This caused the overall proportion of 16–18 year olds NEET to rise by 0.7 percentage points to 10.3%.

From 2006 the proportion of 16-18 year olds NEET in Brighton and Hove has fallen from 10.9% to 7.8% in 2008 (from 710 to 590 young people). In November 2009 this had risen to 8.9%.

In Brighton and Hove the NEET rate for 16 year olds is 5.5%, for 17 year olds 8.1% and for 18 year olds 13.0%.

Education

In 2007/08, 59.5% of pupils achieved 5 or more A* to C grades at GCSE, up from 54.7% in 2005/6 but well below the national average (64.8%). The gap in achievement of 5 A*-C at GCSE including English and Maths between pupils with special educational needs and the rest widened to 47.3% in 2007/8 (from 43.4% the previous year) which is above the national average but in line with benchmark authorities. The gap has narrowed to 43.8% in 2008/09.

The gap in achievement of 5 A*-C at GCSE including English and Maths between those receiving free school meals and the rest increased from 26.7% in 2006/7 to 30.4% in 2007/8 and is now above the national average but in line with benchmark authorities. This narrowed to 26.0% in 2008/09.

Very few looked after children achieve five good GCSEs and this is the case across the country. In 2008 40.9% of children in care achieved 5 or more GCSEs at grades A*-G as against 90.0% of pupils in the local authority as a whole, representing a gap of 49.1 percentage points. For 2009 39.5% of children in care achieved this measure compared to 91.4% of pupils overall, which is a difference of 51.9 percentage points. Therefore the gap has widened slightly since 2008.

Qualifications

Recent figures from the Annual Population Survey suggest 8.2% of the working age population have no qualifications, lower than the national percentage (Great Britain 12.4%) and the South East (8.9%).

In 2008, 76% of the city’s 19-year-olds achieved a level 2 qualification, up from 68% in 2006 and significantly higher than national and benchmark data. Additionally in 2008 52% achieved a level 3 qualification compared to 46% in 2006, much higher than the national rate and benchmark authorities, also of 45%.

26 Brighton and Hove Homelessness Strategy 2008-2013
27 Department for Children, Schools and Families (DCSF)
http://www.dcsf.gov.uk/14-19/index.cfm?go=site.home&sid=42&pid=343&ctype=None&ptype=Contents
28 A child or young person is ‘looked after’ if they are cared for by the local authority either under Section 20 or Section 31 of the Children Act 1989.
29 ONS annual population survey
Life expectancy and all age all cause mortality

Life expectancy in Brighton and Hove is 76.6 years for males and 82.5 for females (2006-08). Whilst females in the city can expect to live on average six months longer than nationally, life expectancy for males is over a year lower than in England (77.9 years), though PCT figures compare well with to its ONS cluster.  

The slope index of inequality in life expectancy between the most deprived and least deprived areas in the PCT is 10.1 years for males and 6.2 years for females for 2004-2008. For females in the most deprived 10% of Lower Super Output Areas (LSOAs) in the city life expectancy is 79.2 years compared with 84.0 years in the least deprived 10% of LSOAs, the equivalent figures for males are 70.8 and 80.7 years respectively (Figure 5 and 6). For males this gap is almost two years wider than nationally, though not statistically significantly different.

The national Health Inequalities Intervention Tool produced by the London Health Observatory gives the contribution of specific causes of death to the life expectancy gap between the most deprived quintile in Brighton and Hove and the national average (Figure 7). For men, the biggest contributor to the gap is coronary heart disease, followed closely by lung cancer, chronic cirrhosis of the liver, suicide and undetermined injury, and other accidents. For women coronary heart disease and other cardiovascular disease are the biggest contributors to the life expectancy gap, followed by lung cancer, other cancers, and suicide and undetermined injury.

The South East Health Inequalities Gap Measurement Tool, produced by the South East Public Health Observatory (SEPHO), shows the trend in All Age All Cause Mortality rates from 2001 to 2007, with projected rates for 2008 to 2010 by quintiles of deprivation within the city (Figure 8). Whilst mortality rates are falling in all groups, they are falling at a faster rate in the least deprived quintile and so inequalities are widening. It is projected that they will continue to widen without focused intervention in the more deprived groups.

30 Brighton and Hove PCT belongs to a cluster of PCTs described as Regional Centres, which includes Newcastle PCT, Plymouth Teaching PCT, Salford PCT, Portsmouth City Teaching PCT, Southampton City PCT, Leeds PCT, Sheffield PCT, Liverpool PCT, Bristol PCT. http://www.statistics.gov.uk/about/methodology_by_theme/area_classification/ha/default.asp
31 The SII is a single score which represents the gap in years of life expectancy between the best-off and worst-off within the PCT, based on a statistical analysis of the relationship between life expectancy and deprivation scores across the whole PCT.
32 The slope index of inequality based upon quintiles of Lower Super Output Areas

33 http://www.lho.org.uk/LHO_Topics/AnalyticTools/HealthInequalitiesTool.aspx
34http://www.sepho.org.uk/viewResource.aspx?id=10985
Figure 5: Life Expectancy by deprivation deciles, showing the Slope Index of Inequality, Brighton and Hove PCT, Males, 2003-07
Slope Index of Inequality = 10.1 years (95% confidence interval: 8.1 to 12.0)

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

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

Figure 6: Life Expectancy by deprivation deciles, showing the Slope Index of Inequality
Brighton and Hove PCT, Females, 2003-07
Slope Index of Inequality = 6.2 years (95% confidence interval: 4.1 to 8.3)

Source: APHO using ONS death registration data and mid-year population estimates & IMD 2007.
Figure 7: Contribution of specific causes of death to the life expectancy gap between the most deprived quintile in Brighton and Hove and the national average

Source: London Health Observatory

Figure 8: Trend in All Age All Cause Mortality rates, 2001 to 2007 and projected rates for 2008 to 2010 by quintiles of deprivation – Brighton and Hove.

Source: South East Public Health Observatory
Interventions to reduce inequalities

The Department of Health (DH 2007) has identified the key interventions for reducing the gap in life expectancy between the most and least disadvantaged PCTs. These are relevant to reducing health inequalities within Brighton and Hove. The specific interventions to consider include:

- Greatly increasing the capacity of smoking cessation clinics
- Increasing the coverage of effective therapies for secondary prevention of cardiovascular diseases in people aged less than 75 years
- Primary prevention of cardiovascular disease (all ages) and hypertension through treatment with antihypertensives and statins.
- The early detection of cancer and
- Interventions aimed at reducing mortality from respiratory diseases, alcohol related diseases and reducing infant mortality.

Health England Leading Prioritisation (H.E.L.P.)35 provides information on the cost-effectiveness, impact on health inequalities, and reach36 of interventions to support the prioritisation of investments in preventative health care.

Matrix for Health England is a pilot project undertaken for Health England. The aim of the project was to develop and demonstrate a prioritisation method to inform investment in preventative health interventions. The results for Brighton and Hove PCT are shown in Table 6.

The Health Inequalities Steering Group across Brighton and Hove PCT and City Council is conducting a review of action underway to reduce health inequalities in the city in order to provide a strategic steer for the development and delivery of the Health Inequalities work programme in Brighton & Hove. This review will draw on this analysis, and other local and national evidence including that from the National Institute of Health and Clinical Excellence (NICE), in order to update the Brighton and Hove Health Inequalities Strategy.

36 the percentage of the population affected
<table>
<thead>
<tr>
<th>Category</th>
<th>Intervention</th>
<th>Priority ranking</th>
<th>Priority score</th>
<th>Affordability</th>
<th>Certainty</th>
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<tr>
<td>Alcohol</td>
<td>Increases in taxation to reduce population consumption of alcohol</td>
<td>1</td>
<td>11.30%</td>
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<tr>
<td>Smoking</td>
<td>Increases in taxation to reduce population smoking rates</td>
<td>2</td>
<td>9.62%</td>
<td>★★★★</td>
<td>★★★★☆☆☆☆☆☆</td>
</tr>
<tr>
<td>Smoking</td>
<td>National mass media campaigns for reducing population smoking rates</td>
<td>3</td>
<td>9.46%</td>
<td>★★★★</td>
<td>★★★★☆☆☆☆☆☆</td>
</tr>
<tr>
<td>Diet, physical activity, obesity</td>
<td>National mass media campaigns to reduce population levels of obesity</td>
<td>4</td>
<td>9.10%</td>
<td>★★★★</td>
<td>★★★★☆☆☆☆☆☆</td>
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<tr>
<td>Smoking</td>
<td>Brief interventions delivered in GP surgeries to improve quit rates</td>
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<td>8.98%</td>
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<td>★★★★☆☆☆☆☆☆</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Brief interventions delivered in GP surgeries to reduce problem drinking</td>
<td>6</td>
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<td>Diet, physical activity, obesity</td>
<td>Brief interventions delivered in GP surgeries to improve uptake of physical activity</td>
<td>7</td>
<td>8.62%</td>
<td>★★★★</td>
<td>★★★★☆☆☆☆☆☆</td>
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<tr>
<td>Smoking</td>
<td>Nicotine replacement therapy to improve quit rates</td>
<td>8</td>
<td>8.25%</td>
<td>★★★★</td>
<td>★★★★☆☆☆☆☆☆</td>
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<tr>
<td>STI / teenage pregnancy</td>
<td>Screening and treatment for reducing the prevalence of Chlamydia</td>
<td>9</td>
<td>7.38%</td>
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<td>★★★★☆☆☆☆☆☆</td>
</tr>
<tr>
<td>Diet, physical activity, obesity</td>
<td>School based group education to reduce population levels of obesity</td>
<td>10</td>
<td>7.25%</td>
<td>★★★★</td>
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<tr>
<td>STI / teenage pregnancy</td>
<td>School based group education for increasing rates of condom use and reducing sexually transmitted infections (STIs) and unwanted pregnancy</td>
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<td>6.00%</td>
<td>★★★★</td>
<td>★★★★☆☆☆☆☆☆</td>
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<tr>
<td>Statins</td>
<td>Statins for primary prevention of stroke and heart disease</td>
<td>12</td>
<td>4.26%</td>
<td>★★★★</td>
<td>★★★★☆☆☆☆☆☆</td>
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<tr>
<td>Mental health</td>
<td>Assessment and support of caregivers for preventing depression in caregivers</td>
<td>13</td>
<td>0.95%</td>
<td>★★★★</td>
<td>★★★★☆☆☆☆☆☆</td>
</tr>
<tr>
<td>Mental health</td>
<td>Screening and treatment to prevent depression in retirees (age over 65 years)</td>
<td>14</td>
<td>0.12%</td>
<td>★★★★</td>
<td>★★★★☆☆☆☆☆☆</td>
</tr>
</tbody>
</table>

Source: Matrix for Health England
Local health issues

Main causes of death

The commonest causes of death within Brighton and Hove; cancers, circulatory diseases, respiratory diseases and digestive diseases (which include liver diseases) - are similar to the South East Coast Strategic Health Authority but in Brighton and Hove mortality rates are higher for all disease groupings (Figure 9).

Figure 9: Mortality rate per 100,000 population for the total population of Brighton and Hove PCT compared with the South East Coast SHA 2003-07

Cancer

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

In Brighton and Hove, the incidence rate for all cancers is lower than the England and ONS peers rate for both males and females, and in both people of all ages and people aged less than 75 years.

The incidence rate for the four most common cancers in people under 75 years in the city is lower than the England and ONS peers. The differences are statistically significant for breast and lung cancer (the latter compared with ONS peers only).

Figure 10 shows that for cancer, the recent mortality trend for all ages in Brighton and Hove has been relatively stable.

The cancer mortality rate is higher in the more deprived areas of the city.
and the gap compared with the most affluent areas of the city is not reducing.

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

**Figure 10: Trend in Cancer Mortality rates, 2001 to 2007 and projected rates for 2008 to 2010 by quintiles of deprivation – Brighton and Hove.**


Mortality from all cancers in under 75 year olds is higher in Brighton and Hove than for England and ONS peers. The national cancer mortality target is to reduce mortality rates from cancer by at least 20% in people under 75 by 2010. Local progress shows an increase in mortality rates in this age group since 2002-04 and if the current trend continues, Brighton and Hove is unlikely to meet the 2010 target. In 2005-07 the rate of increase fell but the rate still remains high.

The uptake of screening programmes tends to be greater amongst people from higher socioeconomic groups. This is demonstrated locally by the NHS Cervical Screening Programme. Overall coverage has been falling over recent years and is now below the national target of 80%; coverage remained the same in 2008/09 as the previous year (75.1%). The coverage is particularly low for the 25-34 years age group. However, for all ages local coverage is lowest in the more disadvantaged parts of the city.

Breast screening coverage has also fallen in recent years. Between 2005/6 and 2007/8 the percentage of women aged 53 to 64 being screened within 36 months fell from 77.1% to 64.3%. Due to staffing issues, the local screening service has not been able to maintain the 36 month screening interval for women. This is being addressed and the service has moved to new premises with modern digital technology.

37 The proportion of women eligible for screening who have had a test with a recorded result at least once in the previous 5 years.
Circulatory disease

Recent estimates of prevalence produced at practice level estimate that there are 65,032 people with hypertension, 11,499 with Coronary Heart Disease (CHD) and 5,207 who have had a stroke in Brighton and Hove. These figures are all significantly higher than prevalence recorded within GP practices, which were 28,722 for hypertension, 7,130 for CHD and 3,768 for stroke in 2008/09. The estimates take into account differences between practice populations e.g. age, sex, ethnicity and social deprivation. It is important to note that discrepancies between modelled estimates and QOF disease registers may be due to local variations not captured by the model and may not be solely attributed to under-diagnosis or recording of diagnoses.

Figure 11 shows that for circulatory disease the recent trend for deaths at all ages in Brighton and Hove has been downwards. However the mortality rate is higher in the more deprived areas of the city and the gap compared with the most affluent areas of the city is not reducing. This will be considered as part of the health inequalities review and circulatory disease has been identified as a priority for Joint Strategic Needs Assessment in the coming year.

Smoking

Smoking is the greatest cause of health inequalities and premature death in the UK, killing around 106,000 people a year. Half of all those who continue to smoke for most of their lives will die of their habit, half of these before the age of 69. Smoking rates and therefore smoking related morbidity are highest in the routine/manual population group. In a local 2003 survey the number of daily smokers had fallen to 20% from 27% in 1992 with approximately 7% more people being occasional smokers. However, amongst people living in the more deprived parts of the city rates of nearly 50% were recorded from a different household survey at that time.

The Health Related Behaviour Survey (HRBS) of 14 to 15 year olds in Brighton and Hove in 2007 found that 15% of boys and 26% of girls had smoked at least one cigarette in the previous week. The national figures were 13% and 20% respectively.

During 2007/8 the local smoking cessation service helped 2,097 people to quit smoking (of 3,563 setting a quit date). In 2008/9 there was a slight reduction in the number of referrals to the service, with 3,472 people setting a quit date and 2,021 successfully quit at 4 weeks (a 58% quit rate) (Figure 12). The service is currently being reconfigured to respond to the changing needs of the local population who currently smoke.

One of the possible disadvantages of providing a specialist smoking cessation service is that it may inadvertently widen inequalities as people living in more affluent parts of the city take up the service more readily than those living elsewhere. In recent years the specialist service has seen more patients from the more deprived parts of the city, however quit rates are lower in more deprived areas of the city (Figure 13).

Source: Information Centre for Health and Social Care

Figure 12: Smoking Cessation in Brighton and Hove 2004/05 to 2008/09; Numbers setting a quit date and successfully quitting at 4 weeks

Source: NHS Brighton and Hove
**Sexual health**

Brighton and Hove has high rates of the commonest sexually transmitted infections such as chlamydia and very high rates of gonorrhoea and syphilis when compared with national rates. Nationally, gonorrhoea cases have been falling, a trend which had not been seen in Brighton over recent years; however there was a substantial fall in the number of new cases in 2008 (Figure 14).

**Figure 14: Number of new cases of the top five STIs seen at the GUM clinic in Brighton & Hove, 2000 to 2008**

![Number of new cases of the top five STIs seen at the GUM clinic in Brighton & Hove, 2000 to 2008](image)

Source: Brighton & Hove GUM clinic KC60 returns

In 2007 Brighton and Hove had the seventh highest HIV prevalence rate in England at 7.38 per 1,000 population aged 15 to 59 years (1,236 people) and the total figure for both sexes has been increasing rapidly; in December 2005 it was 1000, compared with 633 in 2001.

In 2007, in 81% of cases the probable route of transmission was sex between men. However, the increase in infections that were acquired through heterosexual sex between 2006 and 2007 was twice the increase in infections that were acquired through sex between men in the same time period.

It is estimated that one in four gay men infected with HIV are unaware of their infection. This is important not only from a prevention perspective but also for ensuring correct monitoring of disease markers to allow treatment to be started as soon as it is required.

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

During 2008/9 the local chlamydia screening programme target for 2008/9 was 6,355 screening tests completed, which is equivalent to 17% of the population aged 15-24 years – this target was exceeded as 19% of the population were screened.

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

The Tellus3 survey results (2008) indicated that the majority (58%) of year 8 and 10 pupils thought that they received enough information and advice on sex and relationships although 35% thought it could be better.

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40 Sexually Transmitted Infections and Men who have Sex with Men in the UK: 2008 Report
Teenage conceptions

Teenage pregnancy rates in Brighton and Hove remain above those nationally and regionally, but are lowest among its Department for Children Schools and Families (DCSF) statistical neighbours. The highest rates in the city are seen in the most disadvantaged areas and there is a clear association with educational achievement.

Whilst the rate of teenage conceptions in the city has fallen by 9.5% from the 1998 baseline to 2007 (Figure 15), to achieve the local 2010 target of a 45% reduction would require a significant sustained fall in the rate – equating to around 26 fewer conceptions per year.

Figure 15: Teenage conception rate\textsuperscript{41} trend, Brighton and Hove, South East and England 1997-2007 with Brighton and Hove trajectory to meet the 2010 target

Source: Teenage Pregnancy Unit, Feb 2008. (Data for 2007 are provisional)

Rates have fallen by 10.5% and 13.1% in England and the South East respectively. Among DCSF statistical neighbours, rates have changed by between -8.2% and +8.2%.

In 2007, 63% of teenage conceptions in the city resulted in a termination compared with 51% nationally, 53% in the South East and between 43% - 63% among the statistical neighbours. Furthermore, the repeat termination rate for under 19s is 15.2%.

Ward level data indicate that the needs of the young people vary across the city. East Brighton has high conception rates; central Brighton and Hove have high birth rates, particularly in the coastal wards; in the west area there are high termination rates.

There are currently 184 teenage mothers in Brighton and Hove. With around 12% of teenage mothers having a second teenage birth. A local study into the profile of local young mothers highlighted that the majority have complex needs; around 1 in 3 were subject to domestic violence, 2 in 5 were suffering from post natal depression, 1 in 5 had other mental health issues and 1 in 3 babies were subject to child protection proceedings.

Currently 25% of teenage mothers are in Education Employment or Training (EET) and we are currently off track for meeting the 60% EET target by 2010.

\textsuperscript{41} Local authorities deemed to have similar characteristics http://www.dcsf.gov.uk/rsgateway/DB/STA/t000712/index.shtml

\textsuperscript{42} Under 18 conceptions per 1,000 female population aged 15-17 years.

\textsuperscript{43} DCSF

\textsuperscript{44} Health Visitor Caseload report, 2009
Mental health

Brighton and Hove has a high Mental Health Needs Index score together with a large number of people at increased risk of mental health problems. Based on national survey data it is estimated that 25,000 people in the city aged 16 to 65 years suffer from a neurotic disorder at any one time. The most common disorder is mixed anxiety and depression. There are also estimated to be 2,000 people with bipolar disorder and 600 with schizophrenia, which is the most common cause of hospital admission for mental health problems with the longest average length of stay.

An older people’s needs assessment carried out in Brighton and Hove in 2008 found that the two types of mental health problems which affect older people the most are dementia and depression. Applying national prevalence rates to the local population suggests that there are approximately 3,000 people aged 65 years or over with dementia in Brighton and Hove – projected to increase to around 3,300 by 2025. Of these 29% will suffer from severe dementia. It is estimated that 10 to 15% of all older people suffer from depressive symptoms – equating to between 3,900 and 5,900 people in Brighton and Hove with depressive symptoms and between 400 and 2,000 people with a more severe depressive episode.

There is growing demand for psychological therapies with more people expressing a preference for talking therapies over medication. Take up/offer of talking therapies is a LAA local target.

The number of children with mental health needs is significant. Around one in ten children aged 5 to 15 years has a clinically significant mental disorder. Based on this there are estimated to be 2,800 children with a clinically significant mental disorder in Brighton and Hove. LAA NI51

Mental health issues are more likely amongst children who are looked after, adopted, on the child protection register, have learning difficulties, have suffered traumatic life events or are young offenders.

Suicide

Suicide is a devastating event; the consequences are felt by family, friends and the community. Suicide is the leading cause of death among men aged 35 years or under, and is the main cause of premature death in people with mental illness.

Brighton and Hove had the second highest suicide and undetermined injury rate in England between 2006 and 2008 (14.55 per 100,000 population) although the trend is downwards (Figure 16) LAA local

Figure 16: Suicide and Undetermined injury, Brighton and Hove and England and Wales 1995-97 to 2006-08 with trajectories to meet the 2010 target

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

Alcohol

Within Brighton and Hove alcohol misuse has been identified as a substantial and growing problem. A Joint Strategic Needs Assessment on alcohol has been published and is a step towards identifying the unmet needs in relation to alcohol, so that partners can work together in addressing these issues through the Alcohol Strategy.

In Brighton and Hove it is estimated that almost a quarter of adults (24.4%) consume alcohol at hazardous levels and a further 4.9% at levels that are harmful to their health.

In 2008/09 there were 5,149 hospital admissions for alcohol-related harm, a rate of 1,880 per 100,000 population (Figure 17). This compares average to ONS peers but the rate of increase in Brighton and Hove is 15% per year, compared with 7% for ONS peers and 8% nationally. **LAA NI39**

**Figure 17: Rate of hospital admissions per 100,000 for alcohol related harm 2008/09**

Findings from the Health Related Behaviour Surveys (HRBS) indicates that the number of young people aged 14 to 15 years reporting drinking in the previous 7 days has fallen by 7%, from 56% to 49% between 1999 and 2007.

The average reported consumption (units) of alcohol had also fallen during this period. However, the proportion of young people reporting that they consumed more than 28 units in the past 7 days increased by 3%.

Brighton and Hove has a higher level of male alcohol-specific mortality than its comparator local authorities46, except for Bournemouth and Blackpool. Male mortality from chronic liver disease including cirrhosis is double the England average and higher than the regional average. It is also higher than its comparator local authorities but saw a decrease between 2001-03 and 2002-04. In 2004-05 rates in Brighton and Hove remained higher than its comparators.

A 2007 systematic review by the National Institute for Mental Health in England found an increased relative risk of alcohol dependence in lesbian, gay and bisexual groups of at least 1.5 times higher than the heterosexual population. The relative risk for substance misuse was also increased.

46 There are different comparators used for PCTs and Local Authorities. For Local Authorities the Brighton and Hove’s cluster group contains Bournemouth, Cheltenham, Bristol, Hastings, Eastbourne, Southampton, Portsmouth and Blackpool.
Substance misuse
Brighton and Hove local authority had the highest rate of drug related deaths per 100,000 population aged 16 and over in 2008 (20.7 deaths per 100,000), the same rate as in the previous year. Table 7 shows the annual number and rate of drug related deaths in the city. Heroin or Morphine and alcohol were implicated in a significant number of the deaths.

Table 7: Number of drug related deaths in Brighton & Hove 2000-2008

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<td>67</td>
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<td>2008</td>
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</tr>
</tbody>
</table>

Source: Source: National Programme on Substance Abuse Deaths

Brighton and Hove has the highest rate of problem drug users (opiates and/or the use of crack cocaine) in the South East and the 17th highest of the 149 Drug Action Teams (DATs) in England. Approximately 2% of the local working age population (2,305 individuals) are injecting drug users. The target for the number of drug users in effective treatment for 2008/09 was exceeded within eight months.

Findings from the ‘Tellus’ surveys indicate that drug use amongst those aged 10 to 14 years has fallen. This is corroborated by findings from the Health Related Behaviour Survey (1999-2007), which indicate that 30% of those sampled (aged 14-15 years) had used cannabis in 2007 compared with 33% in 2004.

However, there still appear to be higher levels of drug use amongst young people in the city than those nationally: 2008 data from the ‘Tellus’ survey shows that 15% of those sampled had ever taken drugs compared with 11% in England.

Experimentation with drugs and alcohol is not uncommon amongst young people. Data from the ‘Tellus3’ survey (2008) indicates that 13.7% of young people who participated in the survey in Brighton and Hove had either been drunk or taken drugs or solvents at least twice in the past four weeks, or had been drunk and experimented with drugs at least once in their lives. These findings place Brighton and Hove in the top quartile of local authorities, ranked 26 highest out of 150.

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

**Childhood obesity**

Obesity is an increasing concern both for adults and children. Being overweight or obese increases the risk of diabetes, hypertension, heart disease and cancer amongst other diseases. Applying estimates from the Health Survey for England 2007 to the local population there would be almost 14,000 children and young people aged less than 20 years who are overweight or obese in Brighton and Hove.

As part of the National Child Measurement Programme (NCMP), reception (4-5 year olds) and Year Six pupils (10-11 year olds) are weighed and measured each year. In the 2008/09 academic year 89.5% of Year Six pupils were measured as part of the programme and the obesity prevalence was 16.4% (95% confidence interval 14.8%-18.6%). Brighton and Hove had a lower prevalence than nationally (18.3% in 2008/09). The figure is lower than in the 2007/08 academic year (17.7%), but the difference is not significantly significant.

Local analysis has shown clear associations between the prevalence of overweight and obesity with various deprivation measures including the Index of Multiple Deprivation (IMD), the Income Deprivation Affecting Children Index (IDACI) and the Child Well-being Index (CWI) as well as eligibility for free school meals.

Despite wide confidence limits there is significant variation in the proportion of overweight or obese children across the city; Moulsecoomb, Bevendean & Coldean Children’s Centre area has a statistically significant higher prevalence and Preston Park, and Knoll and Stanford Children’s Centre areas have statistically significant lower prevalences (Figure 18).

**Figure 18: Percentage of children overweight or obese by Children’s Centre Area in Brighton and Hove, 2008/09**

Source: National Child Measurement Programme

Using MOSAIC population segmentation, children from groups described as “Ties of Community” and “Blue Collar Enterprise” has significantly higher rates. Encouragingly the latest Health Related Behaviour Survey found that the eating habits of children aged 10-14 are improving as are the levels of physical activity.

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

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48 Ties of Community: People living in close-knit inner city and manufacturing town communities, responsible workers with unsophisticated tastes.

Blue Collar Enterprise: People who though not well-educated are practical and enterprising and may well have exercised their right to buy.
Long term conditions

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

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

In 2008/9 around 700 patients were admitted as an emergency four or more times, and accounted for over 3,700 hospital admissions. More than 40 people had ten or more emergency admissions. ⁴⁹

In Brighton & Hove, there were 538 admissions due to asthma and diabetes during the 2007/8 financial year (217 per 100,000 population). Many of these admissions are potentially avoidable, as these conditions could be managed in primary care. ⁵⁰

In the city over half (52.3%) of older people reported a limiting long term illness which interferes with their daily living. ⁵⁰

A total of 14,326 (18.5%) people aged 50 and over thought that they were not in good health at the time of the 2001 Census. ⁴⁹

According to the 2001 Census, 18.0% of the total population of Brighton and Hove and 38.9% of older people reported having a limiting long term illness as is shown in Figure 19.

Figure 19: Limiting long-term illness by age and gender, Brighton and Hove, 2001

Source: Census 2001, ONS

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

In the more deprived areas of the city, the percentage of people living with a limiting long term illness increases to around 23%.

According to disease registers maintained by GPs, the proportion of people diagnosed with long term conditions is generally lower in the central locality. The prevalence of stroke/transient ischaemic attack (TIA), hypertension, dementia, depression and chronic kidney disease is highest in the west. This may be due to the higher proportion of older people in this locality. The prevalence of CHD, diabetes, COPD, asthma and heart failure is highest in the east. ⁵¹ The high prevalence of COPD, asthma and

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⁴⁹ Brighton and Hove PCT Draft Primary and Community Care Strategy 2009
⁵⁰ Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base. Emergency hospital admissions: chronic conditions usually managed in primary care. Available at: www.nchod.nhs.uk
⁵¹ QOF 2008/09
CHD in the east may be linked to the high smoking rates in this locality.

Within Brighton and Hove modelled prevalence rates are generally much higher than the rates of diagnosed disease recorded on local GP disease registers.

In September 2008, the Eastern Region Public Health Observatory (ERPHO) produced modelled estimates and projections of prevalence of a number of conditions for Local Authorities in England based upon data from the Health Survey for England.

They showed that for Stroke, Hypertension, Coronary Heart Disease and Chronic Obstructive Pulmonary Disease, whilst prevalence of the conditions is expected to change little in Brighton and Hove from 2008 to 2015 and 2020 the numbers of people living with the conditions is expected to increase due to the changing population (Table 8).

Within the city there are projected to be almost 2,000 more people with hypertension by 2015, and almost 4,500 more people by 2020. In addition there will be 266 more people with stroke; 715 more with COPD and; 829 more with CHD by 2020 compared with 2008.

**Table 8: Modelled and projected prevalence of hypertension, CHD, stroke and COPD in Brighton and Hove, 2008, 2015 and 2020**

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th></th>
<th>2015</th>
<th></th>
<th>2020</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>59,093</td>
<td>27.9%</td>
<td>11,192</td>
<td>5.3%</td>
<td>4,886</td>
<td>2.3%</td>
</tr>
<tr>
<td>CHD</td>
<td>11,192</td>
<td>5.3%</td>
<td>4,886</td>
<td>2.3%</td>
<td>9,543</td>
<td>4.5%</td>
</tr>
<tr>
<td>Stroke</td>
<td>4,886</td>
<td>2.3%</td>
<td>9,543</td>
<td>4.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>9,543</td>
<td>4.5%</td>
<td></td>
<td></td>
<td>10,259</td>
<td>4.6%</td>
</tr>
<tr>
<td>Increase 2008 to 2015</td>
<td>1,930</td>
<td>267</td>
<td>75</td>
<td>287</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase 2008 to 2020</td>
<td>4,476</td>
<td>829</td>
<td>266</td>
<td>715</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Carers**

At the time of the 2001 Census, almost 22,000 people of all ages in Brighton & Hove provided some informal care; more than half (52%) of these were people aged 50 years and over. Of people aged 85 years and over, 5% provided some form of unpaid care 50% of whom provided 50 hours or more. Carers also need support in the form of respite care and emotional and financial support.

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52 Older People’s Profile & Needs Assessment (A Part of the Joint Strategic Needs Assessment 2008)
Physical disabilities

The World Health Organisation suggests two approaches to assessing the prevalence of disability within a city; sample surveys such as the health counts survey done in Brighton and Hove recently and agency records of utilisation which involves collation of routinely collected data.

The number of disabled children in England is estimated to be between 288,000 and 513,000. The mean percentage of disabled children in English local authorities has been estimated to be between 3.0 and 5.4%.[53] If applied to the population of Brighton and Hove this would equate to between 1,385 and 2,493 children experiencing some form of disability.[54]

Nationally, parents rated the services received by their disabled child as 59 out of 100. In Brighton and Hove parents rated the services received by their disabled child as 60 out of 100.[LAA NI54]

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

It is estimated that approximately 12,000 Brighton and Hove residents aged 18 to 64 years have a moderate physical disability, and 3,400 have a severe physical disability.

Approximately 5,600 local residents aged 18 to 64 years are expected to have a moderate personal care disability, and 1,300 are expected to have a severe personal care disability.

The number of people with a physical disability aged 18 to 64 is expected to increase by 4.6% between 2008 and 2015.[55]

Brighton and Hove has a young age distribution and a reduction in the number of older people living locally is projected. Therefore the proportion of all people with physical disabilities who are aged less than 65 years is likely to increase. The young age distribution means that for conditions which are typically young onset, such as multiple sclerosis, there are likely to be a higher than average number of new diagnoses in the local population each year compared with other authorities with a similar sized population.

One in twenty adults aged 18 to 64 years in Brighton and Hove received Disability Living Allowance (DLA) in May 2008, however the rate varies considerably by geographical area. In the electoral wards of East Brighton and Queens Park one in twelve receive DLA.

Residents with a physical disability are more likely to live in a home in disrepair and are more likely to be fuel poor.[LAA NI187]

Since 2003 the number of people with physical disabilities helped to live at home by Brighton and Hove City Council has increased considerably, and local performance is higher than the England average.

The proportion of homelessness acceptances with physical disability as their priority need in Brighton and Hove is consistently two to three times higher than the England average, indicating a high level of need locally.

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54 Child and Maternal Health Observatory (ChiMat) www.chimat.org.uk
55 JSNA Adults aged 18 to 64 years with physical disabilities; Final refreshed version April 2009
Learning disabilities

There are 702 people in Brighton and Hove who use a learning disability service (September 2008). In addition there are 70 people supported by the specialist learning disability health team placed here by other councils. Over the last year the number of people needing a service has increased from 647. In 2009/10, there are expected to be 724 people needing a service, increasing to 775 in 2011/12.\(^{56}\)

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

Applying national prevalence rates for learning disabilities to the population of Brighton and Hove suggests that there are approximately 5,000 people aged 18 years or over with learning disabilities (Table 9).

National research tells us there could be about 870 people in Brighton & Hove with a moderate/high learning disability, more than the 702 that are currently getting services. Some of these people might have support from families now, but might need a learning disability service in the future.

The prevalence rates have been applied to population projections to give estimated numbers of people predicted to have learning disabilities to 2030. Within Brighton and Hove the number of people with learning disabilities aged 18 years or over is projected to increase to around 5,100 by 2015 and to over 5,500 by 2030 (a 3% and 11% increase respectively).

Table 9: Projected number of people aged 18-64 years and 65 years or over with learning disabilities in Brighton and Hove

<table>
<thead>
<tr>
<th>Source: PANSI, Projecting adult needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
</tr>
<tr>
<td>People aged 18-24 predicted to have a learning disability</td>
</tr>
<tr>
<td>People aged 25-34 predicted to have a learning disability</td>
</tr>
<tr>
<td>People aged 35-44 predicted to have a learning disability</td>
</tr>
<tr>
<td>People aged 45-54 predicted to have a learning disability</td>
</tr>
<tr>
<td>People aged 55-64 predicted to have a learning disability</td>
</tr>
<tr>
<td>Total population aged 18-64 predicted to have a learning disability</td>
</tr>
<tr>
<td>People aged 65-74 predicted to have a learning disability</td>
</tr>
<tr>
<td>People aged 75-84 predicted to have a learning disability</td>
</tr>
<tr>
<td>People aged 85 and over predicted to have a learning disability</td>
</tr>
<tr>
<td>Total population aged 65 and over predicted to have a learning disability</td>
</tr>
</tbody>
</table>

Table 9: Projected number of people aged 18-64 years and 65 years or over with learning disabilities in Brighton and Hove


People with learning disabilities are more likely to develop early onset dementia.\(^{58}\)

\(^{57}\) These predictions are based on prevalence rates in a report by Eric Emerson and Chris Hatton of the Institute for Health Research, Lancaster University, entitled Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, June 2004.

\(^{58}\) Older People’s Profile & Needs Assessment (A Part of the Joint Strategic Needs Assessment 2008)
Healthcare Associated Infection

Healthcare associated infections (HCAI) and in particular Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.Diff) infections represent a genuine concern for both patients and staff alike. The profile of MRSA has been particularly high and in Brighton and Hove local rates have been among the highest in England and Wales.

In 2008/09 the MRSA rate for Brighton and Sussex University Hospital Trust was still considerably above the national rate (0.79) at 1.32 cases per 10,000 bed days (bed days are the total number of days patients spent in hospital), but this has fallen substantially from 4.71 cases per 10,000 bed days in 2005/06.

Likewise, in 2008/09 the C.Diff rate for Brighton and Sussex University Hospital Trust was above the national rate (0.56) at 0.68 cases per 1,000 bed days, but this has almost halved from 1.25 cases per 1,000 bed days in 2007/08.

End of life care

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

As a result, people approaching the end of their life require a combination of health and social care services provided in the community, hospitals, care homes, or hospices. The majority of people (56-74%) in the UK express a preference to die at home, although as people become sicker as they approach death this proportion may decline, as they want access to more extensive support, such as a hospice. Between 2005-7 of all the deaths in Brighton and Hove 21% occurred at home.
Public voice

Public satisfaction survey

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

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

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

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

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

Fewer people than in the previous survey now disagree that they can influence decisions affect their local NHS than in 2008, but this remains the majority (54%).

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

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

The Place Survey

The Place Survey is conducted annually by each council in England and provides information on the local public’s view of satisfaction with the local area as a place to live. This incorporates services delivered by various local partners. The field work for the latest survey was carried out in late 2008.

Residents in Brighton and Hove are generally happy with their local area as a place to live and we compare well to other Local Authorities on this score. However, residents in deprived areas, council housing tenants, those who rent from a Housing Association, and LGBT residents are less likely to be satisfied.

The picture of whether residents feel their concerns are listened to and acted upon is mixed. White Other groups and Local Authority housing tenants are more likely to feel that they can influence decisions in their local area. LAA NI4

Residents in more deprived areas are more likely to feel that their interests are promoted. Council tenants, women, and BME groups also feel that local services act on the concerns of local residents.

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

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

Overall 77% of respondents were satisfied with their GP, 67% with their local hospital and 66% with their local dentist. Brighton and Hove were in the fifth quintile (lowest satisfaction) of local authorities for satisfaction with GP and local hospital and fourth quintile for dentists.

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59 Public Satisfaction Survey Research Findings for NHS Brighton and Hove, Ipsos MORI on behalf of NHS South East Coast, July 2009
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>CHD</td>
<td>Coronary heart disease</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>CWI</td>
<td>Child Wellbeing Index</td>
</tr>
<tr>
<td>DAT</td>
<td>Drug Action Team</td>
</tr>
<tr>
<td>DCLG</td>
<td>Department for Communities and Local Government</td>
</tr>
<tr>
<td>DCSF</td>
<td>Department for Children Schools and Families</td>
</tr>
<tr>
<td>ERPHO</td>
<td>Eastern Region Public Health Observatory</td>
</tr>
<tr>
<td>ESA</td>
<td>Employment and Support Allowance</td>
</tr>
<tr>
<td>GFR</td>
<td>General fertility rate</td>
</tr>
<tr>
<td>HCAI</td>
<td>Healthcare acquired infection</td>
</tr>
<tr>
<td>H.E.L.P.</td>
<td>Health England Leading Prioritisation</td>
</tr>
<tr>
<td>HRBS</td>
<td>Health Related Behaviour Survey</td>
</tr>
<tr>
<td>IDACI</td>
<td>Income Deprivation Affecting Children Index</td>
</tr>
<tr>
<td>IDAOP1</td>
<td>Income Deprivation Affecting Older People Index</td>
</tr>
<tr>
<td>IMD</td>
<td>Index of Multiple Deprivation</td>
</tr>
<tr>
<td>JSA</td>
<td>Job Seekers Allowance</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
</tr>
<tr>
<td>LAA</td>
<td>Local Area Agreement</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, gay, bisexual and transgender</td>
</tr>
<tr>
<td>LSOA</td>
<td>Lower Super Output Area</td>
</tr>
<tr>
<td>NCMP</td>
<td>National Child Measurement Programme</td>
</tr>
<tr>
<td>NEET</td>
<td>Not in education, employment or training</td>
</tr>
<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
</tr>
<tr>
<td>OSCI</td>
<td>Oxford Consultants for Social Inclusion</td>
</tr>
<tr>
<td>PANSI</td>
<td>Projecting adult needs and service information system</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>POPPI</td>
<td>Projecting older people population information system</td>
</tr>
<tr>
<td>QALY</td>
<td>Quality adjusted life years</td>
</tr>
<tr>
<td>QOF</td>
<td>Quality and Outcomes Framework</td>
</tr>
<tr>
<td>SEPHO</td>
<td>South East Public Health Observatory</td>
</tr>
<tr>
<td>SOA</td>
<td>Super Output Area</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>TIA</td>
<td>Transient ischaemic attack</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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## Appendix 1: Brighton and Hove MOSAIC Public Sector profile 2008

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