

Living well in a healthy city

Annual Report of the Director of Public Health

Brighton & Hove 2016/17



Brighton & Hove
City Council

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Welcome

Welcome to the latest Public Health Annual Report which focuses on prevention. This report is a significant milestone in that it is the first Brighton & Hove report for over a decade which has not been written by Tom Scanlon. I would like to pay tribute to Tom, not just for his remarkable series of annual reports, but for all he did to improve the health and wellbeing of local people. His contribution to the local public health agenda is greatly missed, though his legacy continues.

Nationally and locally the health and social care system is under increasing pressure. Every morning on the radio and television there is yet another news item about the service delays and underfunding of the system. While at the same time tens of thousands of health and social care professionals, working with a range of paid and voluntary partners, set off for work aiming to look after us all as best they can.

This report does not set out to preach about what everyone should be doing. Nor does the report intend to be a comprehensive list of all the prevention work being done locally either within the council or across the city by both the statutory and non-statutory sectors. The report's main aim is to demonstrate what prevention could achieve if given the focus, resource and time to deliver.

The report describes the background information to the significant challenges local services are facing. The early chapters include information about how the population is changing, both in terms of numbers and overall health and lifestyles

and highlight how prioritising prevention can improve health and reduce the demand on health and social care services. The subsequent chapters then discuss the role of prevention in improving health and wellbeing across the life course with examples of local prevention programmes and what more we could be doing.

Producing a report like this involves a lot of people. Thanks as ever to many people but particularly to the lead authors, organisers and design team; Nicola Rosenberg, Annie Alexander, Kerry Clarke, Katie Cuming, Kate Gilchrist, Barbara Hardcastle, Alistair Hill, Ellie Katsourides, Chris Naylor, Justin Pursaill and Peter Gates.

I am sure you will find plenty of interesting reading within the report. And if it inspires you to take that extra ten minute brisk walk each day then all to the good.

Peter Wilkinson
Acting Director of Public Health
Brighton & Hove City Council, 2016-2017



Primary prevention aims to prevent people from becoming unwell in the first place through promoting and protecting their health and wellbeing

1

An introduction to prevention

We are living longer but the number of years we spend living in good health has not kept up and as a result more people are living longer with more long-term conditions. In combination with the constraints of austerity, this is placing unprecedented pressure on our health and social care system, both nationally and locally. Keeping people well, living independently in their own homes, and staying out of hospital, is not only the preferred scenario for ourselves, families and communities but provides a long-term solution for the challenges in health and social care. In addition, investment in prevention can provide excellent value for money compared against the cost of most medical treatments.

The key role of prevention in keeping people well and out of hospital is reflected in national and local plans. The 2014 Care Act promotes a duty of wellbeing and requires local authorities and their partners to prevent, reduce or delay the need for local people to require care and support. The 2014 NHS Five Year Forward View states that “the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health”.

Locally, prevention is integral to Brighton & Hove Caring Together, the local plan for health and social care organisations to work together to provide the best services to residents in the face of increasing demand and reducing resources.

A comprehensive approach to prevention requires action ranging from stopping people becoming unwell and the early diagnosis and treatment of conditions through to helping people live with their disease or impairment.

Primary prevention aims to prevent people from becoming unwell in the first place through promoting and protecting their health and wellbeing. This might be through a population based public health programme, such as childhood immunisation or healthy weight, or the targeting of individuals at high risk of developing ill health in the future, such as supporting smokers to stop.

Primary prevention also includes working 'upstream' to influence the social factors that have an impact on people's health such as their education, employment and housing. These broader determinants of health operate at both a community and individual level; for example, good urban design can provide residents with access to public spaces and parks and good infrastructure, including accessible transport links to local workplaces and amenities. A community with strong social networks is likely to be more resilient and this will help promote the health and wellbeing of the community and the individuals living within it.

Secondary prevention aims to identify and prevent an existing health condition progressing. Cancer screening programmes are population level examples of where the cancer is detected and treated much earlier than it would otherwise have been, frequently resulting in improved health outcomes.

Tertiary prevention aims to help those with existing conditions regain as much autonomy and independence as possible. Examples include cardiac and stroke rehabilitation, and supporting people with complex and long-term conditions to look after themselves and to stay in their own homes/the community.

With growing numbers of people being diagnosed with long-term conditions the effectiveness of secondary and tertiary prevention is an increasing priority.

There is an increasing amount of evidence about what works in prevention. A recent review found that local and national public health interventions are highly cost saving.¹ But one of the challenges prevention programmes face is that when resources are scarce they are often the first service to be cut; however, this is a false economy. The benefits of some prevention programmes can be realised quickly. Examples include improving the detection of hypertension or the uptake of vaccination programmes. Lifestyle changes such as smoking cessation programmes deliver improved health and wellbeing at a population level in the medium term. While changing the broader determinants

of health will take longer to have an effect.

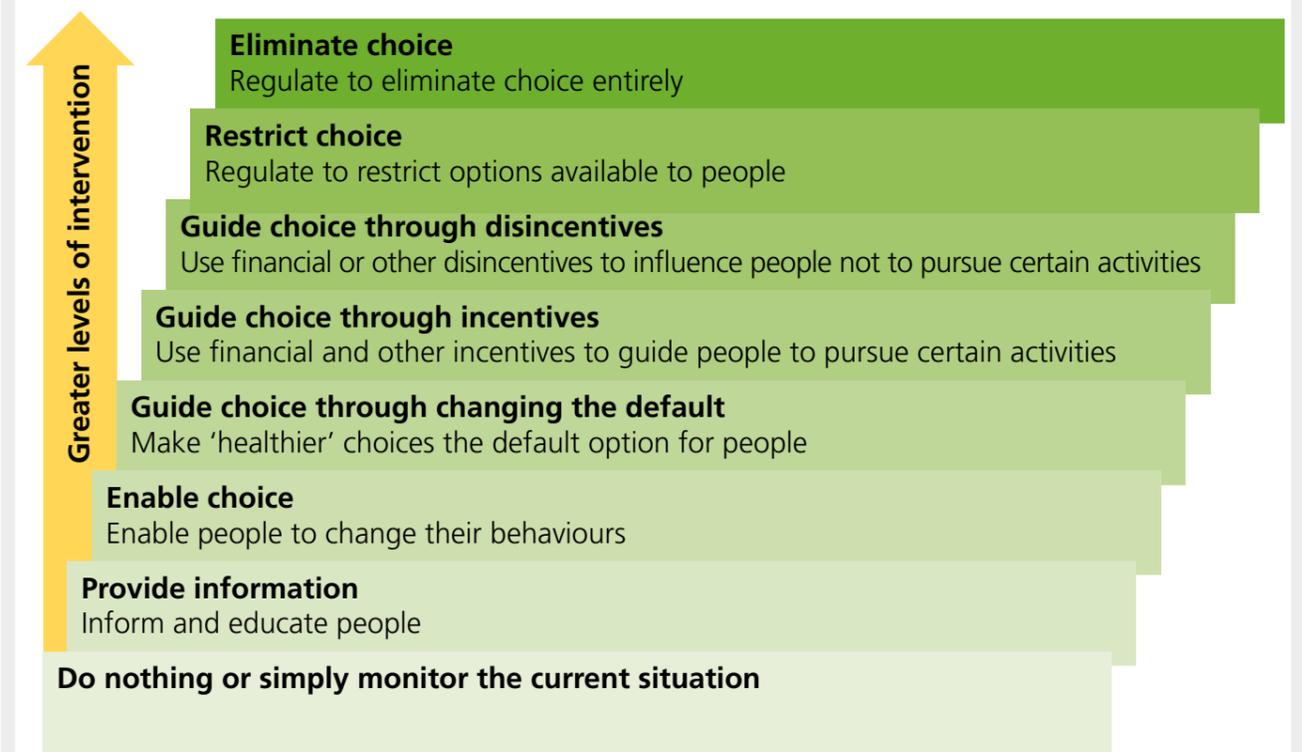
To achieve a real impact on the population's health, and subsequent use of services, primary and secondary prevention interventions should be promoted to and adopted by as many of those who can benefit as possible. This is sometimes referred to as "prevention on an industrial scale". At the same time it is important that prevention services are provided in an equitable way which ensures that people with the greatest need for the services are the ones using them the most.

Changing the behaviour of individuals and communities requires a range of interventions and individual skills. Education, environment and enforcement all have a role to play. Good examples of these approaches are seen in transport and include wearing cycle helmets, improving road design, 20mph speed limits in built-up areas and laws about seat belts.

The 2010 Government's public health strategy² referenced the Nuffield Council on Bioethics' "Ladder of Interventions" which outlines the range of approaches to supporting people to change their behaviours to live more healthily. The range is from minimal intrusion in people's lives, disseminating information, through to enforcement and limiting choice through legislation (Figure 1). At the level of the ladder's lower rungs there is a greater emphasis on enabling informed choice about individual behaviours which has the potential for individuals to improve their own health and wellbeing. But this needs to be balanced against the limited options some people have to change their lifestyles.

In the context of people avoiding being admitted to hospital, or staying in hospital when they are ready to return home, it is relevant to consider self-management and how people can be supported in their own homes. Self-management builds on an individual's ability to maintain or improve their health and wellbeing. This includes a wide range of programmes from education programmes, such as DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed), a course for

Figure 1 A ladder of interventions



Source Healthy Lives, Healthy People; Our strategy for Public Health in England; Dept. of Health

people with type 2 diabetes, that help people to identify their own health risks and to set their own goals, to the use of telemedicine.

Keeping people well at home involves large numbers of people and services. Every day thousands of informal and formal carers help people to stay in their own homes, and improve their wellbeing too. Telecare, including responding to alarm calls, helps to keep people safe at home whether it is following a fall or responding to a Carbon Monoxide alarm. Social prescribing, befriending and other services aimed at reducing social isolation help improve or maintain mental health and wellbeing. Other services aim to enable people to be discharged safely from hospital.

This report covers many of the areas highlighted above. As ever the story remains the same – "An ounce of prevention is worth a pound of cure" - or in this case millions of pounds of health and social care.

Prevention is an integral part of the health and social care system and what it does every day for tens of thousands of people in the city. It is impossible to aspire to sustained improvement in the health and wellbeing of local people without a major role for prevention.

Whilst life expectancy has been increasing, healthy life expectancy has actually fallen in recent years. People are therefore living longer in ill health

2

The case for prevention

Needs of our city

This chapter uses local data to provide a picture of the local population, how healthy it is, the lifestyle factors and broader determinants that can affect health and wellbeing and the impact these behaviours and long-term conditions are having on local services.

A week in the life – every week in Brighton & Hove



57 babies are born



6,701 people have an outpatient appointment



454 people have an elective admission to hospital



414 people have an emergency admission to hospital



51 people are admitted to hospital for acute conditions that should not usually require hospital admission



26 people have a new diagnosis of cancer



41 people die, of whom:



12 people die from cancer and



4 people die from conditions considered amendable to health care



In a given week there are



3,650 people receiving a long-term adult social care service:



360 people supported in nursing homes



819 people supported in residential care



2,471 people receiving a range of support options living in the community



130 people receiving short-term intensive support to maximise their independence



661 items of daily living equipment issued



120 Adult social care assessments/reviews, including:



14 carers assessments/reviews



18 safeguarding enquiries (including mental health)



8 mental capacity assessments

Population change

There were **285,300** residents according to the Office for National Statistics (ONS) latest mid-year population estimate (2015)

12.5% increase since 2005 (32,500 more people)

Between 2005 and 2015 the city saw a bigger increase in its population than:

South East (9.1%)

England (8.3%)

By 2025 there are projected to be **303,800** residents

An increase of **6.5%** from 2015 (18,500 more people)

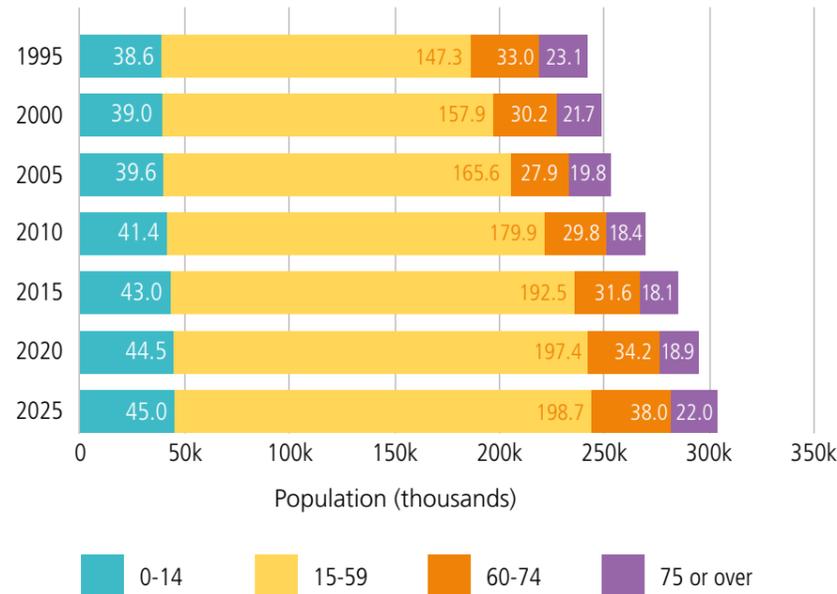
5% increase in those aged 0-14 (2,000 more people)

3% increase in those aged 15-59 (6,200 more people)

20% increase in those aged 60-74 (6,400 more people)

21% increase in those aged 75 or over (3,900 more people)

Figure 1 Population (thousands) by broad age band, Brighton & Hove, 1995 to 2025



Source: Office for National Statistics Mid-Year estimates (1995-2015) and population projections (2020 and 2025)

Over the next decade we expect to see an increase in the number of older people. There will be around 4,000 more people aged 75 or over in the city in 2025 compared with 2015.

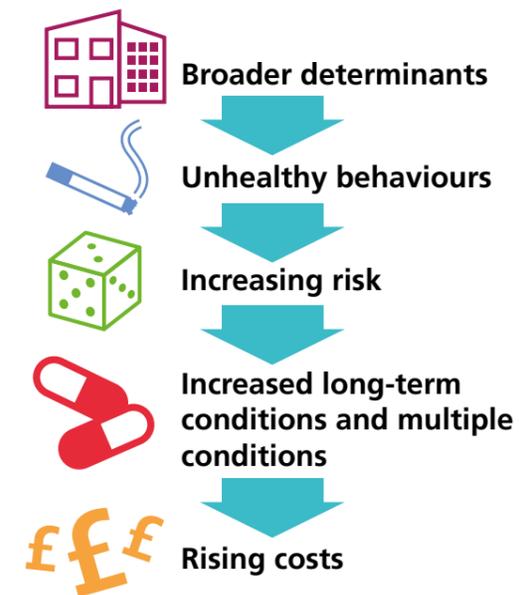
However locally our population is not ageing to the same extent as the national picture.^{1,2} It is worth noting that the 75 or over population in 2015 was smaller in number than it had been in the previous 20 years and by 2025 is expected to equal the number of adults aged 75 or over who were living in the city in the year 2000 (Figure 1).

Life expectancy and healthy life expectancy in Brighton & Hove

Between 2001-03 and 2013-15 life expectancy increased from 75.1 years to 79.3 years for males and from 80.8 years to 83.5 years for females.³ However healthy life expectancy has actually fallen in recent years – from 63.9 years to 62.4 years for males between 2009-11 and 2013-15 and from 64.1 years to 61.3 years for females.³

People are therefore living longer in ill-health. This, alongside the rising retirement age, means that increasing numbers of people of working age are living in ill-health. This further makes the case for prevention to be taken seriously by employers.

Wider social factors and unhealthy behaviours influence our health, lead to long-term conditions, poor health outcomes, greater inequalities and higher health and social care costs:



Wider social factors

- Social factors such as housing, education, employment and deprivation all influence health behaviours and health.

Brighton & Hove is the 102nd most deprived local authority of the 326 in England according to the 2015 Index of Multiple Deprivation

- In 2015, 45% of the population of the city lived in the 40% most deprived areas in England and only 7% in the 20% least deprived areas.

The development of long-term conditions is linked to lifestyle

- 54% of adults in the city did not meet two or more government guidelines in four key areas which affect health (smoking, alcohol, diet and physical activity)
- Similar analysis for 14-16 year olds in the city on having **ever** tried smoking, **ever** drank alcohol to get drunk, and not meeting recommendations around fruit and vegetable consumption and physical activity, showed 83% had two or more of these negative behaviours and 39% three or more.

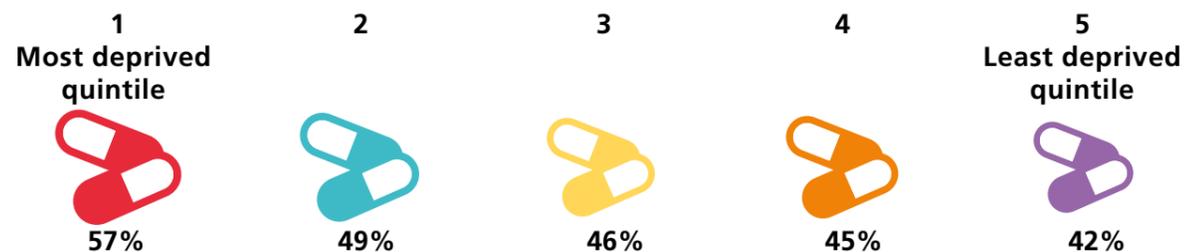
Unhealthy lifestyles are increasingly unequally distributed across the population

- In 2003 adult males living in the most deprived 20% of areas in the city were 2.2 times more likely to have 3-4 unhealthy behaviours compared with those living in the least deprived 20% of areas (of the 4 listed), increasing to 3.4 times more likely by 2012. The equivalent increase for females was 1.7 to 2.1 times
- We do not have trend data for young people but for 2011-2014, 14-16 year olds living in the most deprived 20% of areas in the city were 1.5 times more likely to have 3-4 unhealthy behaviours.

The prevalence of multiple long-term conditions increases with deprivation

- In the most deprived 20% of areas of the city (the most deprived quintile) 14% of patients have three or more long-term conditions compared with between 9-11% in the other quintiles
- For those aged 65 years or over, 57% of those in the most deprived quintile have three or more long-term conditions compared to 42% of those in the least deprived quintile.

Percentage of patients aged 65 years or over with three or more long-term conditions by quintile of deprivation within Brighton & Hove, January 2017



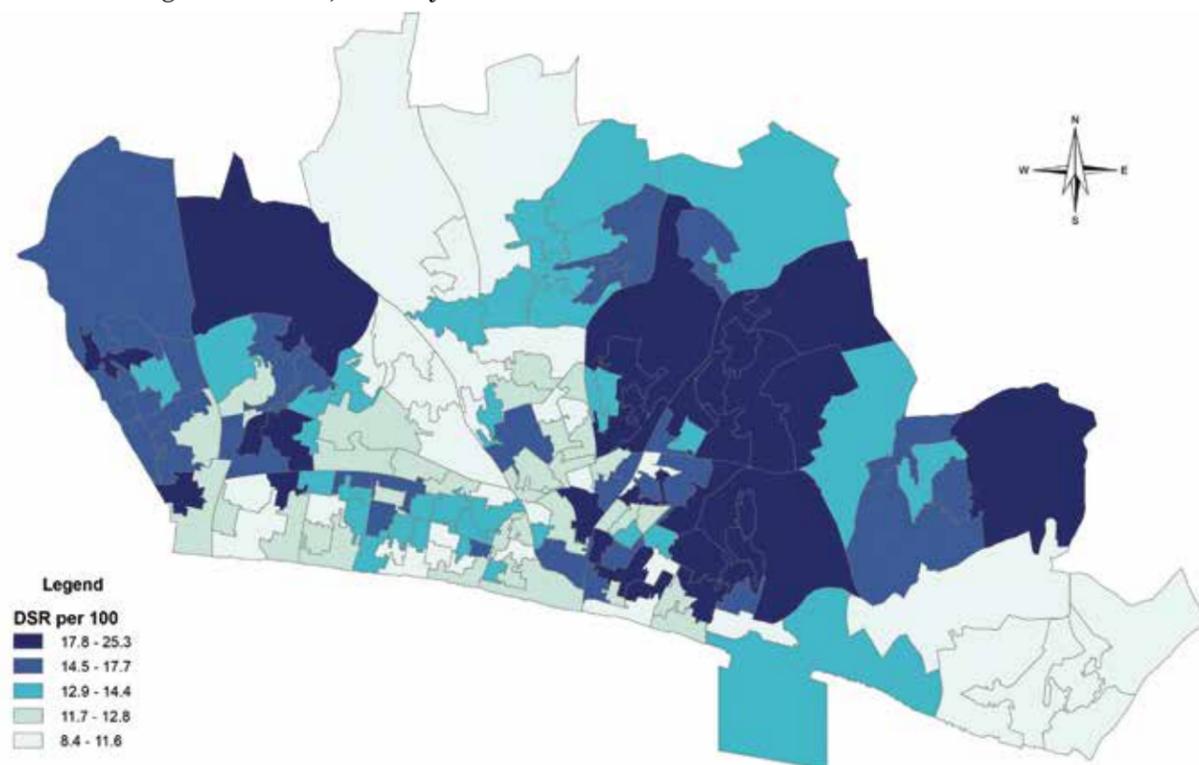
- Once standardised to take account of the different age structures of different areas of the city, we can see that the areas with the highest percentages of people with three or more conditions are concentrated around the more deprived Moulsecomb and Bevendean and East Brighton wards and areas of North Portslade and Woodingdean (Map 1). These areas are similar to those with the highest risk of admission to hospital seen in Map 2.
- We do not have local information on the age of onset of long-term conditions. However, a Scottish study showed that the onset of multiple long-term conditions occurred

10–15 years earlier in people living in the most deprived areas compared with the most affluent, with socioeconomic deprivation particularly associated with multiple long-term conditions that included mental health conditions.⁴

There are large, and potentially avoidable, differences in health outcomes across the city and in some cases these are widening

- There is a 9.6 year difference in life expectancy for males and 6.7 years for females (between the most and least deprived individuals) compared with 9.0 years and 7.0 nationally³

Map 1 Percentage of patients with three or more long-term conditions (directly age-standardised), Brighton & Hove, January 2017



Source Brighton & Hove Public Health Intelligence Team© Crown Copyright. All rights reserved. Licence: 100020999, Brighton & Hove City Council. 2012.Cities Revealed © 2007.

The conditions which would add the most to life expectancy in the city,⁵ by reducing the life expectancy gap between those living in the most and least deprived areas, are highly related to lifestyles and amenable to prevention across all tiers.

If all of the population had the same death rates as those in the least deprived areas this would increase life expectancy by:

- 1.5 years for males and 0.8 years for women for coronary heart disease deaths;
- 1 year for men and 0.6 years for women for suicide and other external causes of death;
- 0.8 years for men and women for lung cancer deaths;
- 0.8 years for men and 0.7 for women for COPD deaths;
- 0.7 years for men and 0.4 years for women for alcohol specific deaths;
- 0.6 years for men and 0.3 years for women for chronic liver disease including cirrhosis.

- Over the five year period 2011-2015 a total of 2,702 deaths in Brighton & Hove of people of all ages can be attributed to the impact of deprivation - equivalent to 540 deaths annually
- There is a larger difference in healthy life expectancy in the city between the most and least deprived individuals – 14.0 years for males and 12.5 years for females (although this is narrower than the gap nationally of 19.0 years for males and 20.2 years for females).³

Service use and costs for Brighton & Hove residents and patients

- The number of inpatient admissions to hospital per year has increased by 5% between 2007/08 and 2015/16 (from 60,812 to 63,941 admissions per year)⁶
- The number of outpatient attendances each year has increased by 114% between 2007/08 and 2015/16 (from 163,056 to 348,480 attendances per year).⁷ An increase in cost from £19.1 million to £40.8 million per year at 2015/16 average prices.⁸

- The number of A&E attendances has increased by 35% between 2007/08 and 2015/16 (from 67,457 to 90,966 attendances per year).⁹ An increase in cost from £9.3 million to £12.6 million per year at 2015/16 average prices⁸
- The number of adults aged 18 or over receiving any form of long-term support from adult social care (residential, nursing home or community care) has increased by 15% between 2011/12 and 2015/16 (from 3,180 people in 2011/12 to 3,650 in 2015/16).¹⁰ More detail on trends in service use is given later in the chapter.



Royal Sussex County Hospital

Long-term conditions

The information presented here is for patients registered with GP practices in Brighton & Hove based on conditions mentioned in patient records, plus medications for those conditions, within the previous year for the 302,246 patients of all ages registered with GP practices in the city in January 2017.¹¹

Figure 2 shows that the most common condition is depression, with over 56,000 patients (19% of patients), followed by persistent asthma (almost 42,000 patients or 14%) and hypertension (41,500 patients or 14%).

Dementia is not coded within this new system, however as at March 2016 there were 1,739 patients with recorded dementia in the city (0.6% of all patients).¹²

Multiple long-term conditions

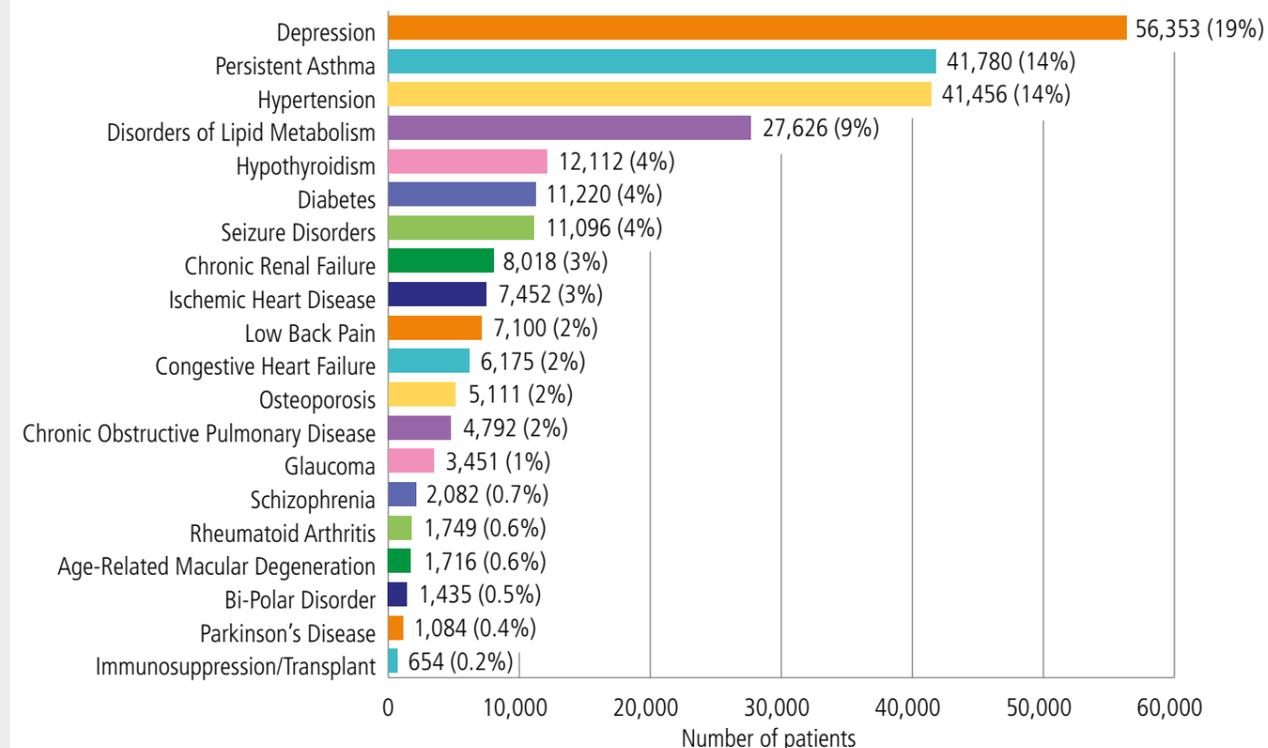
Nationally, the prevalence of multiple long-term conditions has been increasing in recent years due to the ageing population and increased survival from long-term conditions. Multiple long-term conditions are associated with increased mortality and premature mortality, physical impairment/disability, reduced ability to work, increased risk of admission to hospital and longer hospital stays, poor quality of life and adverse drug events.^{13,14}

The number of long-term conditions an individual has can better predict their use of health services than looking at the single specific conditions which they have.¹⁵

Multiple long-term conditions by age group and gender

The percentage of people living with long-term conditions increases with age. In Brighton & Hove, 89% of the population aged 0-4 years have no long-term conditions and up to the age of 49 the majority of patients still have no long-term conditions (Figure 3). For those aged 50-54

Figure 2 Number of patients with various long-term conditions, Brighton & Hove, January 2017



Source Brighton & Hove Public Health Intelligence team

years, 53% have one or more condition, with the average being one condition. By 65-69 the average has increased to two conditions and it reaches three by age 80-84 years. However, those who reach 95 years or over have fewer conditions than those aged 80-94 years.

The Department of Health identified two key populations at risk of multiple long-term conditions across the life course.

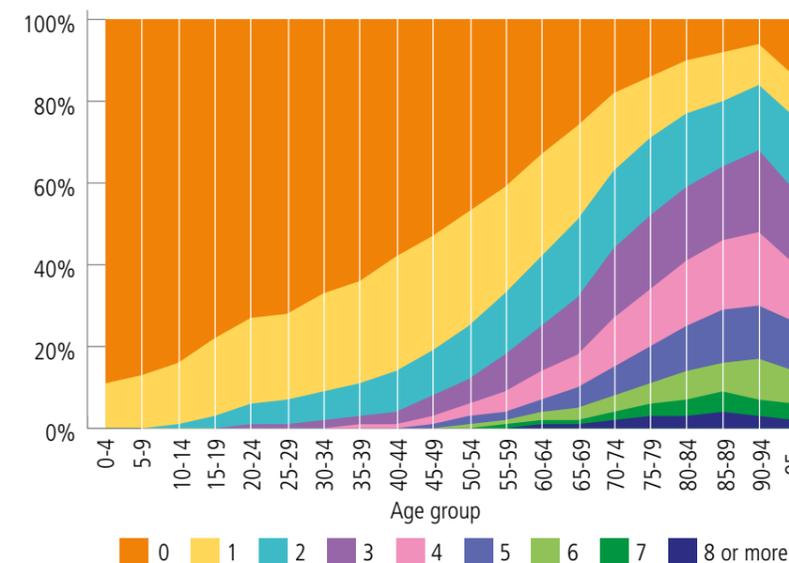
The first group includes those with multiple long-term conditions as a result of accumulated health risks from living longer. For these people it is important to ensure that integrated health and social care help to improve quality of life and their ability to live well and independently.

The second group includes those with multiple long-term conditions due to unhealthy lifestyle factors and adverse social circumstances (for example deprivation). This group presents an important opportunity to target prevention and whole systems action to tackle the wider determinants of health.¹⁶

Average number of other long-term conditions

Patients with diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease all have on average three or more other long-term conditions. This contrasts with patients with persistent asthma, who tend to be younger, and have on average 1.2 other long-term conditions.

Figure 3 Number of long-term conditions by age group, Brighton & Hove, January 2017



Source Brighton & Hove Public Health Intelligence team

Average number of additional long-term conditions (mean number) for patients with specified long-term conditions



The links between mental and physical health

Mental health and wellbeing and physical health and wellbeing are intertwined. The presence of a mental health condition alongside physical health conditions can lead to poorer health outcomes and worse quality of life.¹⁵

In the last year one fifth of all patients registered with GPs in the city (56,353 patients, 19%) had depression.

Depression is most common in those aged 45-64 years, for both males and females (Figure 4).

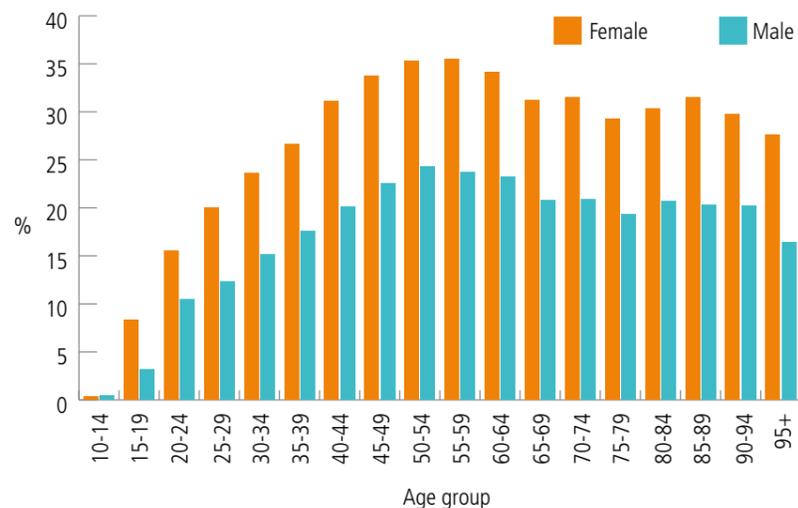
Females were significantly more likely to have depression (22% compared with 15% for males), although part of this difference may be due to lower presentation at GP practices by males.

There is a significant relationship with deprivation, with 23% of those living in the 20% most deprived areas of the city having a record of depression compared with 15% of those living in the 20% least deprived areas.

A Scottish study showed that the likelihood of a mental health condition increased as the number of physical health conditions increased and was much greater in people living in more deprived areas.⁴ The findings are considered to be generalisable to other parts of the UK.

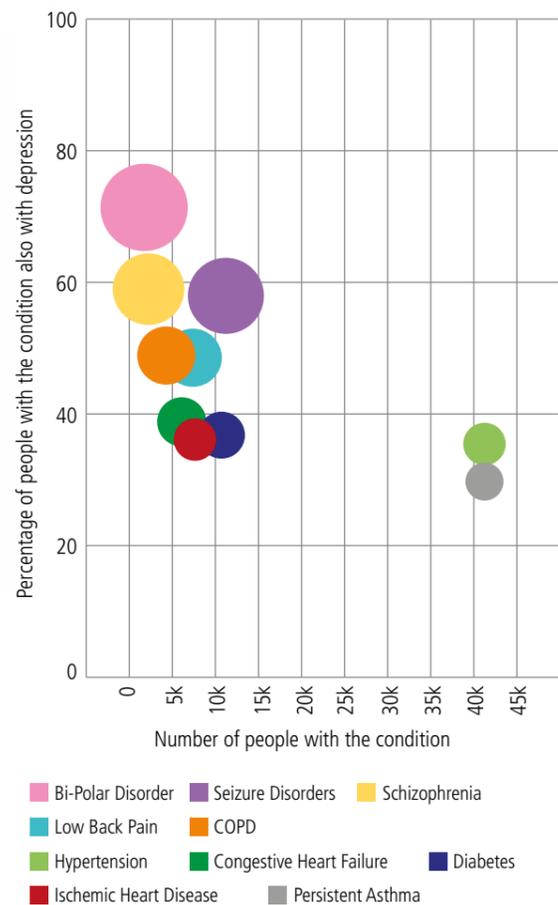
Unsurprisingly, depression is more common for those with

Figure 4 Percentage of patients with depression by age group and gender, Brighton & Hove, January 2017



Source Brighton & Hove Public Health Intelligence team

Figure 5 Odds ratios of having depression versus not having depression by condition (for selected conditions), Brighton & Hove, January 2017



Source Brighton & Hove Public Health Intelligence team

Note The size of the bubble is the odds ratio, the x-axis shows the number of people with the condition in Brighton & Hove and the y-axis the percentage of those people with depression.

mental health conditions, for example those with bi-polar disorder are four times more likely to have depression than those without and those with schizophrenia three times more likely than those without (Figure 5).

However, the impact is also seen for physical health conditions: those with either lower back pain or COPD are three times more likely to have had depression in the last year than those without these conditions, compared with two times more likely for those with persistent asthma. These ratios (called odds ratios) are shown in Figure 5 for selected conditions.

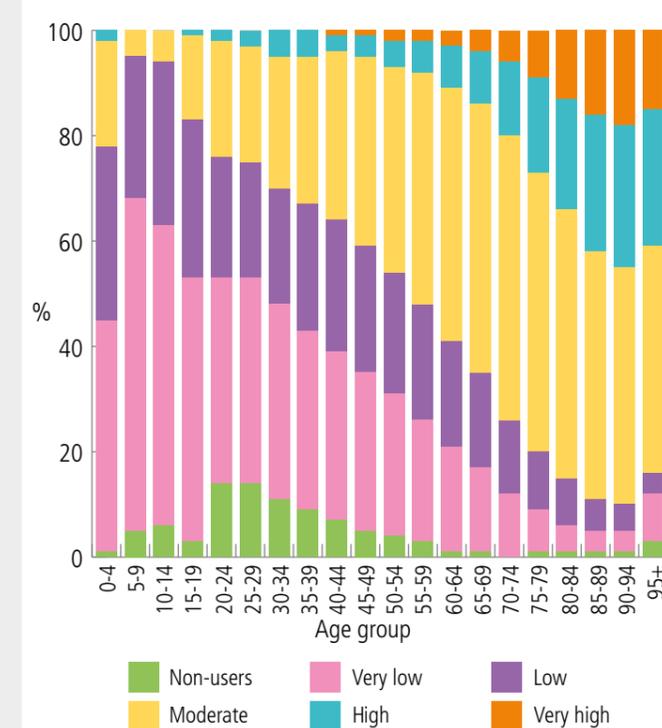
The NHS Brighton and Hove Clinical Commissioning Group and the Public Health team carried out a Premature Mortality Audit finishing in 2016. All GP practices engaged with this work.

The audit found that a high percentage of patients with long-term conditions who died prematurely were also on the GP depression register. Mental health often overlapped with other themes, particularly isolation and vulnerability, smoking and alcohol misuse. Chronic depression was regularly seen in people who drank alcohol excessively and in those with complex health needs. Those with mental health needs were more likely to present signs of self-neglect and a lack of engagement with healthcare services.

Use of services by age

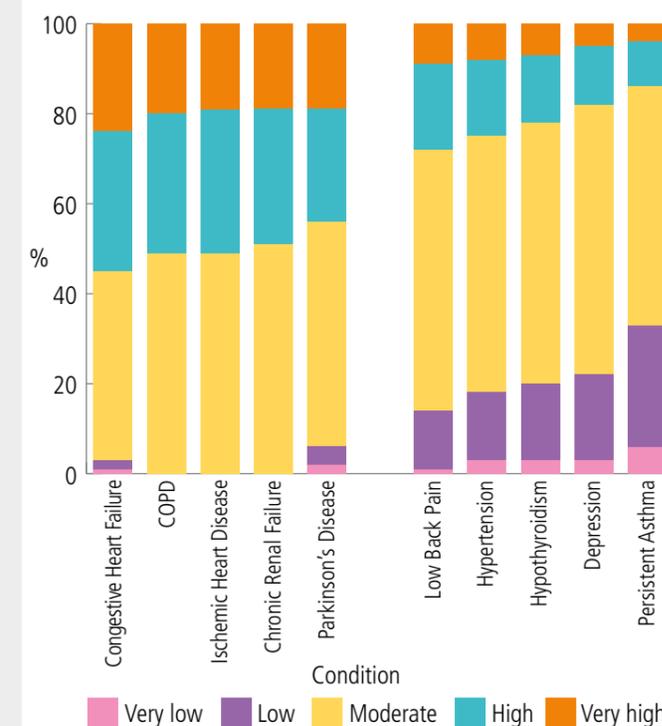
Resource use is very highly age related. In Figure 6 resource use is grouped into non users of primary and secondary health services and then five groups from very low users (the 20% of patients using the least) within the last year to very high users (the 20% of patients using the most services). The majority of those aged 5-29 years are non-users or very low users of services (those under 5 will use a range of routine services which is why use is higher). From the age of 55 the majority of patients are moderate to very high users of health services. At age 70-74 years 20% of patients are high to very high users of services, increasing to 45% of

Figure 6 Resource use by patient age group (%), Brighton & Hove, January 2017



Source Brighton & Hove Public Health Intelligence team

Figure 7 Resource use by condition – selected conditions (%), Brighton & Hove, January 2017



Source Brighton & Hove Public Health Intelligence team

90-94 year olds. As we saw for the pattern for multiple long-term conditions, those aged 95 or over are slightly less intensive users of services than those age 85-94 years.

Non users of services all have no long-term conditions, very low users also have on average no conditions but the average number of conditions rises from 0.6 for low users to 4.5 for very high users.

Use of services by long-term conditions

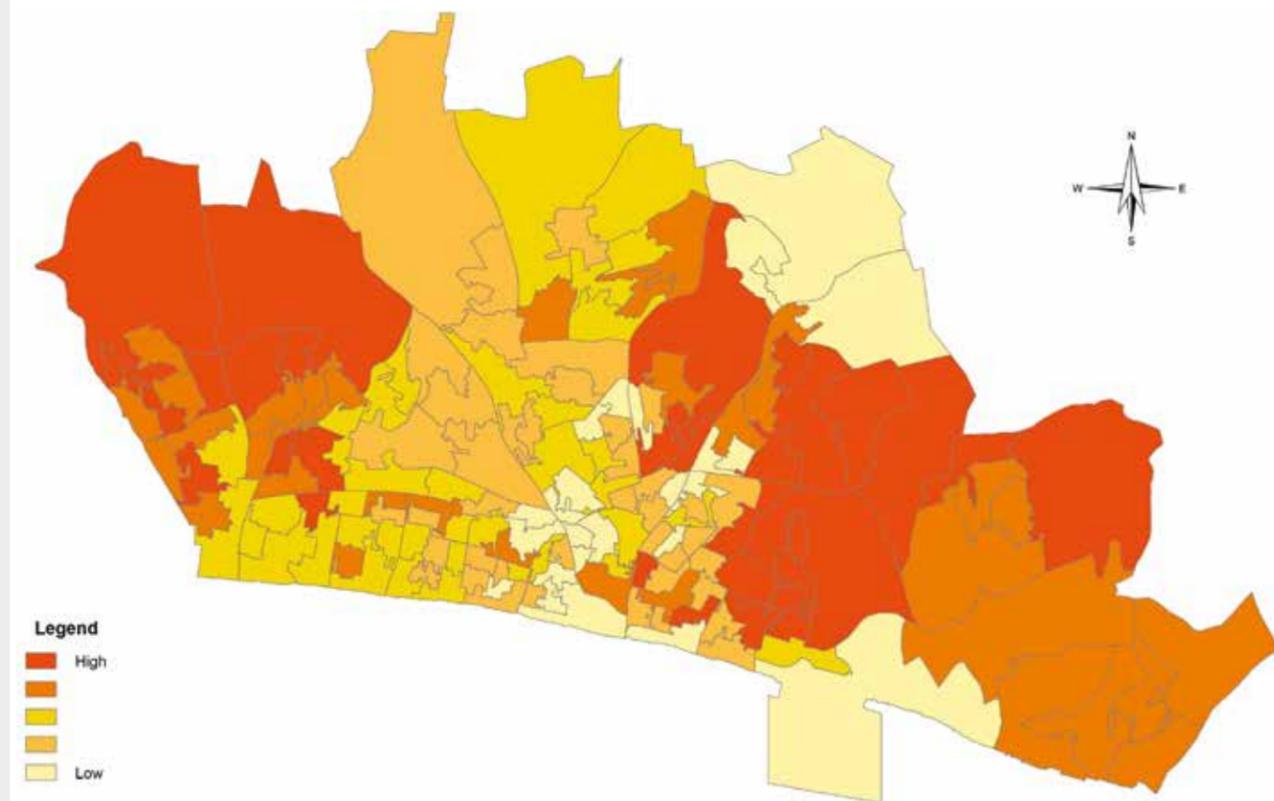
The conditions where patients have the highest use of health services are congestive heart failure (55% of patients high or very high service users), COPD and coronary heart disease (both 51%) (Figure 7 shows the resource use for the five most and five least intensive conditions in terms of healthcare use).

Conditions where patients have the lowest use of resources are persistent asthma (14% high or very high users), depression (18%), hypothyroidism (22%) and hypertension (25%).

Hospital admissions

We can also look at the likelihood of admission to hospital for different groups of patients. Map 2 shows the age-standardised probability of an emergency admission to hospital for patients aged under 75 years. Those living in the east of the city around East Brighton and Moulsecoomb and Bevendean wards and in parts of Portslade, all areas with greater levels of deprivation, are most likely to be admitted to hospital within the next year. These are similar to the areas with the highest rates of multiple long-term conditions seen in Map 1.

Map 2 Probability of an emergency admission to hospital under 75 years (age-standardised), Brighton & Hove, January 2017



Source Brighton & Hove Public Health Intelligence team

Current costs to the healthcare system of multiple-long term conditions

In terms of costs to the healthcare system, the costs increase with the number of long-term conditions an individual has (Figure 8).

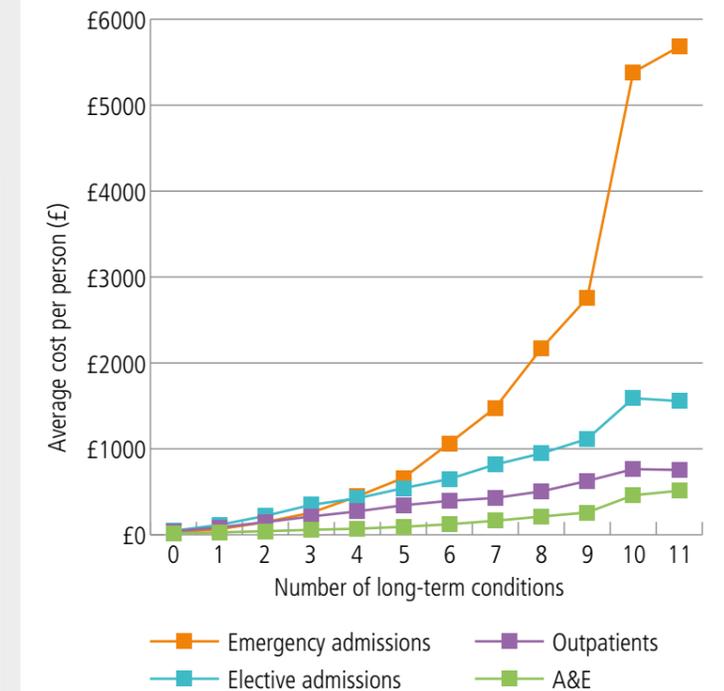
Costs by number of long-term conditions

On average, individuals with no long-term conditions cost £130 in the last year in terms of A&E attendances, outpatient appointments, elective and emergency admissions.

This increases to £877 for those with three long-term conditions; £1,640 for those with five conditions; £3,830 for those with eight conditions and £8,505 for those with eleven conditions.

The costs increase most in relation to emergency hospital admissions, up to £5,681 on average for those with eleven conditions.

Figure 8 Average cost per person of various acute care in the last year by number of long term conditions (mean £ per person)



Source Brighton & Hove Public Health Intelligence team

Note It should be noted that the information presented here is based upon any completed admission within the last 12 months and so these will be underestimates since there is a lag in admissions data being available. This would mean that the potential savings presented here are lower than if using a full year's admissions data. Figures may not sum due to rounding.

Potential savings to the healthcare system by delaying onset of one long-term condition by one year across the population

As an illustration of the potential savings to the healthcare system, if we could delay the onset of one long-term condition across the population by one year we could provide a potential saving across A&E, outpatients, elective and emergency hospital care from £101.7 to £70.9 million - a potential saving of £30.8 million (30%) as broken down in Figure 9.

The impact upon both primary care and social care would also be significant but it is not possible to calculate this. However, this would probably include: fewer GP appointments, delayed need for intensive social care support and greater independence requiring less intensive packages of care.

Figure 9 Potential annual secondary care savings of a reduction of one long-term condition per person (£ millions)



Source Brighton & Hove Public Health Intelligence team

Changing use of services

There are differing underlying patterns in the use of hospital services and social care over the last decade.

In terms of hospital care:

The total number of people admitted to hospital in Brighton & Hove increased by 5% between 2007/08 and 2015/16, this was much lower than the increase seen across England (21%).⁶ This includes admissions for mothers and babies as well as regular day and night visitors. These categories are often excluded from analysis of trends in emergency and elective admissions and this is the case for the rest of this analysis.

Overall:

- The local increase in hospital inpatient admissions has been driven by a large increase of 23% in the number of elective inpatient admissions (from 26,067 to 32,112 admissions per year over the same period)⁹
- However the number of people admitted to hospital as an emergency fell by 9% from 23,712 to 21,569 admissions per year⁹

- The number of people attending A&E increased by 35% between 2007/08 and 2015/16 (from 67,457 to 90,966 attendances per year).⁹

However, these changes were not experienced equally by age. We can see trends more clearly when we look at trends in age specific admission rates (Figures 10 to 12).

The number of people attending A&E per 1,000 resident population increased across all age groups. In 2015/16 compared with 2007/08:

- 103 more 0-14 year olds per 1,000 people attended A&E (from 11,115 to 16,471 attendances)
- 41 more 15-59 year olds per 1,000 (from 40,317 to 53,262 attendances)
- 66 more 60-74 year olds per 1,000 (from 7,275 to 10,254 attendances)
- 151 more 75 or over year olds per 1,000 (from 8,750 to 10,979 attendances).

For emergency admissions the largest changes were for those aged 15-59 and 60-74 years where rates fell, but for children and older people they were relatively stable. In 2015/16 compared with 2007/08:

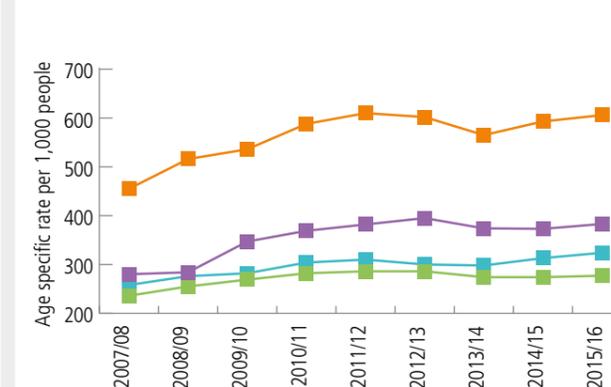
- 1 more 0-14 year old per 1,000 people were admitted to hospital as an emergency (from 2,482 to 2,723 admissions)
- 17 fewer 15-59 year olds per 1,000 (from 10,737 to 8,898 admissions)
- 25 fewer 60-74 year olds per 1,000 (from 3,944 to 3,633 admissions)
- 8 more 75 or over year olds per 1,000 (from 6,549 to 6,315 admissions).

For elective admissions the largest changes were for those aged 60-74 and 75 or over, where elective admission rates increased. In 2015/16 compared with 2007/08:

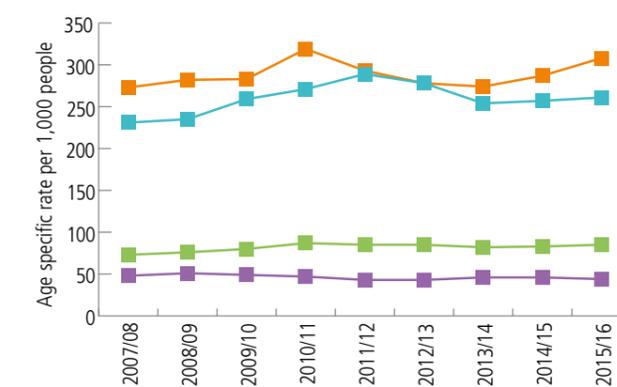
- 4 fewer 0-14 year olds per 1,000 people were admitted to hospital as an elective patient (from 1,896 to 1,876 admissions)
- 13 more 15-59 year olds per 1,000 (from 12,428 to 16,397 admissions)
- 30 more 60-74 year olds per 1,000 (from 6,503 to 8,258 admissions)
- 35 more 75 or over year olds per 1,000 (from 5,240 to 5,581 admissions).

Figures 10-12 Age-specific rates of A&E attendance, emergency admissions and elective admissions per 1,000 population, Brighton & Hove, 2007/08 to 2015/16

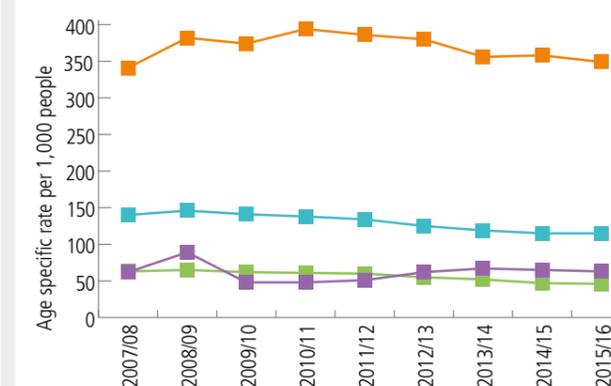
A&E



Elective admissions



Emergency admissions



0-14 — 15-59 —
60-74 — 75+ —

Source Brighton & Hove Public Health Intelligence team

Most common reasons for admission to hospital

The most common reasons for admission to hospital differ by age group and by whether the admission was an emergency or elective admission.

Emergency admissions

For all age groups, admissions due to external causes are among the top six reasons for an emergency admission to hospital. However the external causes differ by age group. For those aged 0-14 years it is primarily accidents, for those aged 60 or over primarily falls. Every year around 1,000 residents in Brighton & Hove aged 65 or over have an emergency admission to hospital after a fall. This is explored further in Chapter 4.

Respiratory and digestive diseases are also among the top six reasons for admission for all age groups. For those aged 0-14 the respiratory admissions are mainly bronchiolitis or unspecified acute lower respiratory infection, asthma and acute upper respiratory infections (laryngitis, tonsillitis and multiple sites) related admissions, whereas for 60-74 and 75 or over, the main cause of respiratory admission was pneumonia.

Circulatory disease admissions become more common in older age groups, increasing from the sixth highest cause of admission for 15-59 year olds to the third highest cause for 60-74 and 75 or over year olds.

For the older three age groups genitourinary diseases are in the top six reasons for emergency admission.

Elective admissions

Looking at elective admissions to hospital, or planned hospital care, digestive diseases are the top reason for admission for 0-14 and 15-59 years and are within the top six reasons for the older age groups. In 0-14 year

olds the majority of the digestive diseases admissions are related to the mouth, most commonly oral decay (284 out of the 392 admissions), see Chapter 6 for more on admissions for children and young people for oral decay.

For those aged 60 or over circulatory diseases are within the top six causes of elective admission, as they were for emergency admission.

Admissions related to ears and eyes are common in both the youngest and very oldest age groups.

For all ages except children, musculoskeletal conditions are in the top six reasons for an elective admission.

Malignant cancers are in the top six reasons for an elective admission, and with the exception of children, non-malignant cancers are also within the top six reasons for admission.

Admissions related to lifestyles issues - smoking and alcohol

In 2014/15 there were 1,734 hospital admissions of Brighton & Hove residents for conditions that are wholly or partially attributed to smoking in persons aged 35 and over and there have been around this number each year since 2009/10 when the data first became available.³

Also in 2014/15 there were 2,852 hospital admissions of Brighton & Hove residents for alcohol-related conditions – with a significantly higher rate of admission than England.

Preventing smoking and alcohol related harm are further considered in Chapter 5 for working age adults and in Chapter 6 for children and young people.

Top 6 causes of elective admissions by age group (number of admissions), Brighton & Hove 2015/16

0-14



15-59



60-74



75 or over



Top 6 causes of emergency admissions by age group (number of admissions), Brighton & Hove 2015/16

0-14



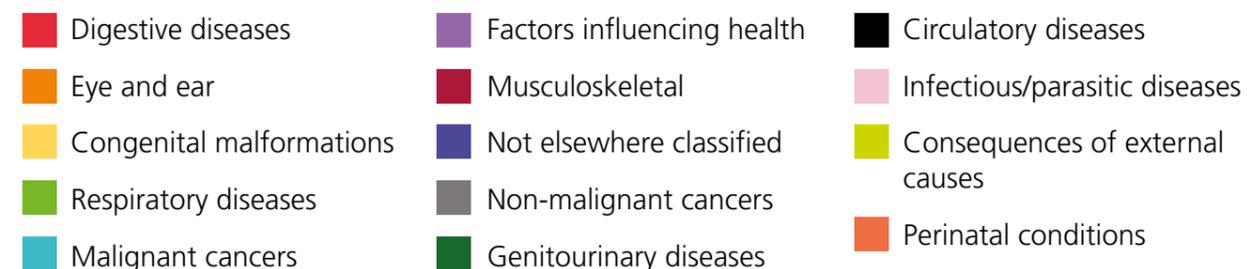
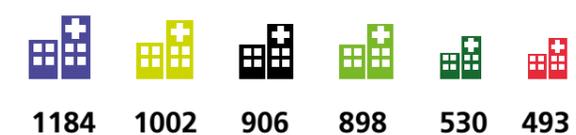
15-59



60-74



75 or over



Source Hospital episode statistics

In terms of long-term adult social care support

(Figures 13-16), we only have trends from 2011/12 – five years compared with the nine years for hospital admissions and attendances.

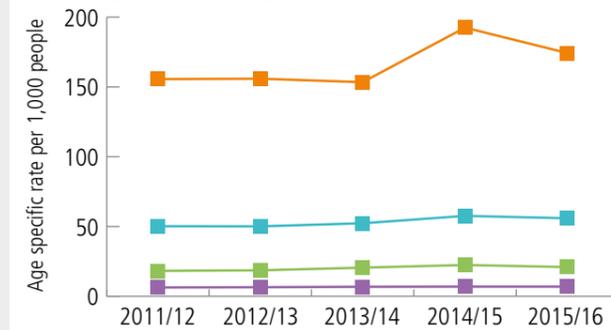
The number of adults aged 18 or over receiving any form of long-term support from adult social care (residential, nursing home or community care) increased by 15% (from 3,180 to 3,650 people). But there are differing trends for different kinds of support, and by age group, between 2011/12 and 2015/16:

- The number of adults in residential care funded by adult social care has remained relatively stable with an increase of just 1% (from 811 to 819 people)
- The number of adults in nursing home care funded by adult social care fell by 8% (from 391 to 360 people)
- Whereas the numbers of people receiving a range of long-term support options within the community increased by 25% (from 1,978 to 2,471 people)
- As was the case for hospital admissions, these changes differed by age. For people receiving any form of long-term support from adult social care the overall increase was 15%; for those aged 18-59 it was 17%; for those aged 60-74 20%; for those aged 75-84 10% and; for those aged 85 or over 12%.

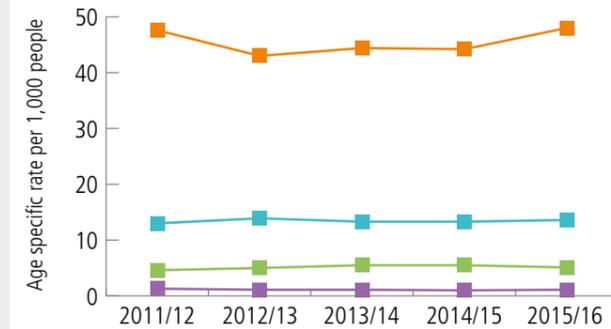
Across all age groups the percentage increase in those receiving long-term support is considerably higher than the increase in the population. The respective population changes were: an increase of 6% in the population aged 18-59 years; 60-74 years an increase of 4%; a reduction of 1% for 75-84 years and; no change for those aged 85 or over years over the same period.

Figures 13-16 Age-specific rates of adult social care long-term support per 1,000 population, Brighton & Hove, 2011/12 to 2015/16

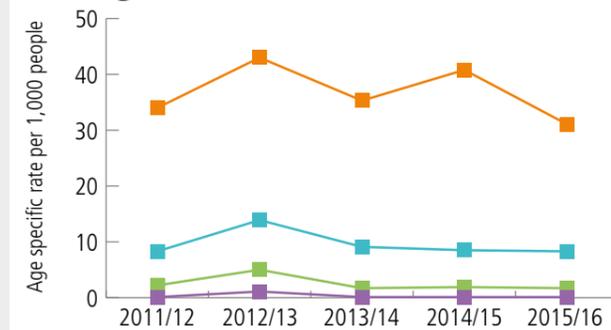
All long-term support



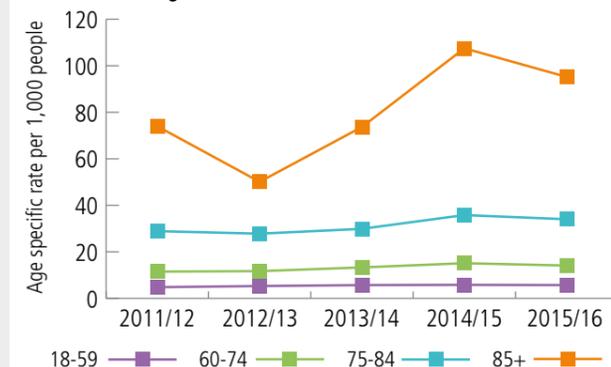
Residential



Nursing



Community



Source Brighton & Hove Adult Social Care team

Note This excludes those receiving short-term support to regain independence and ongoing low level support such as equipment

Again we can see the patterns more clearly if we look at changes in age specific rates over time. The rates have changed little for residential care and nursing home care funded by the local authority by age group. However for community support there are large changes:

- 1 more person aged 18-59 per 1,000 (from 832 to 1,041 people receiving community support)
- 3 more people aged 60-74 per 1,000 (from 347 to 446 people)
- 6 more people aged 75-84 per 1,000 (from 355 to 411 people)
- 19 more people age 85 or over per 1,000 (from 444 to 573 people).

Since the numbers of people receiving long-term community support are far higher than residential or nursing home care, similar increases are seen for any form of long-term support.

Looking beyond care funded by adult social care, we have seen changing patterns in all residential and nursing home care in the city.

Whilst across England between 2001 and 2011 the number of residents aged 65 or over increased by 11%, the number of residents in nursing or residential care homes only rose by 0.3%, indicating that more residents in this age group are either remaining in their own homes, or in alternative supported accommodation.

Between 2001 and 2011

11% ↑ there was an 11% increase in residents aged 65+ across England

0.3% ↑ but only a 0.3% increase in 65+ year olds living in nursing or residential care homes

12% ↓ in Brighton & Hove the 65+ year olds population fell by 12%

31% ↓ but the number of 65+ year olds living in nursing or residential care homes fell by 31%

In Brighton & Hove the number of residents aged 65 or over actually fell over the decade by 12%, but the numbers resident in nursing or residential care homes fell by much more at 31% (from 1,953 people in 2001 to 1,346 in 2011).¹⁷

This is not limited to the younger groups in this age range: the number of people aged 85 or over in the city fell by 7% over the decade but the number aged 85 or over in nursing or residential care homes fell by 30% (for England this was 25% and 5% increase respectively).



What the future might look like

If the trends seen continue, with a higher proportion of the population receiving long-term adult social care support, along with the increases in the population projected over the next decade, the impact on future demand for adult social care services is likely to be great. This demand has reduced for nursing and residential care (either funded by adult social care or self-funded). But with the growing older population, high prevalence of multiple long-term physical and mental health conditions in older people, and the trends seen in support provided in the community, there is likely to be a continued significant increase in the numbers of people requiring more support in their own home or in supported accommodation.

This also looks set to apply to hospital admissions in the older age groups as trends have shown they are more likely to be admitted to hospital than in the past, and this population is growing in size. This is driven by increases in elective admissions, given the falling trend in emergency admissions over the last decade in the city.

Whilst we have valuable new information on multiple long-term conditions in our local population, we do not have trend data and so cannot make robust projections of how this might change in the future. Population increases alone suggest we will have almost 10,000 more people with at least one long-term condition, including over 4,000 more people with three or more conditions by 2025. The greater percentage increase for multiple long-term conditions compared with single conditions is due to the greater population increases in older age groups who are more likely to have multiple conditions.

Evidence from elsewhere tells us that the rates of multiple long-term conditions are increasing, meaning that these figures are likely to be underestimates.

Risk stratification and predictive analytics

Health and social care are using digital technologies to help with managing demand and identifying opportunities for targeted preventative work.

Currently the CCG's Risk Stratification tool uses data on people's health service use to predict their likelihood of unplanned admission to hospital. Those most at risk of admission are offered multi-disciplinary support to promote their independence and wellbeing.

Adult Social Care is also implementing predictive analytics to help understand what causes people's care needs to escalate and to inform development of new preventative ways of working.

These tools will provide more detail about changing demands and long-term conditions and inform future planning to keep people safe, well and independent for as long as possible.

If current rates of multiple long-term conditions continue, by 2025 there would be around:

 134,650 people with at least one long-term condition

8% ↑ an increase of 9,600 people or 8%

 36,400 people with three or more conditions

13% ↑ an increase of 4,200 people or 13%

Conclusion

Based on current information, the growing and ageing local population will require more support from health and social care services in the future.

Older people today are more likely than in previous decades to have multiple long-term conditions through a combination of unhealthy lifestyles and increased life expectancy. This means people are living longer with multiple long-term conditions resulting in the higher associated healthcare costs demonstrated earlier.

But their needs are changing, with a shift towards care in the community rather than traditional nursing and residential care. To meet this need, local programmes should aim to improve wellbeing and to enable older people to live well and independently with long-term conditions.

Without considerable prevention efforts and action to improve the broader determinants there will also be increasing numbers of working age adults with multiple long-term conditions in need of health and social care support.

The clustering of unhealthy behaviours in young people requires action. Continuing to address this is crucial to preventing both their future ill health and future demands on services.

The association between lifestyle behaviours, and multiple long-term conditions, is clear. It is therefore imperative that prevention work continues to focus on creating a healthy city for all.

The prevention measures discussed later in this report can improve the health and wellbeing of the local population and have the potential to have a significant impact on the demand for services.



3

The case for prevention

The evidence

“The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.”
Five Year Forward View 2014

Building on Chapter 2 this section briefly considers the national context and provides further evidence of the importance of prioritising prevention. It sets out the effectiveness and cost effectiveness of system wide prevention measures. Subsequent chapters look at specific interventions across the life-course.

Investing in prevention is an international, national and local priority. The World Health Organization’s About Health 2020 health policy framework¹ makes the case for investing in health and creating societies where health is valued, not only because this is the right thing to do but because good health is vital for economic and social development and supports economic recovery. In a study of 200 public health interventions, 89% were considered cost-effective in terms of the National Institute for Health and Care Excellence (NICE) guidance.²

Preventing health inequalities

The 2010 Marmot review on health inequalities recommended strengthening the role and impact of ill-health prevention. It estimated that inequality in illness accounted for productivity losses of £31–33 billion per year, lost taxes and higher welfare payments in the range of £20–32 billion per year, and additional NHS healthcare costs associated in excess of £5.5 billion per year.³

The national health and care system

Increasing life expectancy, without increasing healthy life expectancy, means that there are more people with care and support needs arising from multiple long-term physical and mental health conditions, including dementia and frailty in old age.

Social care helps people to live as independently as possible, protects people from harm in vulnerable situations, balances risks with rights and offers essential help at times of crisis. Unlike NHS care, most of these services involve an assessment of the individual’s eligible needs and their financial resources (means-testing).

Over the past five years, local authority spending in England on the essential care and support needed by older and disabled people has fallen by 11% in real terms and the number of people getting state-funded help has reduced by at least 25%.⁴

The significant pressures that the NHS and social care are facing across England include overstretched general practice and community

Nationally the number of patient contacts in GP practices has increased by more than 15% between 2010/11 and 2014/15, with contacts with patients over 85 years increasing by 28%

nursing and the uneven distribution of intermediate care beds. The latter promotes and preserves the independence of people who might otherwise face unnecessarily prolonged hospital stays, or inappropriate admission to hospital or residential care.⁴

Primary care has faced funding and workforce challenges with some practices closing. An overall increase in GP numbers has not kept pace with an ageing population, resulting in a drop in the ratio of full-time equivalent GPs to the number of people aged 85 years or over.⁵

In Brighton & Hove the number of GP practices has reduced from 46 in 2015 to 39 in 2017. The number of GPs in the city is 0.63 full time equivalents per 1,000 population compared with 0.7 for England and 0.82 across the Surrey and Sussex Sustainability and Transformation Partnership footprint.

The number and complexity of patients on district nursing service caseloads has increased over recent years, coinciding with a 28% reduction in the total number of full-time equivalent district nurses between 2009 and 2014.⁶

Intermediate care services are most often used by older people and are designed to prevent unnecessary hospital admissions, support independence following a stay in hospital and where possible prevent people having to move into a residential home. A national audit suggests that the current level of spend on intermediate care is consistent with about half of the capacity required to meet demand.⁷

Since 2010, NHS money has been made available to support social care, through the Better Care Fund.⁸ This is considered to have made a difference but not

to have fully compensated for cuts in local authority budgets. In 2015/16, of the £5 billion Better Care Fund across the country, one third of the funding was used to protect social care services.⁹

What is happening locally?

Brighton and Hove Clinical Commissioning Group (CCG) and the council have a number of schemes to prevent avoidable hospital admissions and delays in discharging patients. All these schemes will form part of the Caring Together programme, whereby the council and the CCG are aligning health and social care budgets to better join up services for patients to deliver the following:

- Sustainable, better quality health services
- Improved public health
- Support for vulnerable people to stay well
- Empowered citizens and resilient communities.

The schemes that have been developed to prevent lengthy and unnecessary hospital admissions have built on the 'Discharge to Assess' process, whereby patients can be quickly and safely assessed and provided with care out of hospital by short-term, funded care support at home, where appropriate, or in another community setting. Assessment for longer-term care and support needs is undertaken in the most appropriate setting and at the right time for the person. The schemes are designed to offer patients a shorter stay in an acute hospital where health can often deteriorate over lengthier stays, promote speedier recovery for patients who require hospital care and prevent and avoid admission in patients who do not require acute care.

Local services include:

- The Community Rapid Response Service provides urgent support for patients for approximately three days, to prevent avoidable hospital admission.
- The Community Short Term Service at Home provides short-term rehabilitation and re-

ablement support in peoples usual place of residence and the Community Short Term Service provides people with this support in a local bed unit.

- The Intravenous Therapy Service supports the discharge of patients from hospital and prevents hospital admission.
- Integrated multi-disciplinary primary care teams made up of nurses, therapists, social workers, carer support workers and mental health nurses work with GP practices to support housebound patients who require routine care and support. There are currently nine teams across the city and these teams are being re-structured to align with the six primary care clusters in support of the Caring Together plans. There is

also an urgent homecare service: care provided by the voluntary sector to enable patients to be discharged and to keep patients flowing through hospital services: a roving GP service to support patients in the community, an out-of-hours district nurse service and GP-Led Out of hours and night sitting service to support people at home. A hospital at home scheme is under further development.

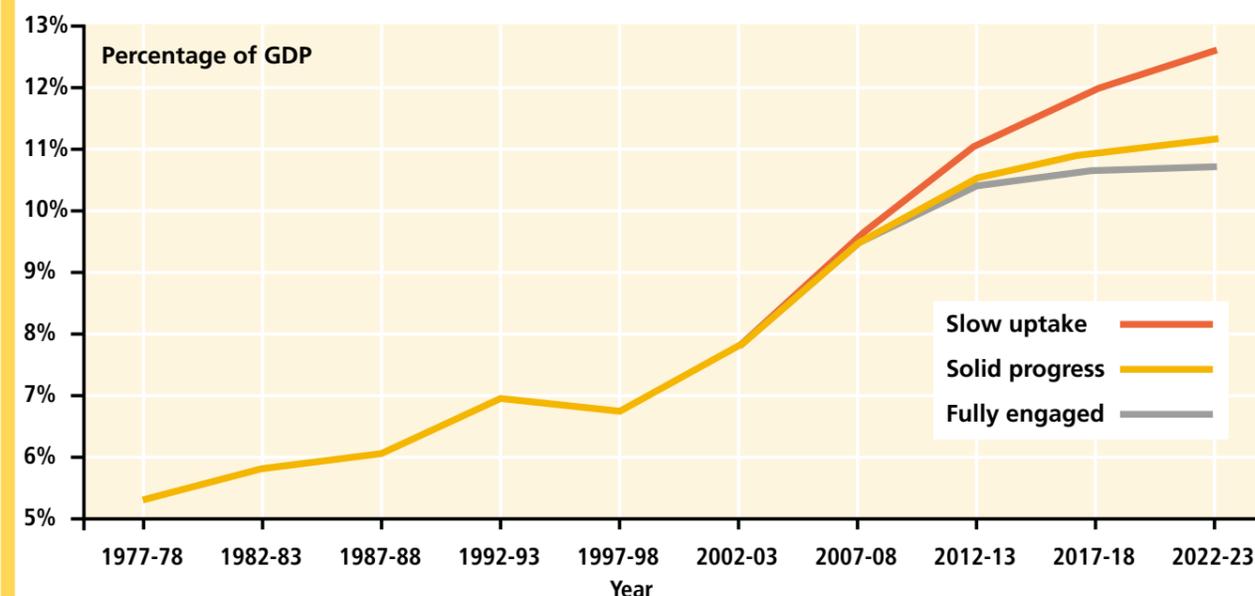
The Wanless fully engaged scenario – what was it and have we achieved it?

The Wanless report of 2002¹⁰ assessed the resources required to provide high-quality health services in the future until 2022. The report identified the potentially large gains to be made by refocusing the health service towards the promotion of good health and the prevention of

illness and warned that unless the country started taking prevention seriously, it would be faced with a sharply rising burden of avoidable illness.

The report illustrated the considerable difference in expected health outcomes and cost depending upon the future productivity of health services and how well engaged people became with their own health.

Figure 1 Estimated UK health spending according to the three Wanless report scenarios of slow uptake, solid progress and fully engaged (% of GDP)



Source Wanless et al Securing our future health: taking a long-term view 2002

The financial consequences of the three scenarios that Wanless focused on (slow uptake, solid progress and fully engaged) are clearly demonstrated in Figure 1.

Key elements of the fully engaged scenario were a dramatic improvement in public health, high levels of public engagement in relation to their health, with a sharp decline in key risk factors such as smoking and obesity as people took more care of their own health.

The Wanless projections for social care showed that due to population changes and ageing of the population, there would be much greater pressure on social care than for health care.

What's happening now?

Although national policy for health and wellbeing has aspired to achieve the fully engaged scenario this has not been realised and

Table 1 Wanless scenarios and life expectancy in England

	Males	Females
Slow Uptake	78.7	83.0
Solid progress	80.0	83.8
Fully engaged	81.6	85.5
ONS Figures	Males	Females
2013-2015	79.5	83.1

the Health and Social Care system is struggling to cope with the consequences.¹¹

Rather than the 'fully engaged scenario' that Wanless spoke of, in Brighton & Hove one in five (21%) adults still smoke, 42% drink over the weekly recommended amount of alcohol, nearly a third of men and half of women don't get enough exercise and just over a half of adults are overweight or obese. The percentage of obese children nearly doubles while children are at primary school from 7.5% in reception class to just over 13% by year 6 and Brighton & Hove has some of the highest rates of smoking, drugs and alcohol consumption in 15 year olds in England (see chapter 6). These patterns are influenced by, and in turn reinforce, health inequalities.¹²

As we can see from Table 1, increases in life expectancy across England have not achieved much more than what was expected in the slow uptake scenario. Life expectancy in Brighton & Hove stands at 79.3 for males and 83.5 for females.¹³

Type 2 diabetes is largely a result of lifestyle factors and an example of where services are now seeing the consequences of a failure to fully engage people with their own health. Currently the NHS spends an estimated £14 billion a year across England on treating diabetes and its complications. The recorded prevalence of diabetes in Brighton & Hove is currently at 4.1% of the adult population, though the true prevalence is considered to be much higher.

Engaging the population

A review by the Kings Fund¹⁴ identified slow progress in relation to workforce development, information technology support and premises improvements. They found that overall, people are not as involved as they want to be in decisions about health and care, yet when they are involved, decisions are better, health outcomes improve, and resources are allocated more efficiently.¹⁵ The lack of systematic progress on engaging the population is considered to be due to:

- The lack of clarity about the business of involving people in health - it is complicated, there are a range of different approaches and terminologies
- Involvement is challenging - it requires professional communities to do things differently and to let go; unwieldy administrative systems to become more responsive and patients and citizens to think about their health and their care in different ways

- Involvement has never been a priority in the NHS – the focus has been on activity, capacity, professions and organisations, and this work is denominated in the currencies of pounds, doctors, nurses and beds.¹⁶

Looking forward - the NHS's focus on prevention

The NHS England Five Year Forward View (2014)¹⁷ and the update report (2017)¹⁸ built on the Wanless review to refocus efforts on essential preventative action in order to develop a more sustainable health service. It outlined a vision for a more sustainable NHS and set out the need to address the health and wellbeing inequality gap, arguing that greater investment is needed in health and health care in more deprived areas.

“The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.” Five Year Forward View 2014

It warned that:

“If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.” Five Year Forward View 2014

This vision of a sustainable NHS that delivers care in new ways is underpinned by six principles for empowering people and communities, which reflect the commitment to promoting wellbeing, preventing ill health and closing the health and wellbeing gap:

- Care and support is person-centred – personalised, coordinated and empowering
- Services are created in partnership with citizens and communities
- Focus is on equality and narrowing inequalities
- Carers are identified, supported and involved
- Voluntary, community and social enterprise and housing sectors are involved as key partners and enablers
- Volunteering and social action are recognised as key enablers.

The update, published in March 2017, acknowledged how life expectancy is rising by five hours a day, but we're using the NHS more. It reported the significant recent public health initiatives such as through plain packaging for cigarettes, the national diabetes prevention programme and a sugar tax agreed to reduce childhood obesity.¹⁸



Brighton Marathon 2017 Photo Grounded Events Company

An example of prioritising prevention in Brighton & Hove: Cardiovascular disease

Circulatory disease accounts for 27% of all deaths in Brighton & Hove and 17% of deaths in the under 75s.

Blood pressure

There are approximately 28,150 people living with undiagnosed high blood pressure and an estimated 1,831 patients with poorly controlled high blood pressure in the city.¹⁹ Treatment for high blood pressure significantly reduces the risk of heart attacks, stroke, heart failure and all-cause mortality. Controlling blood pressure reduces the risk of major cardiovascular events by 20%. In Brighton & Hove this equates to reducing the number of cardiovascular events in 277 patients per year.

In comparison to ten areas with similar populations:

- Estimated prevalence of coronary heart disease

in Brighton & Hove is significantly worse than peers

- Estimated prevalence of hypertension is significantly worse than peers
- Stroke - Atrial Fibrillation observed prevalence compared to expected prevalence is worse than 10 other peer areas and worse than the England average
- Diabetes - Risk of stroke in people with diabetes is 60% worse than peers; uptake of Type 2 diabetes innovative medicines worse than all 10 peers.²⁰

What can be done?

Smoking and alcohol are both factors that contribute towards cardiovascular disease.



Smoking cessation interventions are extremely cost effective and at a population level addressing tobacco control has the potential to benefit disadvantaged groups and reduce health inequalities.²¹ School based smoking prevention programmes are cost effective with longer term savings of £15 for every £1 spent²² and programmes to develop children's life skills, and building self-esteem and resilience to peer and media pressure, can reduce smoking initiation by 12%.²³

General practice

The major interventions that the NHS can deliver to improve prevention, detection and management of those at risk of, and living with, cardiovascular disease are to:

- Increase opportunistic blood pressure testing in the practice
- Promote uptake of NHS health checks within the primary care setting. For every 27 checks carried out, one case of high blood pressure is detected²⁴
- Promote high standards in blood pressure measurement
- Identify patients with high alcohol consumption and offer brief interventions, with the potential to deliver savings to the NHS within five years²⁵
- Better quality recording and analysis.²⁶

Community pharmacy

Pharmacist-led interventions can reduce systolic blood pressure. A 20% improvement in the management of hypertension is estimated to save £14 per year per controlled patient over five years (£5.75 to the NHS and £7.91 to local authorities).²⁵

Hospitals

In secondary care tobacco screening, advice and referral and alcohol care teams offer savings to the NHS over five years.²⁵ Inpatient smoking cessation interventions are effective, regardless of the admitting diagnosis; they lead to a reduction in wound infections, improved wound and bone healing, and longer-term reduced risk of heart disease, stroke, cancer and premature death.

Inpatient alcohol identification and brief advice is effective and likely to have an impact on future admissions and long-term condition management.

The Commissioning for Quality and Innovation (CQUIN) prevention goals, which make up a proportion of healthcare providers' income is conditional on demonstrating improvements in specified areas of patient care, focuses on identifying, providing advice and offering referral to alcohol and stop smoking services for patients in community, mental health and acute trusts.²⁷

Prescribing and medicines management

The appropriate prescribing and management of medication in both primary and secondary care reduces cardiovascular disease:

- Statin therapy is associated with a reduced relative risk of all-cause mortality, and is considered cost-effective in secondary prevention²⁸
- Anticoagulation treatment for those with atrial fibrillation can result in net savings to the system of £1,400 per person per year by year five, with one stroke prevented for every 25 patients treated.²⁵

Population level

There is also a role for population wide interventions such as legislation to reduce salt in food. Such a population wide programme across England & Wales that reduced cardiovascular events by just 1% would result in savings to the NHS of at least £30m a year compared with no additional intervention.²⁹

The table below highlights the primary care interventions required to reduce cardiovascular disease in the city.

Cardiovascular Disease (CVD) Prevention Risk Detection and Management in Primary Care

The Interventions	Cross Cutting					
	1 NHS Health Check systematic detection of high BP, AF, NDH, T2DM, CKD, high cholesterol, CVD risk 2 System level action to support guideline implementation by clinicians 3 Support for patient activation, individual behaviour change and self management					
	High BP detection and treatment	AF detection and anticoagulation	Detection, CVD risk assessment, treatment	Type 2 diabetes preventive intervention	Diabetes detection and treatment	CKD detection and management
The opportunities	5 million undiagnosed – 40% poorly controlled	30% undiagnosed. Over half untreated or poorly controlled	85% of FH undiagnosed & most people at high CVD risk do not receive statins	5 million undiagnosed. Most do not receive intervention	940k undiagnosed. 40% do not receive all 8 care processes	1.2m undiagnosed. Many have poor BP & proteinuria control
The evidence	BP lowering prevents strokes and heart attacks	Anticoagulation prevents 2/3 of strokes in AF	Behaviour change and statins reduce life time risk of CVD	Intensive behaviour change (e.g. NHS DPP) reduces T2DM risk 30-60%	Control of BP, HbA1c and lipids improves CVD outcomes	Control of BP, CVD risk and proteinuria improves outcomes
The risk condition	Blood Pressure (BP)	Atrial Fibrillation (AF)	High CVD risk & Familial H/cholesterol	NDH ('pre-diabetes')	Type 1 and 2 Diabetes (T2DM)	Chronic Kidney Disease (CKD)

Source NHS Rightcare, Cardiovascular Disease prevention optional value pathway (accessed April 2017)

Mental health

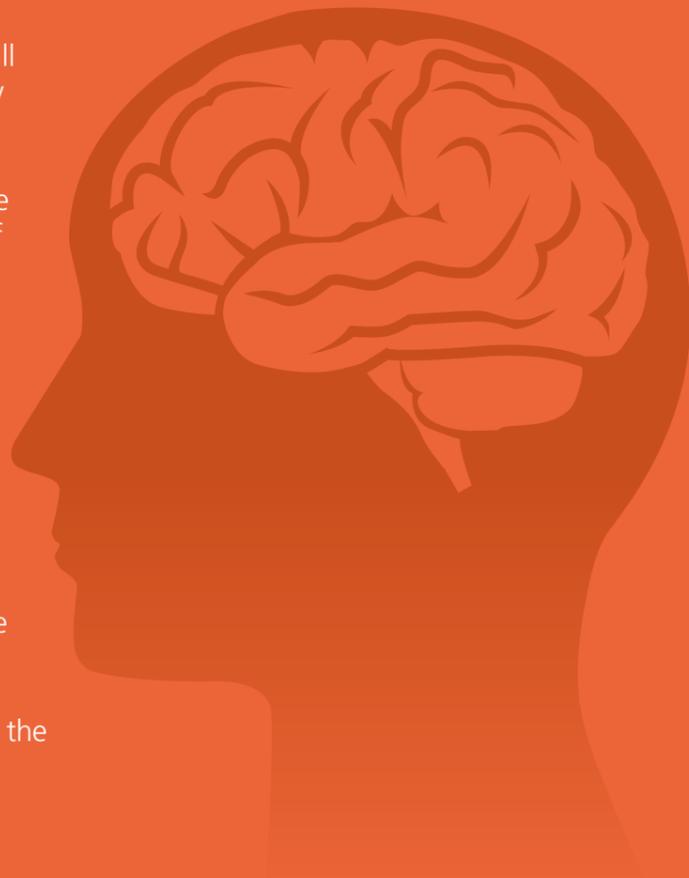
When people's mental health and emotional wellbeing deteriorates their physical health suffers too and vice versa. Poor mental health increases the annual cost of physical health conditions by between £8 and £13 billion.³⁰

As seen in Chapters 2 and 5, Brighton & Hove suffers from high rates of mental ill health. Actions to reduce the prevalence of mental ill health and mental health-related emergency admissions include²⁵:

- Providing early intervention in psychosis services. For mental health trusts to ensure that people experiencing a first episode of psychosis have access to a NICE approved intervention within two weeks of referral. This is happening in 89% of cases in Brighton & Hove.³¹
- Training A&E staff, school nurses, maternity staff, health visitors, GPs and walk-in-centre staff in mental health first aid.

The mental health Five Year Forward View³² calls for a far more proactive and preventative approach to reduce the long-term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services.

The report highlights children and young people as a priority group for mental health promotion and prevention and calls for early intervention and quick access to good quality care.



What else could we be doing to integrate services for prevention?

Self-care and self-management are priorities for continued action. For every £1 spent on encouraging self-care, around £1.50 worth of benefits can be delivered in return.³⁵ The outcome of improving self-management should result in a citizen or patient who:

- Has good access to information throughout life on lifestyle, care and health
- Is able to understand it and act upon it
- Makes informed choices
- Has knowledge that blurs the boundaries between themselves and professionals

- Is confident when and how to use health and care services
- Engages with healthy communities
- As a carer, is engaged on behalf of the patient.

Develop and integrate services using the evidence. The Five Year Forward View Update 2017 reported that in the 'vanguard' areas (these are areas selected for support from NHS England), where services are being integrated, there has been a slower growth in emergency hospital admissions and less time spent in hospital compared to the rest of the country. This has been particularly noticeable for people over 75.¹⁸ Lessons should be learnt from these areas as well as from evolving evidence.

Healthy Living Pharmacies

An estimated 95% of people visit a community pharmacy at least once a year.³³ They provide convenience and anonymity in a relatively informal setting. In November 2016 Brighton & Hove pharmacies ranked the highest for satisfaction of any public service in the city with 94% of respondents very or fairly satisfied.³⁴

Community pharmacies reach communities in more deprived areas and people living in these areas are twice as likely to visit a pharmacy compared to people from less deprived areas. Pharmacies provide an accessible location with trained staff to provide evidence based advice and services to prevent premature mortality.²⁵

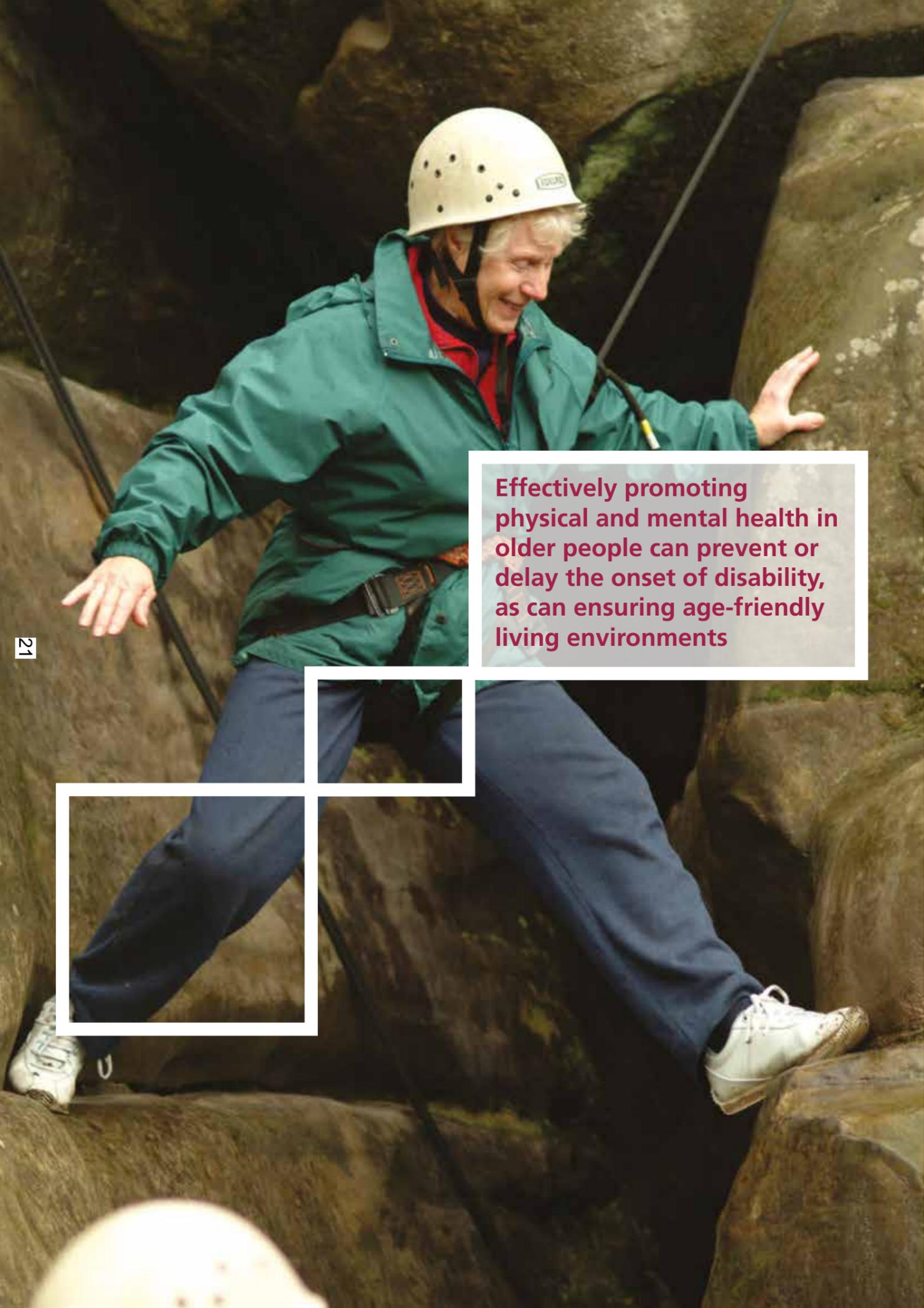
Twenty of the 59 pharmacies in Brighton & Hove are Healthy Living Pharmacies supported by the council's Public Health team and the CCG. Each Healthy Living Pharmacy has a trained Healthy Living Champion to provide advice, support and brief interventions on healthy lifestyles. They run monthly health improvement campaigns and train their team on 'Making Every Contact Count.' Healthy Living Pharmacies also provide stop smoking services and Chlamydia testing as well as advice on medications and other health services.

As more pharmacies now have the opportunity, through the national contract, to become a Healthy Living Pharmacy, we expect more action on prevention in pharmacies across the city.



A Nuffield Trust³⁶ report highlighted the key initiatives with the strongest evidence for preventing hospital admissions, reducing activity and whole system costs. These included improving GP access to specialist expertise; ambulance/paramedic triage to the community; condition-specific rehabilitation; additional clinical support to people in nursing and care homes; improved end-of-life care in the community and remote monitoring of people with certain long-term conditions. There was also emerging evidence for patients experiencing GP continuity of care; to have an 'Extensivist model' which provides holistic care for those at greatest risk; social prescribing; senior assessment in A&E and rapid access clinics for urgent specialist assessment.

In order to deliver on improved prevention, enhanced patient engagement and better supported self-management for long-term conditions, adequate data and performance tools and systems are needed locally to identify where improvements are required in the system and to monitor progress. Local plans and services must be aligned to ensure action is focused on improving the public's health and making services more efficient. The Caring Together programme provides a significant opportunity for health and care organisations to join together to focus more on preventing ill health as well as inequalities in health.



4 Older people Ageing well

Effectively promoting physical and mental health in older people can prevent or delay the onset of disability, as can ensuring age-friendly living environments

The number of older people is increasing

4,000 more people aged 75 or over are expected to live in the city in 2025 compared with 2015

From 18,100 people in 2015

To 22,000 people in 2025



Currently **four in ten** older people live alone compared with **three in ten** across England, with many at risk of social isolation



As described in Chapter 2, the number of older people living with multiple long-term conditions is expected to increase over the coming decade. But growing old need not be the same as growing infirm.

The rate of decline in the health and wellbeing experienced by older people is largely determined by factors related to lifestyle, external social, environmental and economic factors, and the interaction between them. Effectively promoting physical and mental health in older people can prevent or delay the onset of disability, as can ensuring age-friendly living environments.¹⁻⁴

The evidence base on action to improve the health and wellbeing of older people highlights the potential of early intervention to improve wellbeing and save money. A 'whole system place based approach'⁵ is required which addresses the broader determinants of health and wellbeing for the population of the city.⁶ Services need to work together to address the factors resulting in the need for social care, including health and mobility problems, breakdown of informal support and social isolation.

“If we focus on place, rather than institutions, we’ll have healthier communities and a more effective (health) system.” New Local Government Network, 2016⁶

In addition, it is important to recognise the contribution of older people themselves both as an untapped source of information about what works⁷ and as contributors to their communities through voluntary and increasingly paid work.

Loneliness and social isolation

There is a growing recognition that loneliness is

a serious problem with far reaching implications for individuals and wider communities.⁸ Acute loneliness has been estimated to affect 10-13% of older people. It can be a tipping point for referral to adult social care and the cause of GP attendances. Loneliness can increase the risk of premature death by 30%,⁹ and it has been estimated that social isolation and loneliness are associated with 50% excess risk of coronary heart disease (similar to the excess risk associated with work-related stress).¹⁰

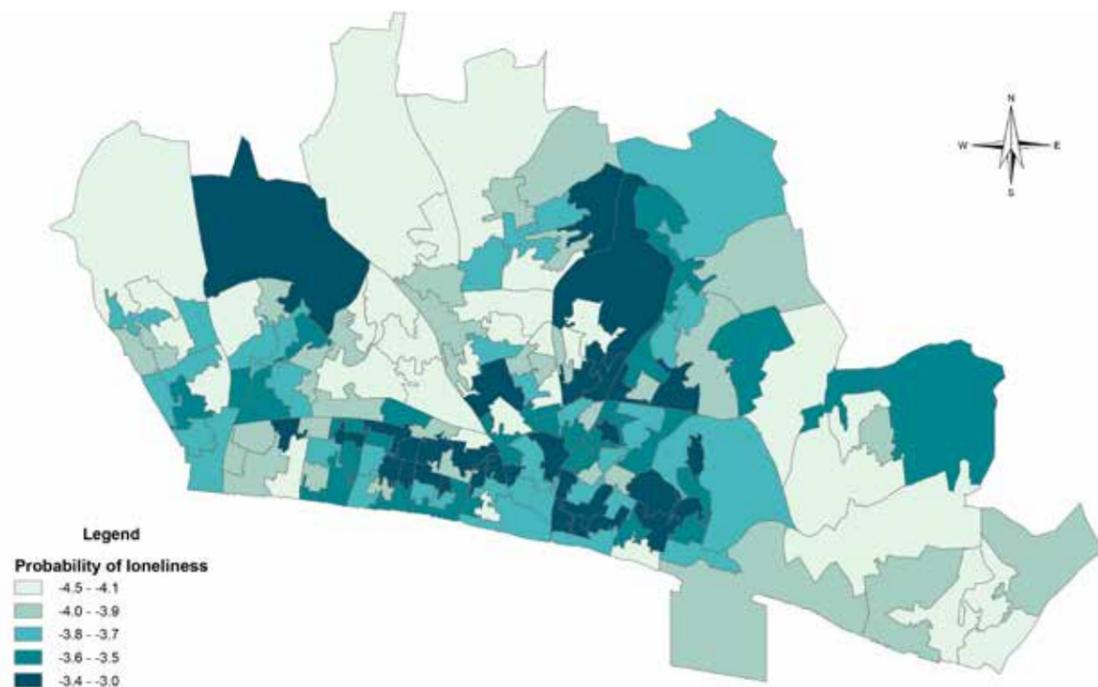
The cost of social isolation is difficult to determine, however effective interventions can deliver substantial returns on the investment.

Risk of loneliness

Map 1 shows the risk of loneliness for people aged 65 or over in households across the city. The model devised by Age UK uses data from the English Longitudinal Study of Ageing (ELSA) survey to predict loneliness. The map shows

that there are older people at risk of loneliness throughout the city, with concentrations around the Lewes Road corridor, Kemptown, Whitehawk and Central Hove.

Map 1 Probability of loneliness for those aged 65 or over (closer to zero = higher probability of loneliness), 2011



Source AgeUK (Explore the map at Brighton & Hove Community Insight <http://brighton-hove.communityinsight.org/>)



Singing together for better health

Going to see culture together at Fabrica



Falls prevention¹¹

In 2015/16 there were:



905 Falls requiring an emergency admission to hospital in those aged 65+ years:



269 were male



636 were female

65-79 **314** were aged 65-79 years

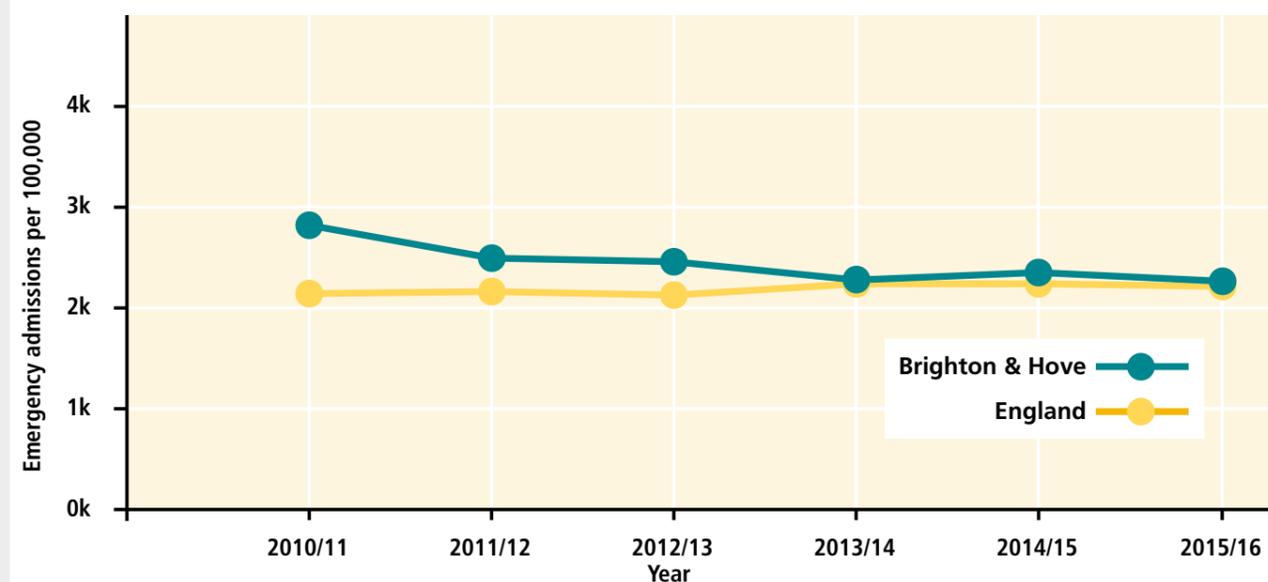
80+ **591** were aged 80+ years

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 or over have the highest risk of falling, with 30% of people aged 65 or over and 50% of people aged 80 or over falling at least once a year. The human cost of falling includes pain, injury, loss of confidence, loss of independence, social isolation and mortality. Overall, hip fracture is fatal in 20% of cases and causes permanent disability in 50% of those affected; only 30% of patients fully recover.¹²

In Brighton & Hove in 2015/16, the cost of admissions to Brighton & Sussex Universities Hospital for people aged 65 or over who sustained a fracture, particularly hip fractures, was £2.6m. This does not include subsequent social care costs.

The number of falls per year requiring an emergency hospital admission has reduced in recent years, from 1,112 falls in those aged 65 or over in 2010/11 to 905 in 2015/16. Accordingly the rate of admission per 100,000 has fallen and is no longer significantly worse than the rate seen across England (Figure 1).

Figure 1 Number of emergency admissions to hospital due to falls (in thousands) per 100,000 population in people aged 65 or over, Brighton & Hove and England, 2010/11 to 2015/16



Source Public Health England, Public Health Outcomes Framework

Community based programmes can be effective in preventing falls:

- Well-designed exercise programmes, even for the very old and frail, can reduce the risk of falling
- Group exercise reduces the rate of falls by 29% and the risk of falling by 15%. Home-based exercise reduces the rate of falls by 32% and the risk of falls by 22%¹³
- Strength and balance programmes are highly cost-effective with one in every 11-16 people participating in the programmes avoiding a fall as a result of their participation.¹⁴⁻¹⁶

Age-friendly cities

Since the publication of the World Health Organization (WHO) Global Age-friendly Cities guide in 2007,⁴ the Age-friendly Cities framework has been helping cities meet the complex challenges and opportunities of population ageing and urbanisation by moving beyond a traditional health and social care model of ageing. Notions of respect and social inclusion are as important as issues of functional mobility and health, and ageing is seen in a broader context than merely as a condition of mounting dependency and need.

‘An age-friendly city encourages active ageing by optimising opportunities for health, participation and security in order to enhance quality of life as people age. In practical terms, an age-friendly city adapts its structures and services to be accessible to and inclusive of older people with varying needs and capacities’.⁴

What are we doing in Brighton & Hove?

In Brighton & Hove, as part of the Keeping People Well programme, services are working together to delay or prevent the onset of disability and frailty in later life by helping older people maintain good health and independence, reducing social isolation, promoting wellbeing and combatting ageism.

There are seven key local priorities. Examples of actions underway include:

1 Information and service access

- Online resources are helping residents find out about local activities and services
- It's Local Actually is a database of free or low cost activities in the city and business and services listings to help with personal care and practical support



Learning digital skills

- My Life is an online directory listing local and national organisations and services to support everyday living
- The council, along with other organisations, is working to improve older people's digital skills and confidence and improve public access to computers and wi-fi
- New models of community based transport are being developed to help people 'to and from' activities, including a pilot volunteer driver scheme in East Brighton and broadening the availability of 'shopmobility' mobility scooters.

2 Supporting older people to adopt healthier lifestyles

- Brighton & Hove is piloting Making Every Contact Count (MECC) with organisations working with older people, training frontline workers to be confident and competent to help older people identify ways to change their behaviour
- Health Trainers offer one-to-one advice, support and encouragement to people who want to change their behaviour and improve their health
- Community Navigation is a social prescribing service currently operating as a partnership between the voluntary and community sector and GP surgeries across Brighton & Hove. Community Navigators are trained volunteers, with previous experience of supporting people, who work with a person to help them identify and access the right local groups and services. Navigators facilitate onward referrals by making arrangements on the person's behalf as needed. Around half the people supported are aged 65 or over.

3 Preventing falls

Cross agency working to reduce falls has included:

- Awareness raising and campaigning around falls prevention. This year's falls prevention awareness campaign will culminate at the TAKEPART Festival
- Training frontline workers about falls prevention including those working with older people (including physical activity practitioners) and providing Royal Society for the Prevention of Accidents (ROSPA) training for people visiting older people in their homes
- Briefing sessions for other key workers including Adult Social Care, community pharmacists, the Older People's Council, community and voluntary sector organisations, care homes and home care organisations
- Promoting national materials such as Get Up and Go - a guide to staying steady¹⁷
- A variety of programmes for older people across the city to support them to lead active lifestyles. All activities are low cost, and suitable for a wide range of abilities, including beginners.



Learning badminton at King Alfred and learning to cycle at The Level



4 Reducing loneliness and isolation and improving older people's mental health

In total there are more than 1,000 low or no cost activities and interest groups on offer to older people across the city, and participation is increasing year on year.

Last year, around 3,500 older people got involved in activity and interest groups offered by organisations funded through the **Public Health Older People Programme**, ranging from art and gentle exercise to IT skills training, language and cookery classes, and dance nights.

The **Citywide Connect** initiative brings together organisations and services (including health and social care, emergency services, care homes, home care providers, community and voluntary sector and faith groups). Through regular Locality Hub meetings they share information and resources, gain knowledge and work together to broaden what's on offer for isolated and vulnerable older people. There are hubs in the east, central and west of the city.

Last year the **Brighton & Hove Befriending Coalition**, a collaboration between 18 organisations, enabled more than 600 volunteers to support over 800 older people, people with learning, physical and sensory disabilities, people with cancer, carers and others at risk of isolation and loneliness. There is now a single contact point to direct referrers and volunteers to the best suited befriending group.

The **Dementia Action Alliance**, formed in 2015, aims to: make Brighton & Hove a Dementia Friendly Community; raise awareness across the city about dementia; improve the health and wellbeing of people with dementia; reduce their social isolation and that of their carers; and improve their experience of living in the city.

Supporting unpaid carers is a key priority for the city – it is estimated that there are nearly 24,000 unpaid carers in the city and Carers UK estimate the economic value of their contribution to be £437million per year.¹⁸ The proportion of the population providing unpaid care generally increases with age with around 5,000 people aged 65 or over providing unpaid care in the city in 2015, estimated to rise to over 6,700 by 2030.¹⁹



Knitting together



Playing boccia together



Swimming together

- Services and opportunities for carers include:
- A Carers Digital Offer, provided by Carers UK, provides carers with a range of online support
 - A local Carers' Information Booklet outlines carers' rights, provides a directory of support services and gives a checklist of things for carers to consider
 - 'Employers for Carers' provides local employers with access to a range of initiatives to help them support carers
 - Carers self-assessments enable carers to identify their needs and support in relation to their caring role

- The Carers' Card provides access to discounts and offers on health and wellbeing activities, as well as promoting carer awareness within local businesses.

From summer 2017 a new Carers' Hub will provide a range of dedicated support to all carers, via a partnership of organisations as well as through Adult Social Care Carer Support Workers, who will provide assessment and support to carers and take a lead role with those most at risk, including older carers.

Case study: Brooke Mead

Brooke Mead is a council-led extra care housing development in Central Brighton comprising of 45 one bedroom units of accommodation with both communal and community

facilities on the ground floor. It will provide 24 hour on site care and support for older people and those living with dementia when it is completed in summer 2017. Facilities will include two

communal activity rooms, a cafe, lounge, courtyard garden, and laundry room. The development will meet the latest standards in design for age-friendly and wheelchair accessible housing.



What Brooke Mead will look like when completed

Supporting isolated men

In recognition of the isolation experienced by men, especially unemployed and newly retired men, a Men's Shed has recently been set up in East Brighton offering opportunities for men to come together to 'make and mend'.

5 Supporting people to live independently

Telecare describes a range of services and equipment that support people at home and out and about by providing emergency assistance when needed. CareLink Plus is Brighton & Hove City Council's telecare alarm service. It provides a range of technological support to 5,000 people with specialist needs. In addition to the 'red alarm button', CareLink Plus offers a wide range of sensors to residents such as for bed and chair occupancy, temperature and falls detection.

CareLink Plus also offers a support programme called Living Well, which allows more in-depth work with people who need bespoke support following discharge from hospital or residential care, or help to maintain their health and



A Men's Shed in action photo James Gasston

independence and prevent crisis situations, leading to hospital admissions.

In 2015 Seniors Housing (previously known as Council Sheltered Housing) remodelled its approach to embed prevention and wellbeing. Residents are supported by scheme managers to maintain their health and wellbeing and prevent isolation. Increasingly, this involves working in partnership with a wide range of statutory and voluntary organisations, health promotion services, and arts and faith organisations.

received treatment as soon as possible. After returning home for a second time, Jim reported being very cold at home. Living Well workers contacted the Red Cross discharge service who provided extra blankets and a warm pack straightaway. They also made a referral to Initial Response Service Technicians (IRST) to trial hearing equipment for the doorbell, phone and TV, which will help Jim to hear when he has visitors and phone calls, as well as ensure he can enjoy the programmes he likes to watch.

Jim continues to be able to get out and about and live independently.

Case study: Jim

NB names have been changed

Jim is a fiercely independent man in his mid-90s who lives in the east of the city. He has a history of pneumonia, a heart bypass and a hearing impairment. Jim was admitted to hospital with pneumonia, and was referred to Living Well to support him to return home. Living Well Support Workers were able to visit Jim the same day they received the referral. They installed a CareLink unit and alarm pendant so Jim could call for help in an emergency.

A week later Jim pressed his button and reported shortness of breath, and was admitted to hospital in an appropriately timely way, and



Brighton & Hove's Older People's Festival

Health Promoting Care Homes:

Local care homes are being offered support to develop a health promoting approach with their residents, staff and visitors. Examples of initiatives offered to participating homes include:

- The Active Forever Moves programme involving seated exercise in senior/care settings
- The Falls Prevention 'Strong and Steady' campaign
- Support to promote the oral health of older people in care homes, including hygiene and tooth care, and care of dentures
- The Healthy Choice Award to encourage good nutritional awareness and practice in residential settings
- Support to promote the five ways to emotional wellbeing – Connect, Be active, Take notice, Keep learning, Give
- Development of care homes as healthy workplaces – working towards the Workplace Wellbeing Charter.

6 Tackling stigma around ageing

The Public Health Older People Programme aims to present a positive profile of older people, their assets, issues and concerns. A highlight is the annual older people's festival, attended by more than 2,000 older people in 2016, which

offers a range of activities for older people from dancing, the arts, political and social history events which celebrate the contributions older people continue to make to this city.



Older People's Festival 2016, Maria Scard exhibition, images of older people highlighting their contribution to the city



Silver Strings performing at Brighton bandstand

7 Mainstreaming an age friendly city approach

The Brighton & Hove Age Friendly City programme is led by the City Council in partnership with key older people's organisations in the city. A series of workshops brings together the evidence base, shares local and national good practice and identifies new

approaches and solutions to reshape the city's urban environment and services in line with age-friendly approaches and principles. Recent examples include employment and volunteering, sex and relationships and working together to promote active living.

Kayaking by Brighton pier



What more could we do?

Falls

Currently there is a limited citywide programme to reduce the number of older people falling, particularly a first fall. There is a need for a more comprehensive approach, especially the provision of strength and balance classes delivered in community settings. Evidence indicates that one fall would be prevented for every 11-16 people that attend such a programme.^{14,15}

Befriending

The Clinical Commissioning Group (CCG) and city council have commissioned a pilot project exploring the potential for a citywide befriending service that is:

- Neighbourhood based and community focused
- Accessible and equitable across the city so that anyone who meets the criteria is eligible to receive the same type of service, no matter where they live

- Supported by a central contact point.

The findings of the pilot should be considered to inform how befriending is offered across the city in the future.

Community Navigators

The Community Navigator service is currently only accessible in 15 out of 39 GP practices in the city. Evidence suggests that it is successful in identifying people with social rather than medical needs and signposting or supporting them to access appropriate community based services. This programme could be developed into an open access Community Navigator service across the city, supported by a multi-agency Social Prescribing Network.

Food and nutrition

Nationally, it is estimated that one in ten older people either suffer from or are at risk of malnutrition. Good nutritional care is not always prioritised by either older people or health professionals. Being malnourished increases the risk of frailty and the need for health and social care.²⁰ National Institute for Health and Care Excellence (NICE) guidance on nutrition²¹ and quality standards²² supports screening for malnutrition both in hospital and the community. The MUST (Malnutrition Universal Screening Tool) is not currently used routinely in hospital and care home settings.

The Food Partnership has highlighted that older people are increasingly at risk of food poverty, skipping meals and eating unhealthily. Promoting lunch clubs is one way of both ensuring a healthy meal and companionship, as is setting up groups where people come together to eat.



Sunday lunch at the Hop 50+

There are opportunities, especially for the voluntary and community sector, to help provide some of these options around food, whether that is rebranding existing lunch clubs so that people feel they are for them or developing new methods of delivering cooked meals e.g. Casserole Clubs. The most effective mechanism is a preventative approach so that people don't become isolated and/or vulnerable to food poverty in the first place. It is important to target times when people are especially vulnerable (e.g. following bereavement or hospital discharge).

The flu jab

Flu can cause unpleasant illness in children and severe illness and death among at-risk groups including older people, pregnant women and those with an underlying health condition. Flu vaccination is the best protection available against flu. However, it can't stop all flu viruses every winter and the level of protection it provides varies between people, but if someone vaccinated does get flu it's likely to be milder than it would have been if they hadn't had their flu jab.

Historically, the uptake of the flu jab by older people living in Brighton & Hove has been low compared with other parts of the country. Many different approaches have been tried over the years but as this year's data shows there is still much room for improvement.

The flu vaccine uptake in Brighton & Hove for patients aged 65 or over was 64% in 2016-17 compared to 65% in 2015-16. This is the lowest rate in Surrey & Sussex and lower than the England average of 70%.²³ NHS England, the CCG and public health continue to work together to try and address this.

The next chapter considers working age adults and prevention with a view to improving healthy life expectancy. Many of the programmes discussed there are just as relevant to older people.

- 1 Be active**
150 mins a week
- 2 Stop smoking or don't start**
Be smokefree
- 3 Be happy**
Learn, give, take notice, be active, connect
- 4 Eat well**
Less salt, and sugar, 5-a-day
- 5 Maintain a healthy weight**
BMI < 25
- 6 Drink in moderation**
< 15 units a week
- 7 Have safer sex**
Prevent unwanted pregnancy & infections
- 8 Go for cancer screening**
- 9 Get checked out**
- 10 Stay connected**
Volunteer, work

5 Working age adults Living well

How we live as working age adults plays a significant role in our long-term health. Our behaviour makes a bigger difference to our risk of a premature death than health care.¹ Poor diet, smoking, high blood pressure, being overweight or inactive are risk factors for all of the most common causes of disease in the UK. Having poor mental health is also a risk factor for less healthy lifestyles and poor physical health. There is a two way relationship between poor mental health and many of the risk factors discussed in this chapter. Social factors such as unemployment, poverty and poor living conditions increase the risk of developing less healthy behaviours and poor mental health.

This chapter focuses on ten ways working age adults can help maintain their health and wellbeing and gives examples of what we are doing in the city.

Staying physically active is a simple way to achieve a happy and healthy life. Adults are recommended to do 150 minutes per week of moderate exercise (30 minutes on five days) and muscle strengthening exercise on two days a week, minimising inactivity.²

1 Be active
150 mins a week

This 'wonder drug' reduces death from all causes by 30%²; heart disease and stroke by 25-30%; the risk of type 2 diabetes by 35-50%; and the risk of cancer, including a 35-50% reduced risk of bowel cancer. Staying active also helps maintain a healthy weight and higher bone density and reduces the risk of depression and dementia. It is a good way to make life more enjoyable, with those who are active having an enhanced sense of well-being, self-esteem, mood and sleep quality, with reduced levels of anxiety and fatigue.²



Supporting the most inactive people to be more active would prevent one in ten strokes and cases of heart disease, one in eight cases of type 2 diabetes and one in six premature deaths.

One of the best ways to get more active is to start travelling actively, walking or cycling and taking public transport. Switching from car travel to active travel provides very good value for money, with a return on investment of £1,220 per year on switching to walking and £1,121 on switching to cycling.³

Brighton & Hove residents are more active than the national average, but physical activity levels are lower amongst Black and Minority Ethnic groups, in more deprived areas of the city and amongst older people. Overall one in five local adults is inactive.⁴

The national strategy 'Everybody Active Every Day'⁵ aims to increase activity through:

- Creating safe and attractive environments where everyone can walk or cycle, regardless of age or disability
- 'Making Every Contact Count' for professionals and volunteers to encourage active lives
- Leading by example in every public sector workspace.

What we are doing locally:

- **Active for life** provides opportunities for residents to be more active through

discovering free or low cost sports and physical activities. They include targeted sessions for groups who may experience barriers to being more active.

- **Health trainers** provide behaviour change support for individuals wanting to become more active, with advice on travelling more actively
- Training and support is available for **workplaces and other organisations** to help the workforce and communities become more active
- Over 50 **community engagement events** take place each year including citywide events and campaigns such as One You, Dance Active and the TAKEPART Festival.

What more should we be doing to support adults to get active?

- Support health and other professionals to recognise inactivity, raise the issue, deliver brief advice (Making Every Contact Count) and support behaviour change. Local clinical champions can support this too
- Support businesses and the workforce to become more active through active travel and physical activity during the working day including promoting cycling and walking to work and for recreation
- Work with local planners to support active travel.

2 **Stop smoking or don't start**



Be smokefree

Half of all life-long smokers die prematurely losing on average 10 years of life. Smoking is the single largest cause of health inequalities, accounting for half the difference in life expectancy for those living in more deprived areas compared with less deprived areas. It causes one in six of all deaths over the age of 35 including over one-third of respiratory deaths, one-quarter of cancer deaths and one in seven deaths from heart disease.⁶

In Brighton & Hove one in five (21%) adults smoke, significantly more than in England (17%).⁷ One in three routine and manual workers smoke (34%), compared with 27% in England. The estimated annual cost to Brighton & Hove due to smoking is £82.9m, broken down into: £38m lost productivity from smoking breaks, £18m early deaths, £8m sick days, £10m smoking related diseases (NHS), £7.4m social care related to smoking, £2m smoking related fires and £1m passive smoking.⁸

Smoking not only adds to the overall social care bill but smokers also need care on average four years earlier than non-smokers.⁹ Current and ex-smokers who require care in later life as a result of smoking-related illness cost an additional £7.4m a year across Brighton & Hove

Every week in Brighton & Hove - smoking



33 people are admitted to hospital with a smoking attributed illness



7 people die of smoking attributable illnesses



1.6 million is the estimated weekly cost due to smoking in lost productivity, smoking-related illnesses, social care, domestic fires and clean-up operations



But 26 people successfully quit smoking with local stop smoking services

(£4.1m to the local authority, which equates to 185 individuals, and £3.4m to 92 individuals who self-fund their care). An additional 1,254 individuals receive informal care from friends and family.

Cost effective interventions include protecting people from tobacco smoke, warning them of the dangers of tobacco, enforcing bans on advertising, increasing tobacco related taxes and counselling. Smokers who quit reduce their lifetime cost to the NHS and social care providers by 48%. The biggest short-term savings are from helping smokers who are in contact with the NHS; the greatest long-term savings come from preventing people starting smoking altogether.¹⁰

Smoking and poverty

When net income and smoking expenditure is taken into account, more than 8,900 local households (24%) with a smoker fall below the poverty line. If these smokers were to quit, 2,900 households in Brighton & Hove would be taken out of poverty, including the 3,500 working age adults, 1,350 dependent children and 600 pension age adults who live in them.¹¹

The Brighton & Hove Tobacco Control Alliance is focusing efforts on reducing health inequalities from smoking and tobacco through:

- Supporting smokers to quit using evidence based support with counselling and medication. During 2015/16 local stop smoking services supported 4,216 people to try to quit smoking, with 2,715 successfully quitting at four weeks. Health trainers are providing additional stop smoking services in more deprived areas and in workplaces
- Making Every Contact Count (MECC) and training frontline staff from East Sussex Fire and Rescue Service, the NHS and council in providing very brief advice
- Streamlining the referral process for adults to stop smoking services at the Royal Sussex County Hospital and Sussex Partnership Foundation NHS Trust and training NHS staff to provide stop smoking support for inpatients and outpatients in secondary care.

What more should we do to prevent smoking related harm?

- Increase the use and effectiveness of stop smoking services in primary care
- Promote the local 'electronic-cigarette friendly' stop smoking services, reaching areas with the highest smoking rates
- Train voluntary sector, allied health professionals and non-professionals in very brief advice to support people to stop smoking
- Reduce illicit tobacco use in Brighton & Hove.

Stop before the Op

A smoker has a higher risk of death and complications, including heart and lung problems and risks of infections, at the time of an operation when compared with a non-smoker. Smokers are more likely to have a longer hospital stay and to be readmitted to hospital. Supporting smokers to give up smoking before their operation, 'Stop before the Op' can help reduce all these risks for a patient and save the costs of treating these complications and time spent in hospital.¹²



Emotional wellbeing promotes physical health and mental distress undermines physical health.¹³ Parity of esteem is a central concept of the national strategy, No Health without Mental Health,¹⁴ which requires that funding, services and attitudes to mental health should more closely match those for physical health. Mental health problems are very common, with at least one in four adults diagnosed with a mental health problem at any one point in time¹⁵ and they account for more years of ill health (23% of disability adjusted life years) than cardiovascular disease (16%) or cancer (16%).¹⁶ The cost of mental ill-health to the UK economy has been estimated at £110 billion per year.^{17,18}

Brighton & Hove has higher rates of mental health problems than the national average: for all of the following indicators, Brighton & Hove has a significantly higher rate than England;

- 1 in 4 residents reports high levels of anxiety
- 1 in 12 residents is on a GP register for depression
- 1 in 83 residents is on a GP register for severe mental illness.¹⁹

Everyone can incorporate the **Five Ways to Wellbeing**²⁰ into their lives:

- Connect
- Be active
- Take notice
- Keep learning
- Give²⁰



These everyday actions help to build emotional resilience so that we are better able to cope with the challenges that may come our way.

What are we doing to improve local mental health and wellbeing?

- With the CCG, and in line with our local strategy **"Happiness", the Brighton & Hove mental health and wellbeing strategy**, we commission programmes to promote positive mental health for all and to support groups that are particularly vulnerable to mental health problems
- Events such as World Mental Health Day are promoted locally
- Screening for the early identification of mental health problems is cost effective in certain settings and groups e.g. the workplace,²¹ NHS health checks, people with diabetes and postnatal depression screening by health visitors.

What more can we do to support mental wellbeing?

- **Helping everyone to look after their own mental wellbeing** by promoting individual resilience through the "Five Ways to Wellbeing" and other approaches such as mindfulness, providing easily accessible information on services and support groups, challenging stigma and working with employers to promote workplace wellbeing and to support those affected by mental health problems

- **Identifying and supporting people in groups at higher risk of mental health problems** such as those who are homeless or insecurely housed; people with long-term conditions; unemployed people; offenders; lesbian, gay and bisexual people; transgender people and military veterans
- **Provide training for frontline staff and volunteers** to develop confidence and competence in understanding mental health problems and signposting to further help.²²

Preventing suicide

Suicide is the leading cause of death for men under 50. Local rates are consistently higher than for England. There are around 35 deaths per year with one in twenty adults reporting having experienced suicidal thoughts in the past year.²³ The effects of suicide are far-reaching and include family and friends, work colleagues and professionals. In England, each suicide costs the economy an estimated £1.7 million. Locally, everyone can help by:

- Talking to someone and asking for help if they are having suicidal thoughts
- Asking directly about suicide if they are concerned about someone, accessing training via Grassroots Suicide Prevention www.prevent-suicide.org.uk and knowing where to find help: www.brighton-hove.gov.uk/suicide-prevention.

The city's action plan for suicide prevention includes training and signage along the seafront, a higher risk area, support for groups that are more vulnerable to thoughts of suicide or have already made an attempt on their own lives, learning by clinicians from deaths by suicide and better support for those bereaved by suicide.

4 Eat well



Eat a healthy and balanced diet

Diet related disease costs Brighton & Hove £80 million each year.²⁴ In the UK we eat two to three times as much sugar as the recommended maximum of 30g a day,²⁵ and 70,000 deaths per year could be avoided if diets matched nutritional guidelines.²⁶

Dietary salt raises blood pressure resulting in a higher risk of heart disease and stroke. Three quarters of the salt in our diet comes from processed food. The recommendation is to eat no more than 6g of salt a day, but currently the average is over 8g a day. However, over the last decade the salt content of bread has slowly reduced (by 40%), with overall daily salt intake reduced by 1g since 2000.²⁷

Only 30% of adults aged 19-64 years in the UK eat the five portions of fruit and vegetables recommended daily,²⁸ with those in lower income groups having lower consumption. Eating fruit and vegetables helps prevent heart disease, some cancers and provides essential vitamins and minerals for a balanced diet.²⁹ Local work on food poverty highlights the challenges some residents have in affording a healthy diet in the current economic climate.³⁰

Interventions to promote public awareness, health education in workplaces, the replacement of trans fats with poly-unsaturates and counselling in primary care have all been found to be cost effective in promoting a healthy diet.²¹

Brighton & Hove's Sugar Smart survey found that over 80% of residents were concerned about the amount of sugar in their diet and had become increasingly concerned in recent years.³¹ Local Sugar Smart information helps residents swap sugary foods and drinks, cut out snacks and cook from scratch. National apps such as Be Sugar Smart and Be Food Smart apps help with healthier choices when shopping and the One You programme provides encouragement and motivation to make dietary changes.

Additional work in the city to promote healthier food environments includes working with catering procurement, advising on contract details regarding healthy food provision and linking with tourist locations, health care settings and businesses.

What more can be done to prevent diet related disease in the city?

- Encourage and support more businesses to adopt the Government Food Buying Standards or work towards the Brighton & Hove Healthy Choice Award to help support a healthier food environment when eating out. Residents said they need clearer information to make healthier choices when out and about³²
- Work with local hospitals, workplaces, local partners and educational settings to improve the food environment and food available.



A local chef champion helps promote Sugar Smart actions for food businesses

What's in your food?



Find out by downloading the FREE Be Food Smart app



Download the Food smart or Sugarsmart app to find out what's in your food as you shop or cook



Shape Up can help you lose weight, change your diet and get more active

a half times the risk of high blood pressure and five times the risk of type 2 diabetes compared to someone who is not obese.³³ Costs include £6.1 billion to the NHS, £352 million to social care and £27 billion^{34,35} to the wider economy including costs of £16 million to employers through sick leave,³⁶ and costs in welfare benefits with those of an unhealthy weight experiencing an increased risk of unemployment.³⁷

What are we currently doing?

Partners across the city are taking a 'whole system' approach, including work on a healthier food environment, promoting physical activity and providing support for weight management.

What more could we do to help people maintain a health weight?

- Recognising when someone is overweight in NHS and other settings is important but staff require support and confidence to offer help and signposting
- Over 800 local residents are supported by the healthy weight referral scheme annually but many more could benefit. The systematic offer of referral to weight management services increases referrals and improves outcomes³⁸
- There is potential to increase the scale of services including new treatment pathways and the delivery of support in additional healthcare and community settings, workplaces, and employment support services.

5 Maintain a healthy weight

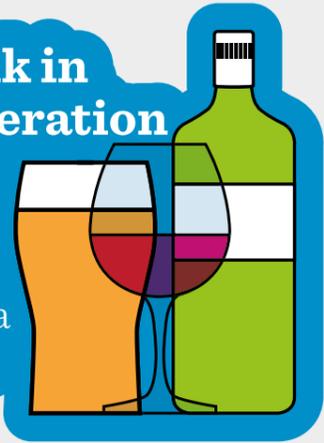


BMI < 25

Half of adults in Brighton & Hove are overweight or obese, with higher rates among men, those living in more deprived areas and some ethnic groups. Life expectancy is reduced by three years for moderate obesity and by eight to ten years for severe obesity.³² An individual who is obese has three times the risk of bowel cancer, two and

6 Drink in moderation

<15 units a week



The UK's Chief Medical Officers recommend that to keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis.³⁹ In England, 33% of men and 16% of women are at increased risk of alcohol-related ill health.⁴⁰ In Brighton & Hove 41% of adults are drinking more than the recommended amount of alcohol weekly. Drinking too much alcohol increases the risk of cardiovascular disease, cancers, depression and accidental injuries⁴¹ with wider harms including violent assaults, domestic violence and marital breakdowns, as well as road traffic accidents. Heavy drinking increases the risk of unemployment and work absences and is a leading cause of working years of life lost. Alcohol also widens health inequalities - whilst households in more deprived areas are less likely to drink at greater risk levels, they are more likely to die from alcohol-related conditions.

What are we currently doing to help reduce alcohol related harm?

- Alcohol campaigns during alcohol awareness weeks and 'rethink your drink' cards encouraging residents to be more aware of how much they are drinking
- YMCA Safe Space provides support and first aid for those who are intoxicated during a night out
- Identification and brief advice in primary care can reduce weekly drinking by 13-34% reducing the relative risk of alcohol

related conditions by 14% and lifetime alcohol related death by 20%. NHS Health Checks and health trainer support are examples of how this can be integrated with other lifestyle and preventative interventions

- Patients attending A&E because of excessive alcohol consumption are followed up by the local community alcohol and drug misuse service.

The impact of alcohol in Brighton & Hove

Every week in the city there are, on average:

-  **90** ambulance call-outs due to alcohol⁴²
-  **48** attendances at Brighton A&E department related to alcohol, 28 of whom are Brighton & Hove residents⁴³
-  **11** people under the age of 25 years seen by Safe Space, a service supporting those who are too inebriated or injured to get home
-  **87** alcohol-related inpatient hospital admissions for adult residents in Brighton & Hove⁴⁴
-  **2** deaths associated with the impact of alcohol, with almost 1 death wholly related to alcohol⁴³

Costs to Brighton & Hove of alcohol misuse are estimated to be **£107 million** per year including **£11 million** for health, **£25 million** lost to the economy and **£72 million** as a result of crime.⁴⁵



What more could we do to help prevent alcohol related harm and reduce health care and other costs?

A number of interventions are extremely cost effective - from restricting access to alcohol, enforcing bans on advertising, raising taxes, enforcing drink driving bans and delivering brief advice:

- Hospital alcohol care teams raise awareness amongst staff about alcohol-related ill health and provide specialist care to alcohol misusing patients. There is good return on investment with £3.50-£3.85 returned per £1 invested
- Identify and provide support, and if possible, treatment to those patients who attend A&E most frequently for alcohol related reasons

- Assertive outreach services that aim to reduce hospital admission and A&E attendance among those who use them frequently can deliver a return of £1.86 per £1 invested.⁴⁶

Sensible on strength

The Sensible on Strength scheme promoted by the council, Sussex Police and Equinox supports local businesses to remove high strength, low cost alcohol from their shelves. It has been running for three years and has more than 150 members across the city. In the first two years street drinking numbers fell by 31% and it has resulted in more street drinkers being able to successfully engage with treatment.

Preventing drug related deaths

Across England, it is estimated that drug addiction costs society £15.4bn per year,⁴⁷ with the number of drug related deaths reaching a high of 2,300 in 2015. In Brighton & Hove there was no significant increase during that year but each year there are between 20 and 30 deaths. The national increase was attributed to an increase in the availability and purity of heroin. The ageing cohort of heroin users was also considered to be a possible contributory factor.

Recommended actions to try and reduce the number of deaths include harm reduction approaches such as needle exchange

programmes, supporting drug users into effective treatment services and widening the distribution of Naloxone. Naloxone is an antidote which can reverse the harmful effects of heroin overdoses such as the effect on breathing. Naloxone is regularly carried by ambulance crews, but in Brighton & Hove service users and their carers, as well as hostel staff and some police officers, have been trained to administer it. St John Ambulance also provides first aid training as part of the programme and there is a scheme to enable the A&E clinical team to give out Naloxone to patients presenting with a heroin overdose, on their discharge from hospital.

Health trainers



Health trainers in Brighton & Hove can help residents change behaviour related to risk factors such as lack of physical activity, healthy eating, alcohol and smoking. Although many of these risk factors have improved nationally, they are increasingly clustered together in the poorest parts of society, increasing the risk of death and widening inequalities.⁴⁸

Health trainers offer one-to-one advice, support and encouragement and focus on areas most affected by health inequalities. They can help people:

- explore the benefits of making a change
- find out what the guidelines are around physical activity, healthy eating, alcohol and smoking
- decide the lifestyle changes that are most important for them
- learn how to set goals they are more likely to achieve
- understand what gets in the way of making changes and create ways of coping with difficult situations
- build motivation and confidence to help them keep going.

Fast Track City

The Martin Fisher Foundation was launched in 2015 in memory of the late Professor Martin Fisher, a Brighton & Hove-based HIV physician and researcher. The aspiration of the charity is to achieve zero HIV stigma, zero new HIV infections and zero deaths from HIV in Brighton & Hove by 2025. The Foundation has supported Brighton & Hove to be the first UK city to sign up to the international **Fast Track Cities** initiative which aims to achieve 90% of people living with HIV to

know their status, 90% of those diagnosed to be receiving anti-retroviral medication and 90% of those on anti-retroviral medication achieving viral suppression by 2020. The Foundation also plans to pilot and support new initiatives in HIV prevention and testing. www.martinfisherfoundation.org

7 Have safer sex



In 2015 Brighton & Hove had the 17th highest rate of new sexually transmitted infections (STIs) of all 326 English local authorities, including high rates of gonorrhoea and syphilis. In specialist sexual health clinics one third of new STIs were in young people aged 15-24 years (compared to 45% in England) and just over a half (56%) were among men who have sex with men (MSM). Between 2010 and 2015 an estimated 7% of local women (similar to England) and 14% of local men (9% for England) were re-infected with a new STI within 12 months.⁴⁹

The prognosis and health and social care needs for people living with HIV in the UK have improved significantly in recent years. Preventing one UK-acquired HIV infection saves £360,000 in lifetime treatment and clinical care costs. In 2015, 1,784 Brighton & Hove residents received HIV-related care, 1,630 of whom were male. This equates to eight people with HIV per 1,000 population compared to 2.3 per 1,000 in England and represents a 17% increase between 2011 and 2015. With regards to exposure, 83% probably acquired their infection through sex between men and 15% through sex between men and women.

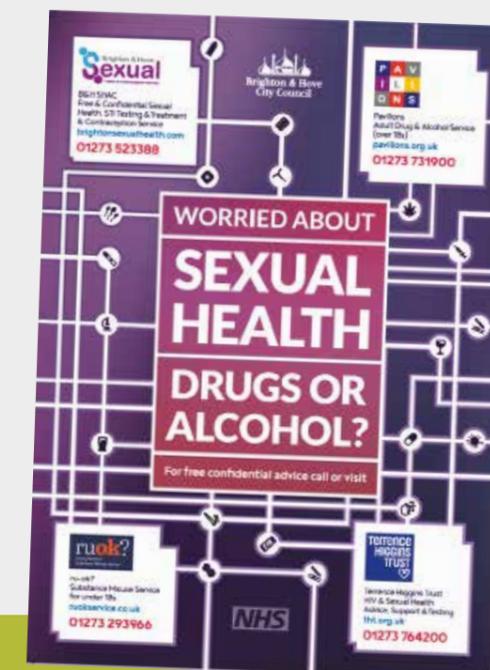
A challenge for HIV prevention is that nationally 13% of people living with HIV are unaware of their infection and are at risk of unknowingly transmitting the infection if they are having sex without using condoms. This undiagnosed proportion may be smaller locally, as the majority of people living with diagnosed HIV in Brighton & Hove are MSM who are more likely to be diagnosed than heterosexuals.

What are we currently doing?

- Delivering outreach, including online, to encourage residents to know their HIV status
- Increasing HIV testing around the city, including in saunas and primary care, and encouraging the uptake of home sampling
- Preventing and treating STIs by promoting condom use, regular testing, treatment and contact tracing as well as providing health advice and offering psychological support.

What more can we do to prevent HIV and other sexually transmitted infections?

- Promote the consistent and correct use of condoms
- Regular testing for HIV and STIs. MSM should have annual tests for HIV and three monthly for HIV and STIs if they are not using condoms with new or casual partners. Sexually active under 25 year olds should be screened for chlamydia every year and with every change of partner
- Increase HIV testing, particularly in primary care. A diagnosis of HIV can reduce onward transmission through treatment and changes in behaviour. Individuals diagnosed with HIV infection demonstrate a reduction in risky behaviour, which contributes to reduced onward transmission.



Local services offer advice support and treatment

- Deliver more targeted outreach, particularly amongst the African communities
- Support the introduction of Pre-exposure prophylaxis (PrEP) to high risk MSM. PrEP has been demonstrated to be 80% protective against HIV infection for some people who are at increased risk of HIV infection who are unable or unwilling to use condoms.



Screening and prevention

Half of all people will develop cancer during their lives.⁵¹ Cancer is the main cause of death for all ages and for those under 75 years in the city. In 2014 it was the cause of nearly a third of all deaths (29%) and 40% of all premature deaths locally, with lung, bowel, breast and prostate cancer accounting for nearly half of all cancer diagnoses.⁵² Half of all cancers are potentially preventable through lifestyle changes, such as stopping smoking, maintaining a healthy weight, drinking less alcohol, eating a balanced diet and avoiding excess sun exposure.⁵³

National cancer screening programmes aim to detect early cancers or abnormalities that may progress to cancer, allowing earlier treatment. Screening coverage rates are lower in Brighton & Hove than in England and most of the South East. In March 2016 local breast screening coverage was 72% (England 76%), but this has increased over the last two years. Cervical screening coverage was 70% (England 73%) which represents a continuing decline in coverage as is happening nationally. Bowel screening coverage had increased from the previous year to 56% (England 58%).⁵⁴

Albion in the Community taxi initiative weekly pop up outreach events



Long Acting Reversible Contraception (LARC)

It is estimated that just over half of pregnancies are planned and that the annual direct costs to the NHS of unplanned pregnancies is around £240m.⁵⁰ LARC doesn't depend on daily compliance, or on the woman or couple making a decision at the time of sex and are 99.9% effective in preventing pregnancy compared to 92% for the contraceptive pill or 82% for the male condom.

It is estimated that if 1,000 women were to switch from oral contraceptives to LARC, 291 unplanned pregnancies would be avoided over five years,⁵⁰ Local women and young people can access LARC at the integrated sexual health service, including the dedicated young people's clinic, following termination of pregnancy, including for those aged under 19, and at GP practices. It is important the option of LARC is discussed with women.

What are we doing locally?

A locally commissioned cancer service is currently being piloted in a small number of GP practices. GP practices will identify cancer coordinators to increase screening rates through proactively following up non-responders, improved record keeping and patient and carer support, and training for practice staff. Public Health and the CCG have commissioned Albion in the Community to deliver the 'Speak Up Against Cancer campaign' to increase awareness, knowledge and confidence about cancer screening and about spotting the early signs of lung, skin and bowel cancers and to encourage people to seek advice.

Lung cancer is the commonest cause of cancer death locally, so tackling smoking more effectively is important. The CCG has commissioned an enhanced stop smoking service which aims to target hard to reach groups, increase quit rates, improve stop smoking awareness and early detection targets through outreach, communications and behaviour change.

What more should we be doing locally to increase cancer awareness and screening coverage?

- A new national bowel cancer screening test being introduced from April 2018 is expected to result in a fifth more cancers being diagnosed earlier
- Primary HPV (Human papilloma virus) testing for cervical screening being introduced nationally from April 2019 is expected to benefit over three million women a year and prevent about 600 cancers annually in England⁵⁵
- Continue to raise awareness of the symptoms and signs of potential cancers. Recent campaigns have raised awareness of breast cancer, testicular cancer and cervical cancer. To improve cancer survival, people need to know what to look out for so that a diagnosis is made when the cancer is at an earlier stage. Be Clear on Cancer campaigns help raise awareness of symptoms and encourage residents to get checked by their GP. These include the 'blood in pee' campaign to increase awareness of early signs of kidney and bladder cancers, and the three week cough campaign for lung cancer symptom awareness.



High blood pressure

High blood pressure, or hypertension, affects more than one in four adults. It is the third biggest risk factor after smoking and poor diet for developing disease.⁵⁶ The risk of developing high blood pressure can be reduced by reducing salt and alcohol intake, maintaining a healthy weight and being more active. The risks are higher for those of Black African and Black Caribbean origin. Hypertension costs the NHS over £2bn each year and the wider economy much more. If England achieved a 15% increase in the proportion of adults with diagnosed hypertension, an estimated £120m in related health and social care costs would be saved over ten years.⁵⁷

How can more Brighton & Hove residents check out their blood pressure and prevent health risks from hypertension?

- Know Your Numbers and NHS health check awareness campaigns raise awareness of the importance of having blood pressure checks at a GP, pharmacy, workplace or through a wellbeing or NHS health check
- Local health check schemes prioritise those living in the city's deprived areas
- Promote healthy lifestyles particularly diet to lose weight, increase physical activity levels and reduce salt in the diet.

Diabetes

Nationally type 2 diabetes is the cause of 22,000 premature deaths every year. In 2013 it was estimated that 6% of the adult population had diabetes, 90% of whom had type 2 diabetes. Since 1994, cases of diabetes in men have increased from 2.9% to over 7% of the population and increased from 1.9% to 5.3% among women.⁵⁸ Many cases of type 2 diabetes are preventable, with 90% of cases in people who are overweight or obese, and there is strong evidence for behavioural interventions which help people maintain a healthy weight and be more active, significantly reducing the risk of developing the condition.⁵⁹

For those who already have diabetes, regular checks in primary care can help prevent complications such as diabetic eye disease, amputations and kidney disease.

What more should we be doing to help prevent type 2 diabetes?

- NHS health checks help detect those with undiagnosed diabetes, or at increased risk of type 2 diabetes. Increasing the uptake of health checks and the diabetes prevention programme (see box) with a focus on those at higher risk or who are harder to reach
- Increase GP, hospital and self-referrals to community weight management services, health trainers and active for life groups to help residents lose weight and increase levels of physical activity
- Support the development of a city where it is easier to make a 'healthy choice' including active travel being part of everyday life.

10 Stay connected



Volunteer, work

Good work is good for our health, whilst unemployment increases the risk of heart disease and mortality. This is a two way relationship: one in seven men develops clinical depression within six months of losing a job⁶¹ and are at increased risk of suicide and health damaging behaviours⁶²; but poor mental health, stress and job insecurity are leading causes of sickness absence and worklessness. This makes getting people into, and remaining in good work a priority for physical and mental health. Not all work is paid work. Volunteering can also be good for physical and mental health.

Almost 30% of employees have a long-term health condition and this is predicted to rise to 40% by 2030, increasing the impact on the economy.⁶³ Long-term conditions are associated with an increased risk of long-term unemployment. There is a strong value for money case from programmes to get disadvantaged groups back into work, with a return of £3 from reduced costs of homelessness, crime, benefits and NHS care for every £1 spent.⁶⁴

The NHS diabetes prevention programme

The NHS diabetes prevention programme, introduced in Brighton & Hove in 2016, is designed to help identify those at high risk of developing type 2 diabetes and enrol them on a nine month programme to support behaviour change to reduce their risk of developing the condition. It is estimated that one in 20 high

risk cases of diabetes will be prevented and that for every 100,000 people enrolled in the programme nationally the cumulative impact over five years will result in 4,500 diabetes diagnoses prevented or delayed. Over 20 years the net financial impact of the programme is an estimated saving of £35 million.⁶⁰

This chapter has reviewed some of the lifestyle and other factors that affect our health and wellbeing during our working life and beyond. Many of these factors do not require additional resources or time, and ideally should be woven into our everyday lives. Living well at this age is also likely to be easier to achieve if it builds on a good start to life. The next chapter considers some of the factors that influence our development, health and wellbeing during those early years.





6

Children and young people Starting well

Giving children the best start in life places them in the strongest position to reach their full potential, to lead healthy and happy adult lives and to create a stronger society. It is therefore important to support families to achieve this and to minimise the exposure of children to harmful experiences. A whole population approach providing universal services builds on the family's own assets and enables the early identification of need for additional help and support.

Fundamental to children and young people starting well and developing resilience to health-harming behaviours is stable and nurturing parenting. At birth the infant brain is one quarter of the adult size, growing to 90% of an adult brain by age five. Parents and carers have a significant influence during this time. For example, speaking and reading with children is vital for the development of language and cognitive skills. Failing to invest in health and wellbeing during the early years has longer term costs. Perinatal mental health problems have an estimated economic and social long-term cost to society of £8.1 billion for each one-year cohort of UK births.²

Adverse childhood experiences (ACEs)

Strong universal services enable early identification and access to early intervention. This is particularly important for children who are exposed to harmful experiences. Adverse childhood experiences (ACEs) include verbal, physical and sexual abuse, parental separation, exposure to domestic violence, parental drug

Every week in Brighton & Hove



57 babies are born of which



50 new mothers breastfeed their baby



41 mothers are still breastfeeding 6-8 weeks after the birth of their baby



4 new mothers are still smokers around the time of delivery of their baby



3 0-4 year olds are admitted to hospital due to an unintentional or deliberate injury

Giving children the best start in life places them in the strongest position to reach their full potential

use, parental mental illness, parental alcohol abuse and incarceration of a family member. Since the first ACE study was conducted in the USA, ACEs have been linked to a range of health-harming behaviours and non-communicable diseases.^{3,4} These behaviours have health, social and economic implications across communities over the many years to come.^{1,3}

There is a strong relationship between the extent and severity of the exposures to ACEs and the impact on physical and mental health and wellbeing across the life course, increasing the risk of depression, asthma, obesity, heart disease, cancer and premature mortality.^{1,3}

In England



50% of individuals have experienced at least one ACE

9% have experienced four or more

For children growing up in a home where repeated exposure to ACEs is the norm, the repeated stress they experience can affect the development of the brain and delay their emotional, physical and social development.⁵ Children who have suffered such stress may also complain of a range of physical symptoms, self-harm and have difficulty forming relationships or coping with a routine school day.

Early screening for ACEs with co-ordinated support across a range of agencies can protect

young people from future health-harming behaviours and long-term conditions. In the USA, the impact of ACEs has been reduced though investment in programmes designed to improve parenting. Once positive parenting practices are established, they are likely to be passed down through generations.¹

What is public health doing in Brighton & Hove to support children and young people?

There are three main public health programmes that support children and young people and their families in Brighton & Hove. These connect with the Early Help, Safeguarding and other work being done across the city led by the Families, Children and Learning Directorate alongside partners (<http://www.brighton-hove.gov.uk/content/health/public-health-schools>).

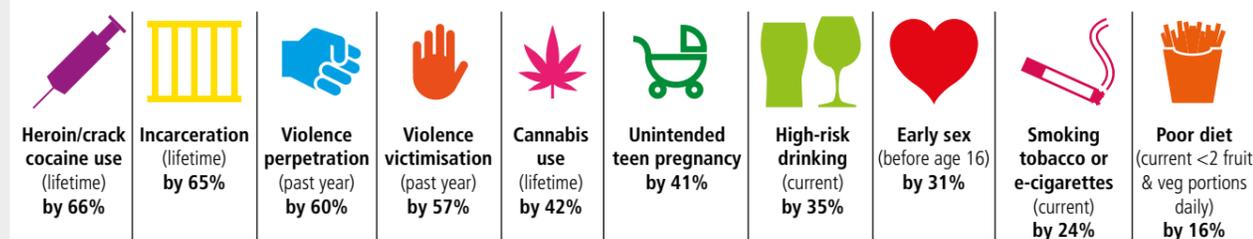
The Healthy Child Programme

The Healthy Child Programme (HCP) is a universal, evidence based, early intervention and prevention service for all children and families, aimed at supporting children to achieve the best start in life.⁶

The new Public Health Community Nursing Service (0-19 years) was established in April 2017, through the integration of the school nursing, health visiting and other services. The new service will continue to work at four levels and across six high impact areas to deliver the Healthy Child Programme (Figure 2). The role of this service is central to improving health and wellbeing outcomes for 0–19 year olds and their families and in reducing inequalities across the city.

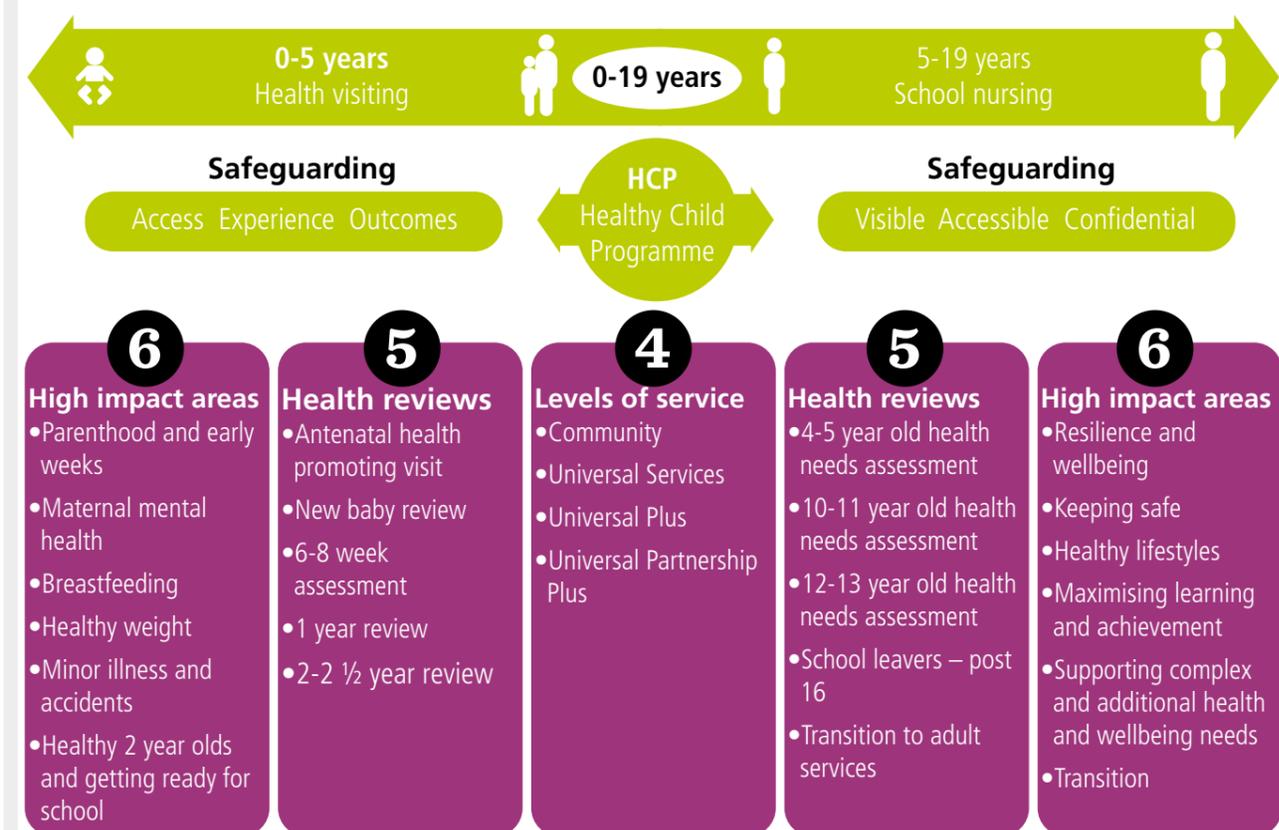
The HCP offers a programme of screening tests, developmental reviews, specialist health

Figure 1 Preventing ACEs in future generations could reduce levels of:



Source: Welsh Adverse Childhood Experience Study

Figure 2 The Healthy Child Programme; The 4-5-6 approach for Health Visiting and School Nursing



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Source: Public Health England

advice and information and guidance to support parenting and healthy choices, alongside targeted interventions for families with more complex needs, including safeguarding concerns. Locally the integrated service will provide:

- A specialist team to support families with specific vulnerabilities, including teenage parents, homeless families, travellers, young carers and refugees
- A specialist programme on perinatal and infant mental health
- A named lead for GP practices and clusters
- A community-based continence service with greater support for children and young people experiencing bladder and/or bowel dysfunction

- Improved services for families with children aged 0-5 years in children's centres with school nurses based in these locations
- Increased numbers of health drop-ins in schools and community settings and involvement with local youth providers in the city
- Expanded use of technology by making the CHATHEALTH text messaging service for teenagers available to families.

At present, the Public Health Team is exploring the potential to screen for Adverse Childhood Experiences as part of early identification and prevention.

Healthy Child Programme: Immunisation

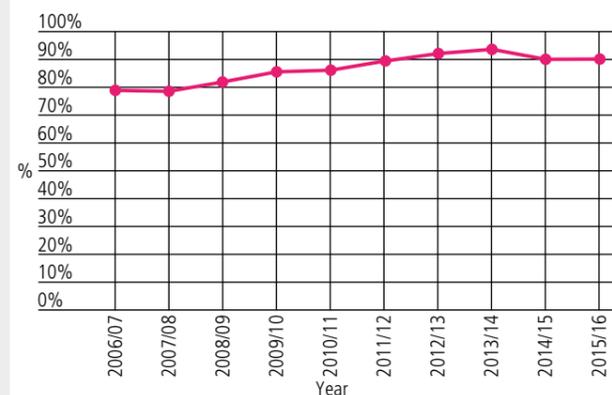
Immunisation is a highly effective approach to health protection. Deaths from vaccine-preventable infections are now rare in the UK. However, not having the MMR (measles, mumps, rubella) or other vaccinations leaves individuals at risk of potentially fatal infections.

When a sufficient percentage of the population is immune to a disease, through vaccination and/or prior illness, the disease is unable to spread, and those people who are not immune will also be protected. This is known as 'herd immunity' and is particularly important for those who are unable to be vaccinated, or who will suffer more severe consequences from catching a disease, for example due to young age or immunosuppression. To achieve herd immunity, immunisation rates need to reach and be maintained at 95%. This has not yet been achieved in Brighton & Hove (Figure 3 shows MMR trend). The coverage of some primary immunisations and the pre-school boosters has been significantly lower than for England.

What are we doing in Brighton & Hove?

To ensure progress is made on childhood immunisations, a task group involving the council, the Clinical Commissioning Group, health visiting and school nursing team leads

Figure 3 MMR immunisation rate by age two years, Brighton & Hove, 2006/07 to 2015/16



Source NHS Digital, NHS Immunisation Statistics, England

Childhood immunisations in Brighton & Hove

95%
The World Health Organization (WHO) has set a target of 95% coverage for key immunisations

89.9%
Completed primary immunisation courses against Diphtheria, Tetanus, Pertussis, Polio and Haemophilus influenzae type b by their first birthday in Brighton & Hove (93.6% across England)

90.1%
Received the first dose of the MMR vaccine (Measles, Mumps and Rubella) by their second birthday in Brighton & Hove (91.9% across England)

From historic lows in the 2000s we saw increases in immunisation coverage up to 2013/14. But since 2013/14 immunisation coverage has started to fall again

and NHS England has been set up to implement a recently developed action plan which includes local professionals promoting the importance of vaccinations whenever they have contact with the family throughout the life of the child. Work is also underway to improve reporting that will support GP practices to follow up with families whose children who have not had their vaccinations.



Colleen and Lettie, who are Breastfeeding Peer Support Volunteers within the peer support programme

Healthy Child Programme: Breastfeeding

The healthiest start for children includes exclusive breastfeeding until six months of age and for it to continue to be part of the diet until the child is two. Breastfeeding strengthens attachment, helps the child's cognitive development and reduces hospital admissions for infectious diseases.⁸ Women who breastfeed are at lower risk of breast cancer and benefit from a faster return to pre-pregnancy weight.

In 2016, the breastfeeding rate in Brighton & Hove at 6-8 weeks was 72% which was the second best rate in the country and significantly higher than England (43%). The breastfeeding initiation rate was 88%, well above the England rate of 74%. However, there is wide variation across the city, with lower rates in more deprived areas.

What are we doing in Brighton & Hove?

- A dedicated specialist breastfeeding health visitor provides expert advice, support and practical help, and leads a team of breastfeeding peer support volunteers to provide support in the hospital and community
- A city-wide network of breastfeeding drop-ins
- Information, support and advice is available from www.facebook.com/sctbreastfeeding

Oral health What are we doing?

305 tooth extractions
In 2015/16, 305 Brighton & Hove children aged 19 or under had a tooth extracted in hospital. 131 of these were children aged 5-9 years.^a Dental caries is the main reason for the extraction of first permanent molars in children.

With good oral health care dental disease in children is mostly preventable. Without it children may experience pain from toothache, difficulty in eating, sleeping and socialising. Poor oral health can have an impact on:

- School readiness, and school absence, as well as time off work for parents/carers
- Hospital admissions. It is the top cause of admissions to hospital for 5-9 year olds
- Dental neglect and wider safeguarding issues

National Institute for Health and Care Excellence (NICE) has found that targeted tooth brushing and fluoride varnish programmes and targeted provision of toothbrushes and paste by post and health visitors, are all effective in reducing tooth decay in five year olds. They also offer a return on investment. After five years £3.06 is returned for every £1 spent on a supervised tooth brushing programme.^b

In Brighton & Hove the oral health promotion programme for children delivered by Sussex Community NHS Foundation Trust includes:

- Training for childhood workers
- Tooth brushing schemes in children's centres and some primary schools and distribution of tooth brushes and tooth paste in childhood settings
- Working with the public health schools programme on healthy diet and the Sugar Smart city
- Integration into the 0-19 Healthy Child Programme
- Campaigns and events, such as National Smile Month
- Signposting to the dentist

^a Public Health England. Dental Public Health Intelligence Programme. Hospital Episode Statistics. Extractions Data 0-19. 2011/12 – 2015/16
^b Public Health England. Children's Oral Health Improvement Programme Board 2016.

The Public Health Schools Programme brings together partners in education, Public Health, the NHS, the third sector and universities to improve the health and wellbeing of whole school communities, with initiatives for pupils, parents, carers and staff. During the 2015/16 school year, the Public Health Schools Programme worked with 48 infant, junior and primary schools and all of the city's secondary schools.



Children and young people are at the centre of developing and shaping how services respond to the health issues that affect them, such as emotional health and wellbeing, smoking tobacco and cannabis, healthy eating and sugary drinks. Public health is exploring the use of digital technology for health messaging to families and young people about self-care and guidance on accessing services.

The programme also supports schools to promote staff wellbeing through the Workplace Wellbeing Charter and health and wellbeing checks.

Public Health Schools Programme: Healthy weight

Childhood obesity is one of the most serious public health challenges. Overweight and obese children are more likely to have low self-esteem, experience bullying and to be overweight into adulthood. Obese adults are more likely to develop diabetes and heart disease, and more likely to have depression. Obesity doubles the risk of dying prematurely.⁹

Between 2007/08 and 2015/16 the proportion of children with a healthy weight in Brighton & Hove has increased in reception (4-5 years) from 78% to 80% and year 6 (10-11 years) from 68% to 73%. This is against an overall

unchanged level for reception and a worsening trend for year 6 across England. Obesity rates are highest for children from the most deprived areas of the city. For children who are overweight in reception year, one quarter are obese by year 6. However, half of children who are overweight in reception are a healthy weight in year 6, showing change is possible.

In the 2015/16 school year, in Brighton & Hove:

- 65% of primary schools had healthy eating assemblies
- 66% of the city's primary school breakfast clubs were supported to improve the nutritional content of their breakfast provision through the Healthy Choice Award
- The Food Partnership delivered cookery demonstrations and workshops in seven primary schools which had low rates of healthy weight, eating fruit and vegetables and physical activity
- Public health began to explore how to improve the nutritional content of secondary school canteen food and to adapt the canteen layout to encourage healthy food choices.



Public Health Schools Programme: Physical activity

It is important for children and young people's health, growth and development to be physically active. It can reduce the risk of long-term conditions and improve emotional health and wellbeing. It is recommended¹⁰ that all children and young people aged 5-18 should:

- Engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day
- Include vigorous intensity activities, including those that strengthen muscle and bone, at least three days a week
- Minimise the amount of time spent sitting for extended periods.

Daily Mile: Four schools in Brighton & Hove are among the first in the South East to see the benefits of a project encouraging all children to do at least 10 minutes of exercise a day – the equivalent of running a mile or more.

According to teachers and parents alike, the running, skipping and hopping pupils are doing through the 'Daily Mile' project are leading to better concentration, improved academic performance and better behaviour – at home as well as at school.

And it's not just children who are getting involved. At Balfour primary school all the staff are doing their 10 minutes as well. And to get the maximum benefit, they do it in lesson time, not during breaks. Balfour's PE coordinator, Laura Gibbons, said: "We've measured out the mile – it's 12 laps of the playground or two laps of the playing field. Some of our children have managed to do 16 laps of the playground in their 10 minutes."

Case study: the Bike It project



The Bike It project has worked for several years with schools to develop a cycling culture across the city. Children and young people across 60 schools are given access to cycling including the responsibility to look after their bikes.

The intervention at Brighton & Hove Pupil Referral Unit (BHPRU)

One example is at BHPRU, a special school working with children from Key Stage 1-4 who are not in a mainstream school for a number of reasons. Many of the pupils have a fear of failure, along with very low fitness levels, and the Bike It project is a great way to promote behaviour change. The pupils use the bikes several times a week which helps to build up their base level fitness and self-esteem. Older pupils have the opportunity to work with the Bike It project across the city in other schools.

Outcomes There has been a 100% take up of cycling within the school (BHPRU). Many children now own bikes that they have built themselves and both staff and parents have seen the changes in behaviour and self-esteem:

- "Working with Ben Sherratt is fantastic! He helps to engage some of our most challenging and disengaged young people. More please!" a teacher
- "Oh, You're Bike It Ben!! My son is always talking about you! We are going to use our bikes on holiday next week, he's made me get a bike!" a parent
- "Can I do this every day?!" PRU pupil working at another local primary school.

Meeting the guidelines for physical activity

16% of 15 year olds in the city meet the guidelines for levels of physical activity

68% of 15 year olds in the city have an average of over seven sedentary hours per day

Mental ill health

50% of all mental ill health starts by the age of 14 and

75% of cases have developed by the age of 24

Public Health Schools Programme: Emotional health and wellbeing

The emotional health and wellbeing of children and young people is as important as their physical health and wellbeing.¹¹ Over recent years it has been recognised that changes need to be implemented to mental health services for children and young people, and locally services are now being taken to where young people are.

Mental health problems range from short spells of depression or anxiety through to severe and persistent conditions that can isolate, disrupt and frighten those who experience them. Mental health problems in young people can result in lower educational attainment, poor physical health, poor social relationships and future employment prospects as well as behaviours such as smoking and using drugs and alcohol. The impact of improving emotional wellbeing and mental health is seen at an individual and family level.¹²

In Brighton & Hove:

- Hospital admissions as a result of self-harm have fallen from 348 in 2011/12 to 284 in 2015/16 for 10–24 year olds and the rate is similar to England
- The hospital admission rate for mental health conditions for 0–17 year olds is similar to England. In 2011/12 there were 48 admissions and in 2015/16 there were 40
- The suicide rate amongst teenagers is lower than for the general population, although in 2016 the Local Safeguarding Children’s Board raised concerns about the number of suicides in recent years amongst young men

- The top worries reported by secondary school pupils in 2015/16 were exam stress/anxiety, being healthy, their future in work or education, school work and problems with friends
- Only one in three local children and young people access the help and support they need for mental health issues.

What are we doing in Brighton & Hove?

Schools, the council, NHS and specialist mental health services are working together to implement a whole school approach to improve children and young people’s emotional health and wellbeing. Secondary schools report improvements in:

- Strategic leadership
- Their ability to identify and respond earlier
- Clarity on the roles and responsibilities for school staff and the primary mental health team
- Communication with parents and carers
- Outcomes for young people who have been identified as in need of emotional health and wellbeing support
- Referrals to children and young people’s mental health services.

A city wide anti-stigma campaign **IAMWHOLE** was launched by local agencies, with many young people leading inspiring campaigns across the city’s schools. In the year of the launch, two thirds of young people aged 14–16 years recognised the **IAMWHOLE** brand.

The public health schools team’s next priority is to work with schools to develop the role of children and young people in mental health improvement. For example, through increasing the number of young people who are mental health first aid champions.



IAMWHOLE campaign

Improving adolescent health

During adolescence the brain is still developing as young people learn how to assess risks, make moral and political judgements and control impulses.¹³ The balance of influence shifts during this stage from parents to peers or other significant adults. It is important to support young people to live healthy lives, make healthy choices and protect themselves. However, the local rates of smoking, substance misuse and teenage conceptions remain too high in Brighton & Hove.

To date, approaches to prevent early teenage conception and improve poor sexual health, prevent the use of tobacco, drugs or alcohol or to mitigate the harms caused by these substances have generally been delivered independently. The greater understanding of the clustering of lifestyle behaviours has resulted in the proposal for a more integrated adolescent health offer.

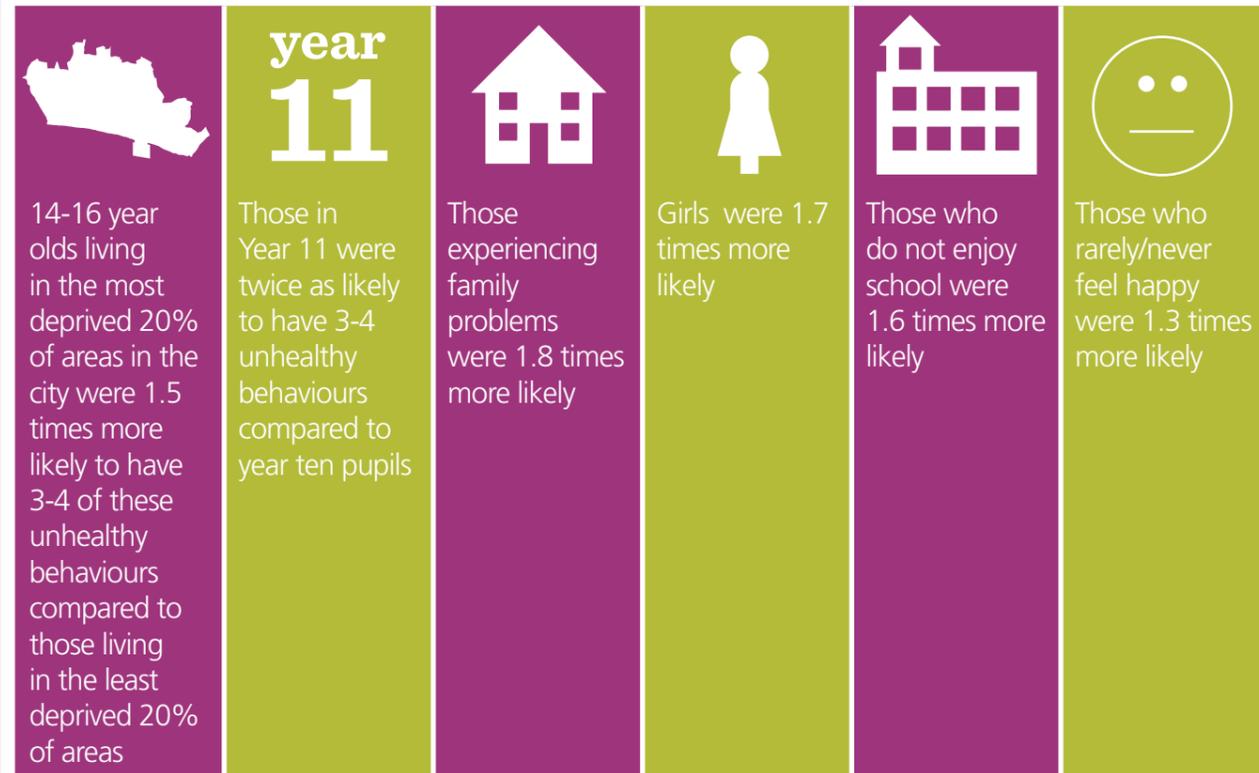
Brighton & Hove rankings for key health related behaviours in 15 year olds (where 1st is the worst), 2015

- 1st** 15% of 15 year olds smoke, the highest rate in England
- 1st** 24% of 15 year olds have ever tried smoking cannabis, the highest rate in England
- 3rd** 11% of 15 year olds drink at least once per week, the joint third highest rate in England

Source What about YOUth survey, NHS Digital

Clustering of behaviours

Recent local analysis for 2011-2014 has shown that four key unhealthy behaviours (having ever tried smoking, ever drank to get drunk in addition to not meeting recommendations around fruit and vegetable consumption and physical activity) are clustered in young people:



Source: Safe and Well at School Survey

There has not always been sufficient recognition of the distinct stage of adolescence or an understanding that adolescent decision making and behaviours differ from adults. A local theme often discussed when considering the relationship between behaviour and emotional wellbeing is that it is easier to just work with 'what we see' rather than identify and address what is causing this.

Improving adolescent health: Smoking

Young people who smoke are more susceptible to coughs, wheeziness and shortness of breath, which affects their school attendance and educational performance. There is evidence linking exposure to second-hand smoke with impaired health and wellbeing.^{14,15}

What we did in Brighton & Hove in 2015/16

- A smoke free school gates initiative was developed for infant and primary schools

- A normative non-smoking campaign was developed with young people
- Direct support to young people, parents/carers and staff on the impact of smoking on health as well as stop smoking support or signposting to stop smoking support in local pharmacies.



Improving adolescent health: Substance misuse, sexual health and teenage pregnancy

Having children at a young age has an adverse impact on young people's health and wellbeing and limits their education and career prospects. While some young people can be good parents, children born to teenagers are more likely to experience a range of negative outcomes in later life, and are up to three times more likely to become a teenage parent themselves. Young fathers are twice as likely to be unemployed.¹⁶

Because their brains are still developing, teenagers are particularly vulnerable to the effects of cannabis and alcohol. Regular cannabis use predicts an increased risk of schizophrenia,¹⁷ and regular, early substance misuse is linked to addiction in adult life.

In Brighton & Hove:

- The under 18 conception rate decreased by 48% between 1998 and 2015, a similar reduction to England
- The trend in the percentage of conceptions leading to abortion from 1998 to 2015 has consistently been above England. In 2015, Brighton & Hove was 10% higher than England with 61% of conceptions leading to an abortion
- The proportion of 15-24 year olds screened for Chlamydia in 2015 was 35%, higher than England (23%)
- Safe and Well at Schools Survey (SAWSS) data shows that the percentage of 14-16 year olds who had never tried a whole alcoholic drink increased from 15% in 2010 to 27% in 2015
- SAWSS data shows the percentage who had never tried drugs not prescribed to them was stable (77% in both 2010 and 2015)
- There was a 24% reduction in the numbers of young people in substance misuse treatment in 2016/17 compared with April 2013.



What we are doing in Brighton & Hove

Agencies are working together to provide a balance between specialist treatment for young people involved in risky behaviour and universal prevention work which includes strong Personal Social and Health Education (PSHE) and supporting parents and carers to talk with their children.^{18,19}

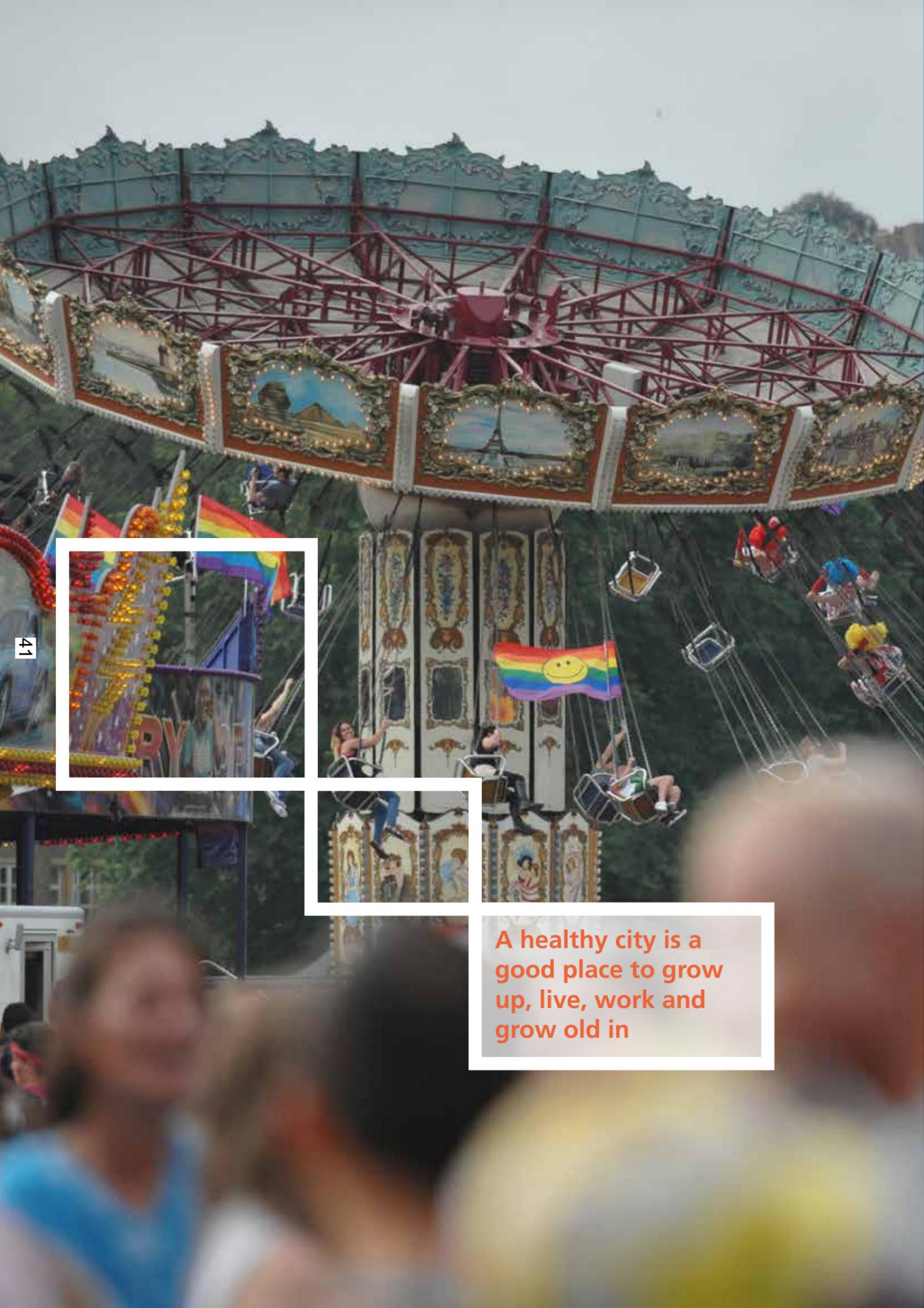
A new integrated young people's Drugs, Alcohol and Sexual Health (DASH) Education team offer targeted support to young people requiring early help around drugs, alcohol, sexual health and forming positive partner relationships. One of the

workers said: "We know that it is often the relationships that young people form with their workers that can make all the difference when we work for healthy behaviour change. Now with the integration of drugs and alcohol, and sexual health/healthy relationships work, young people only have to meet and get to know one professional who they can trust for information, advice and support around all of these issues."

There is concern across a number of agencies in the city about the high rates of cannabis use, smoking and alcohol consumption amongst local young people. It has been suggested that the city's more tolerant attitudes do not discourage such behaviours amongst young people. Currently partners are considering how to address this including campaigns aimed at keeping the city safe for our children and young people.

The DASH Education team





7

Our healthy city

A healthy city is a good place to grow up, live, work and grow old in. It supports healthy behaviour and reduces health inequalities as well as promoting physical and mental health. It promotes active lifestyles through good urban design, providing access to local services and facilities and safe, green and open spaces for food growing and active play, as well as accessible walking, cycling and public transport. Creating healthy living environments also enhances community cohesion and connectivity.

In this chapter we have adopted the preventative framework used by the London Borough of Richmond¹ to identify the evidence base for implementing sustainable interventions at place, community and individual levels. These must work together in a coordinated way to make the healthy choice the easy choice and make healthy behaviours sustainable.

The focus of this chapter is upon place and community level interventions. More detailed accounts of individual interventions have been included in the preceding chapters.

Examples of action being taken in Brighton & Hove to maximise the opportunities to improve health and wellbeing and prevent illness at the place and community levels are included in the following examples of interventions.

A healthy city is a good place to grow up, live, work and grow old in

Place

Environment and planning, policy, legislation and regulation

Community

Mass media campaigns, volunteering, community cohesion and connectivity

Individual

Targeted services delivered one-to-one or in groups

Place

Place based interventions can have major impacts on health and wellbeing by changing behaviour as a result of changes in infrastructure

and environment. NHS Trusts, GP practices, the council, large employers and local businesses can all have a positive impact on the health

of a place, for example legislation for smoke free premises has resulted in a reduction in the number of hospital admissions for heart attacks.² At the same time, they can influence health by engaging with residents to promote healthy behaviours, for example workplaces that sign up to the Healthy Workplace Charter can encourage their employees to become more active.

There are a wide range of place level interventions (see Box 1).

Box 1 Examples of place interventions

 **Partnerships**
Brighton & Hove Connected and its associated thematic partnerships

 **Whole systems approaches**
Healthy Choice Award
Sugar Smart City
Age Friendly City

 **Regulatory approaches**
Effective licensing policy, including use of public health data
Smoke-free places
Plain cigarette packaging
20 miles an hour speed restrictions

 **Environmental approaches**
Building health and wellbeing into the Brighton & Hove City Plan
Air Quality Management Plan
City Centre Low Emission Zone
Cycle lanes

 **Specialist housing**
Patching Lodge extra care housing for older people
Brooke Mead extra care housing for residents with low to moderate dementia

Building health and wellbeing into the Brighton & Hove City Plan

What's the evidence base?

The benefits of joint health and urban planning have been highlighted by a range of reports and organisations.³⁻⁷ The National Institute for Health and Care Excellence (NICE) suggests the benefits of building cycling and walking into urban planning outweigh the costs by 168:1 and by 60:1 respectively. Public Health England,⁸ the Joseph Rowntree Foundation⁹ and the Committee on Climate Change¹⁰ highlight the impacts of climate change on health and the role planning plays in promoting adaptation and reducing its effects. The City Plan¹¹ contains evidence supporting the city's needs for suitable housing, job growth, open spaces and sports facilities together with other community facilities including schools and health.

What are we doing?

The City Plan¹¹ includes a requirement for Health Impact Assessments (HIAs) to be applied to planning policy and strategic developments. It also encourages developments to include resident-led activities, to be accessible and to have a range of services and amenities. It also promotes provision of outdoor spaces that encourages social contact, social networks that support wellbeing and a range of affordable housing options (Lifetime Neighbourhood principles)¹² and local employment opportunities. The Plan also aims to adapt and mitigate climate change threats to health and wellbeing.¹¹

To reduce health inequalities and promote healthier lifestyles, the council works with partners to achieve equality of access to community services, sports and recreation facilities, and lifelong learning, as well as reducing crime and the fear of crime.

Major residential and mixed use planning applications are required to complete a Sustainability Checklist which includes criteria for travel plans, open spaces and physical activity.¹³

What more could we be doing?

We could strengthen healthy urban planning by reviewing the health and wellbeing related content in the Sustainability Checklist and providing guidance for developers on conducting HIAs as part of strategic developments.

Air quality

What's the evidence base?

Air pollution is a serious public health issue. Short and long-term health effects include worsening the health of: those with cardiovascular and respiratory disease,¹⁴ infants, aggravating asthma and in the longer term reducing life expectancy at a population level.¹⁵ People with cardiovascular and respiratory diseases, especially older people, can be adversely affected by day-to-day changes in air pollutants, including an increased risk of hospital admission and death.¹⁶

What are we doing?

Our seafront and the South Downs National Park have some of the cleanest air in South East of England. However, in recent years the English and EU limits for Nitrogen Dioxide (NO₂) were not met or were at risk of not being met at specific roadside locations (including affected residential properties) in the city centre, parts of Portslade and part of Rottingdean. Road transport is the primary cause of these breaches. These areas have been defined as Air Quality Management Areas and detailed plans are in place to improve air quality in these locations.

Specific actions have included:

- National grant funding has supported exhaust retrofits of buses and minibus taxis
- Bus companies have been procuring new low emission Euro VI standard buses
- Active travel has been widely promoted, including supporting walking and cycling, and new infrastructure has been developed, for example, improved bus stops and cycle lanes on the Lewes Road Corridor.

What more could we be doing?

Recently, levels of NO₂ have improved in some areas locally but air quality remains a major contributor to ill health. Public health has an important role to play in raising awareness of the importance of air quality and advocating for cleaner air to improve the health of the population. We need to ensure that the Air Quality Management Plan remains effective in continuing to drive improvements in the city's air quality.

There is great potential to achieve even higher rates of active and/or low or zero emission travel locally due to our low level of car ownership, high rates of bus usage and higher than average rates of physical activity. Brighton & Hove has been awarded £1.5 million over three years until April 2020 to deliver projects that promote sustainable transport as the preferred way for people to access the seafront area for employment and leisure.

Sugar Smart City



What's the evidence base?

The role of public services in promoting healthier food environments is set out in NICE guidance.^{17,18} The national Childhood Obesity Plan¹⁹ and NICE quality standard²⁰ outline ways to promote healthier catering and food environments for children. The Local Government Association (LGA) has published reports on Healthier Food Procurement²¹ and Tackling Poor Oral Health in Children.²² The NHS standard contract²³ and guidance²⁴ also promotes reducing sugar consumption.

What are we doing?

The Sugar Smart City initiative is part of a whole system approach to targeting obesity in the city. It has included a Sugar Smart City debate

held in 2016 aimed at residents, schools and food outlets. As a result, 70 food outlets have made sugar smart commitments, including promoting free tap water, altering recipes and using pricing and promotion to influence healthier choices. There have been Sugar Smart assemblies in 30 primary schools and 24 have achieved the Healthy Choice Award for their breakfast clubs.

What more could we be doing?

Initial discussions have taken place to develop work with sports and leisure settings, hospitals, secondary schools, colleges and universities. We have been working with the Food Partnership to develop four Sugar Smart challenges which will be used with families and community groups to support people to make swaps and reduce sugar intake. We have also been working in partnership with the Jamie Oliver team on sugar reduction and have made a successful bid to the national Behavioural Insights Team for funding to improve the way food is provided in secondary schools.

Communities

The health of communities can be enhanced by providing information about unhealthy behaviours and supporting the development of people's skills and resilience to make changes. These interventions can bring communities closer together and strengthen neighbourhoods. Examples of community interventions are included in Box 2.

Active travel

What's the evidence base?

Public Health England (PHE) has published guidance for local authorities on promoting physical activity in everyday life by building active travel, such as walking and cycling, into the local environment. This is based upon peer reviewed evidence, including NICE guidance.²⁵

What are we doing?

'Personalised Travel Planning' has been introduced in Whitehawk, which includes motivational interviewing, short walks and Dr Bike sessions. There is cycle and maintenance

Box 2 Examples of community interventions



Population level interventions

National Diabetes Prevention Programme
Falls Prevention Programme



Whole systems approaches

City Employment Skills and Learning Plan for sustainable employment
Healthy Workplace Charter



Partnership approaches

Befriending coalition
Dementia Action Alliance
It's Locally Actually – website
Public Health Schools Programme



Health promotion events and activities

Annual physical activity events e.g. TakePart and Active Forever (keeping active in older age)
Annual Older People's Festival
Annual Best of Health Event for people with learning disabilities
Breastfeeding friendly scheme
Healthwalks
Active travel e.g. cycling and walking
Making Every Contact Count (MECC) training
Mental health first-aid training
Healthy Living Champions in pharmacies



Increasing community connectivity

Community development and volunteering
Healthy Neighbourhood Fund
Dementia Café
Lunch clubs
Men's Shed

training for over 14s, and school based work has included promoting school travel plans and linking with the SMILES Five Ways to Wellbeing public health campaign.

Case study: Dawn



"Here's Dawn of Whitehawk who's asked for support to get back into cycling to lose weight and keep in shape. Dawn has the goals of riding to work and with her family at the weekend. We helped with three quarters of the price of the bike she took a shine to at a local volunteer bike workshop. We also offered confidence boosting cycle training and mapped her a route to work."

Feedback via the Personalised Travel Planning Team

What more could we be doing?

A successful bid has been made to the Access Fund for Sustainable Travel. Planned interventions include a "Love to Ride" campaign running in 2017 targeted at workplaces and secondary schools, a second "Bike It" officer for schools and the "Brighton Bike Share" public bike hire scheme.

Working with communities

What's the evidence base?

National guidance has been published on community centred approaches to health and wellbeing.^{26, 27} Research indicates that

community capacity building brings a positive return on investment, for every £1 spent on community development there is an £11 return on investment.²⁸

What are we doing?

The Healthy Neighbourhood Fund (HNF) is funded by public health to reduce health inequalities. Residents are supported by community development organisations to identify projects which will benefit local people's health and wellbeing. Interventions include cooking and growing, food skills to reduce obesity, active living and exercise, five ways to wellbeing, reducing social isolation and improving health-related quality of life for older people, substance misuse and sexual health programmes.

What more could we be doing?

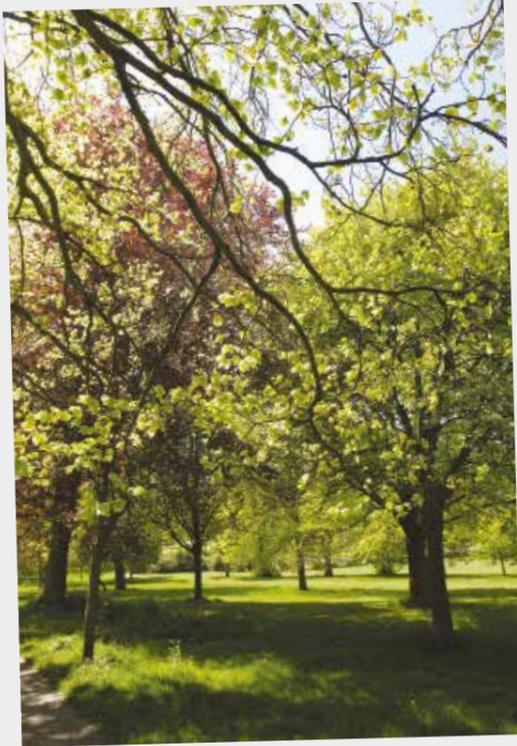
In line with PHE guidance, we could develop a range of interventions, for example Health Champions in each neighbourhood, building health literacy through offering workshops for residents on issues of interest and more service outreach into communities, including sessions based at community centres.

Case study: celebration event

"In the last three years the celebration event has offered local groups an opportunity to showcase their work and to network with visiting service providers such as Active for Life, Mind and the Alzheimer's Society; as well as the opportunity to raise funds for their group by putting on an activity. This in turn improves the access for local residents to free and affordable activities at the same time as raising awareness of what activities and groups they can get involved in locally. This is particularly important as Lower Bevendean is physically isolated, creating financial and social barriers to accessing activities in other parts of the city."

Extract from Bevendean Community Development Report²⁹

Green and open spaces



What's the evidence base?

There is growing evidence of the health benefits of accessing good quality green spaces.³⁰⁻³² These include better self-rated health, lower overweight and obesity levels, improved mental health and wellbeing and increased longevity. The Marmot Review noted the indirect health and wellbeing benefits.³³ Green spaces encourage social contact and integration, provide space for physical activity and play and improve air quality.

What are we doing?

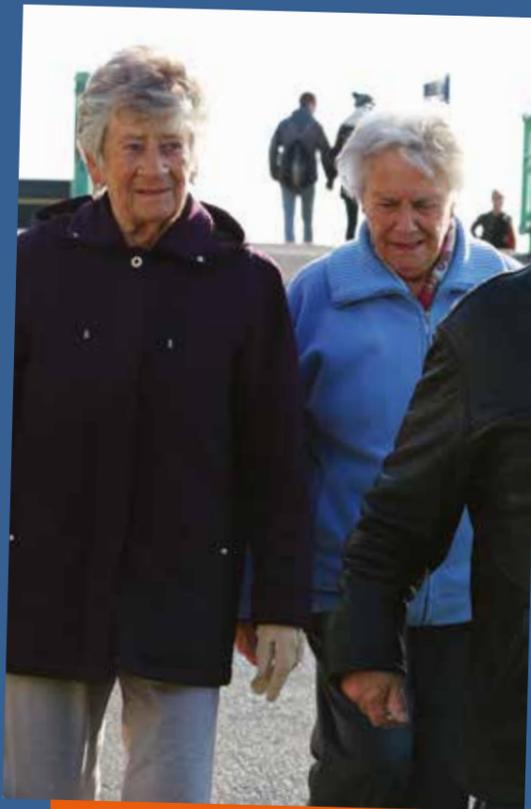
The city has a range of interventions in green and open spaces including parks and the seafront. For example: Healthwalks, the TAKEPART festival, engaging volunteers, Ping table tennis tables, skate parks, outdoor fixed gym equipment and Parkrun. The new Open Spaces Strategy 2017 also promotes health and wellbeing in these settings.

What more could we be doing?

As part of implementing the Open Spaces Strategy we could support action to increase access for vulnerable groups and further develop accessible physical activity opportunities within parks and open spaces.

Case study: Kathleen

"I joined the Healthwalks because I'd just lost my dog and found that because of that I was walking less. My doctor also recommended them because I had had a quadruple bypass operation and needed to do a certain amount of regular exercise. I feel the walks really do me good. I really like meeting people, especially since losing my husband, it has really helped and I feel better for it. I used to get a lot of pains in my legs, but I don't anymore and I don't get so breathless. Last year I had a Stress Cardiogram and the doctor said the results were brilliant, the best I had had in ten years. The walks are also good because I find hills too much for me, and with Healthwalks I can just choose the ones that are on the flat."



Kathleen (on the left), Preston Park, Hove Park and Seafront walker

Warmth for Wellbeing

What's the evidence base?

NICE guidance recommends a single-point-of-contact health and housing referral service and tailored solutions for individuals living in cold homes.^{34,35} Providing home heating and insulation interventions to households where someone has chronic obstructive pulmonary disease, heart disease or is aged 65 or over was found to be cost effective from the perspective of the health sector.³⁵

What are we doing?

From January 2016 to March 2017, a best practice Warmth for Wellbeing single-point-of-referral service was established, enabled by a grant from the British Gas Energy Trust. This offered comprehensive, personalised advice and support to improve finances and home energy efficiency and warm up the homes of vulnerable residents, including those aged 65 or over, people with long-term conditions and households with children aged under five. Findings from the project evaluation demonstrated a large positive impact on client mental health, financial situation, and self-

reported health and wellbeing. The service provided advice and support to 1,118 people, a significant number of whom were unemployed, had mental health conditions or disabilities. On average, each recipient of a home energy advice visit is now better off by £154 per year and each client receiving advice casework is better off by £2,712 per year.

What more could we be doing?

Warmth for Wellbeing was funded as a short term intervention using external funding. The Clinical Commissioning Group (CCG), council and partners could explore how to deliver the benefits of the programme in the future, including improving the least energy efficient homes that vulnerable people live in. In addition to savings to primary and secondary healthcare, this could lead to savings in social care costs, reduce sickness absence from schools and workplaces and reduce carbon emissions. We could also improve identification, recording and referral by health and social care staff of people at risk of ill health due to living in cold homes.



Case study: Emma

Emma is 55, single and living in private rented accommodation. She has long-term health conditions and her only income is the Employment Support Allowance. Her mental and physical health had been deteriorating due to debts of £17,000 and having no gas or hot water for three months. Emma was suicidal and couldn't see a way out. Following a referral to Warmth for Wellbeing, an energy advice home visit found her meter was taking £8 a week

for a wrongly estimated debt. The energy adviser got this cancelled and arranged a refund for excess charges. A Debt Relief Order wrote off debts and a hardship payment was made for Emma to top up her gas pre-payment card. Emma can now afford hot water and heating, and has gone from feeling suicidal to looking for work and making plans for the future.

Healthy workplaces

What's the evidence base?

Providing healthy lifestyle interventions in the workplace reaches people where they are living their everyday lives. There is strong evidence that promoting wellbeing at work has a positive impact on employees' physical and mental health and wellbeing; it can increase job satisfaction and productivity and reduce sickness absence and address presenteeism, making sense for both the business and for public health.³⁶

Effective workplace health programmes require organisational commitment, a clear strategic approach and involvement of key staff, alongside embedding traditional health improvement interventions such as those that aim to increase physical activity. Senior leadership actively supporting employee health and wellbeing through a participatory leadership style, clear communication, management training and job design, as well as the development of policies that support mental and physical health, can help businesses to create a supportive workplace environment.³⁷

Employers who invest in appropriate and successful workplace health initiatives can see a return on investment of between £2 and £34 for every £1 spent.³⁸

What are we doing?



The city has a range of interventions to help businesses create healthy workplaces. This includes supporting businesses to achieve the Workplace Wellbeing Charter; a standardised national accreditation programme that recognises good practice and provides

employers with a systematic method to improve and embed a holistic approach to healthy workplace practice.

Onsite staff health and wellbeing checks, stop smoking services and general health promotion activities and events are available to employers in the city.

Schools are supported with a staff health and wellbeing survey to help them gain insight into the concerns of their staff and they have the opportunity to apply for a grant to implement targeted health and wellbeing programmes.

Case study: Southern Water

Southern Water employs more than 2,400 people. The Workplace Wellbeing Charter provided a framework and standards for building the workplace wellbeing strategy and measuring the success of the awareness, guidance, activities and information provided for employees. The council interviewed 30 employees and managers as part of the charter assessment process.

The company is now working on a Time to Change pledge and company action plan. Time to Change is a national campaign focusing on removing the stigma and discrimination associated with mental health. The charter will help to develop the wellbeing strategy and provide employees with the necessary resources and tools to manage their own mental health and wellbeing.

What more could we be doing?

We could support more businesses to meet the NICE quality standards³⁹ for healthy workplaces to improve employee mental and physical health and wellbeing and continue to promote the Workplace Wellbeing Charter as a framework that can help businesses to develop a holistic approach to workplace health.

Local businesses can promote a culture where employees can discuss stress and mental distress openly without stigma or discrimination.

Public health, regulatory services and transport teams in the council could work together to offer businesses a 'package' of health improvement interventions including the workplace travel programme and the healthy choice food award.

A health and travel network of business partners could be established to share best practice. By working together in these areas we are likely to help individuals adopt healthy behaviours and ensure health, food and sustainable travel is an everyday feature of working in the city.

This chapter has reviewed preventative approaches to developing a healthy city through place and community level interventions. These need to be co-ordinated with the individual approaches that have been outlined in the previous chapters.



8 Recommendations



- 1 Effective prevention improves health and wellbeing and reduces inequalities.** To enable an integrated approach to prevention across the council, NHS and other partners, Public Health should lead the development of a local prevention framework.
- 2 Public engagement is essential to improve people's health and wellbeing.** Local agencies must engage with people and their communities in developing prevention programmes.
- 3 Investment in prevention is important, particularly when resources are limited and increasing numbers of people are living with multiple long-term conditions.** When integrating health and social care, local agencies must use the best available national and local evidence to ensure effective investment in prevention programmes.
- 4 Mental health is just as important as physical health.** We must ensure the physical health needs of people with mental health issues are addressed as well as the mental health needs of people with physical conditions.
- 5 The number of older people is expected to increase over the coming decade.** For older people, falls prevention and addressing social isolation should be prioritised for investment.
- 6 Circulatory disease accounts for a quarter of all deaths in Brighton & Hove.** Improving the identification and treatment of cardiovascular risk factors in primary care will provide both short and long-term benefits for patients and services.
- 7 Good work is good for health and wellbeing.** We should have a greater focus on supporting people with long-term conditions to be in meaningful employment in order to improve their health and wellbeing.
- 8 All front line workers can play a role in prevention.** It is important to continue the roll-out of Making Every Contact Count (MECC) across the local health and care system.
- 9 Protecting our children and young people's health and wellbeing is fundamental.** The city needs to address the high levels of health and wellbeing related risk taking behaviours amongst local children and young people.
- 10 Immunisation saves lives.** Improving the uptake and coverage of immunisations across all age groups needs a renewed focus including additional local action.
- 11 We are fortunate to have many natural local assets.** We all need to make the most of our parks and open spaces to increase our levels of physical activity and improve wellbeing.
- 12 Our city needs to be both healthy and accessible.** Improving air quality will improve our health. Switching more journeys to active travel will benefit physical and mental health and help to tackle air pollution.

Living well in a healthy city

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