Appendix 1

Public Health and Health Inequality Priorities in Brighton and Hove

Presentation to Health Overview Scrutiny Committee
September 2008

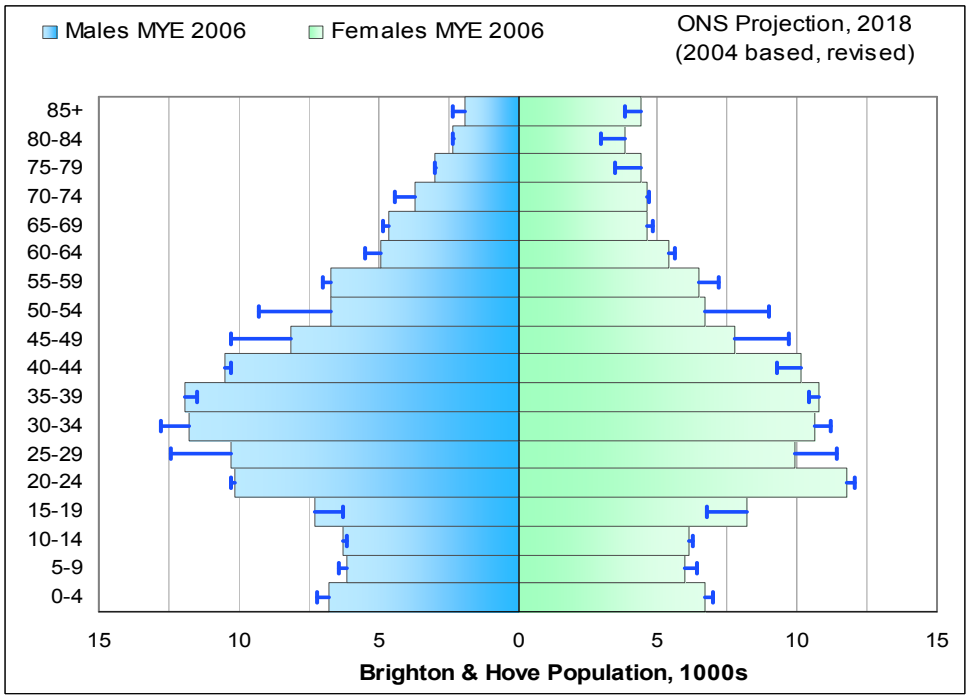
Introduction

This document presents an overview of the public health and health inequality priorities for Brighton and Hove. The information has been collated from a variety of sources, in particular the Joint Strategic Needs Assessment portfolio which includes the last five Annual Reports of the Director of Public Health. This information has also been used to inform the Strategic Commissioning Plan for 2008-2009 in the context of World Class Commissioning.

Local demography

In 2006 the Brighton and Hove local authority area had an estimated resident population of 251,400 people. The estimated reconciled PCT population was 260,700. The diagram below shows the age structure of the local resident population in 2006 and the projected changes until 2018.

Figure 1 Population structure of Brighton and Hove 2006 and projected changes by 2018.



Brighton and Hove has an unusual distribution compared with the national picture. There are relatively large numbers of people aged 20 to 44, with relatively fewer children and older people. However, it is important to note that there are relatively more very elderly people, particularly women who are likely to have increased needs for services. During 2007/8 people aged 85 years and above occupied more than one fifth of all hospital inpatient bed days used by PCT residents.

Over the next ten years the population is predicted to increase to 264,600. As the above figure shows the predicted greatest increase will be seen in the 45 to 54 year age group. The population of younger adults will continue to increase, but there will also be increased numbers of younger children. The number of people aged 75 years and above is expected to fall.

With regard to the different subpopulations within the city a recent review of inequalities in the city reported (OCSI 2007):

- 15% of the city's residents were born outside England, well above national and regional levels.
- The population of Black and minority ethnic (BME) groups is estimated to have increased by 35% between 2001 and 2004 (compared to 13% nationally)
- 20% of all births in 2005 were to mothers born outside the UK
- the city ranks among the 10% of local authorities for migrant worker registrations
- a growing Lesbian, Gay, Bisexual and Transgender (LGBT) population (latest estimate,35,000)

Sections of the LBGT community are at increased risk of mental illness and sexually transmitted infections including HIV and are more likely to be smokers and to drink above the recommended "safe levels" of alcohol.

At the time of the 2001 census 94.2% of the Brighton and Hove population were from white groups compared with 91% nationally. More recent estimates produced for 2005 suggest that the local picture is changing (Table 1).

Table1 Estimated ethnic composition of Brighton and Hove 2005

	2001		**2005**		**% change**
All Groups	247.3	100 %	249.8	100 %	1.0%
White: British	218.1	88 %	213.2	85 %	-2.2%
White: Irish	4.0	1.6 %	3.8	1.5 %	-4.2%
White: Other White	11.4	4.6 %	12.5	5.0 %	9.6%
Mixed	4.7	1.9 %	5.4	2.2 %	14.7%
Asian	4.5	1.8	6.9	2.8	54.7%

		%		%	
Black	2.0	0.8 %	3.7	1.5 %	86.7%
Chinese	1.2	0.5 %	2.2	0.9 %	77.6%
Other	1.5	0.6 %	2.1	0.8 %	41.2%

Source ONS

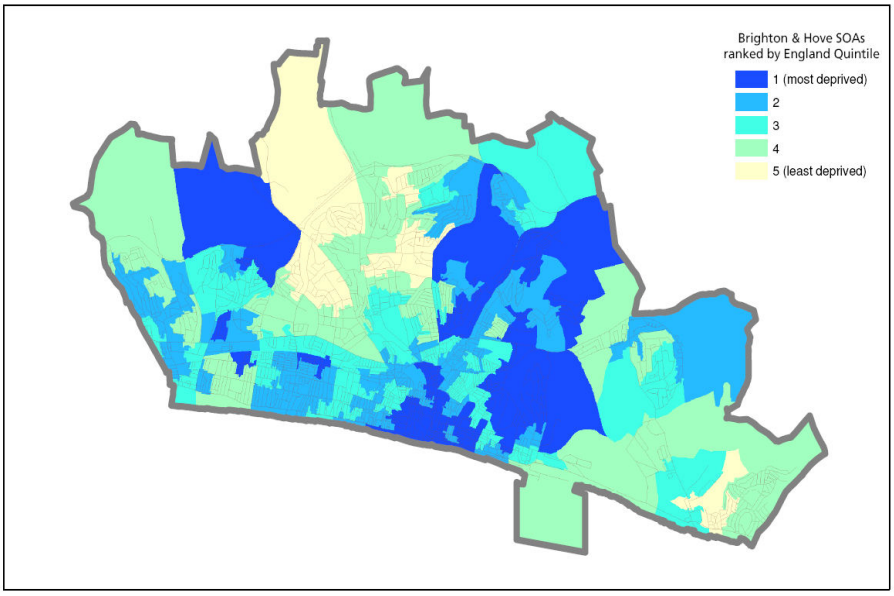
These changes are important as different ethnic groups experience different disease patterns. For example Asians as well as Black Africans and Caribbeans are at increased risk of cardiovascular disease and diabetes.

The broader determinants of health

Many different factors influence health. It has been estimated that the NHS can only contribute 8% to any increase in life expectancy (SECSHA Health Inequality Strategy) and that other factors, the broader determinants of health, such as education, employment and housing have a greater impact. Some of the major socio-economic problems in the city are the levels of young people not in education, employment or training, sections of the population with low skills, the number of people claiming incapacity benefit and high numbers of children both in lone parent households and in households with no working adults (OCSI 2007).

Inequalities exist cross the city both within population sub groups such as people from different ethnic groups and people living with disabilities, as well as between neighbourhoods. The Index of Multiple Deprivation 2007 identifies Brighton and Hove as the 79th most deprived authority in England (out of 354), with 9% of all Super Output Areas in the City falling within the 10% most deprived SOAs in England and 8 SOAs falling in the 5% most deprived. Map 1 shows that most of the deprived areas are in the East of the city. However, the majority of people suffering disadvantage in the city do not live in the most deprived 20% of SOAs.

Map 1 Brighton and Hove Super Output Areas deprivation ranking from IMD 2007

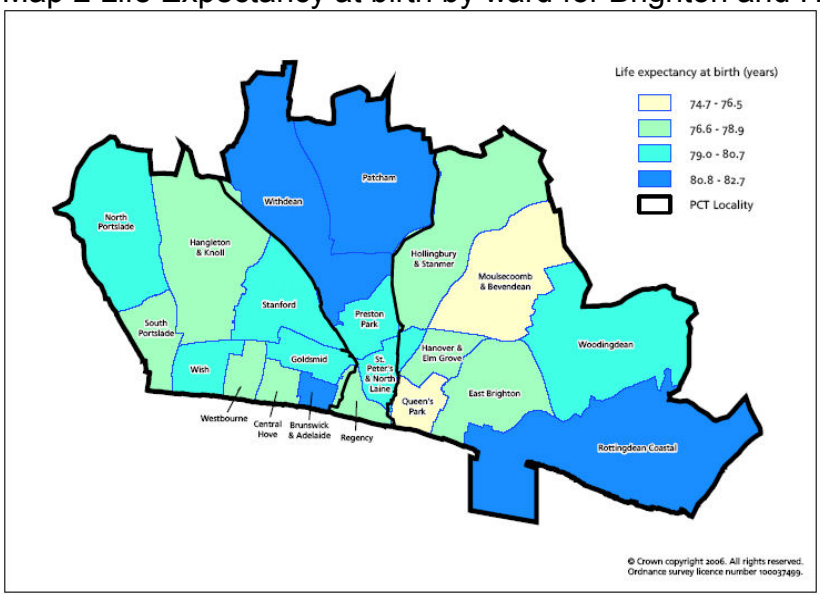


Source: Office of National Statistics, 2007

Life Expectancy

There is a national health inequality target for Life Expectancy. Life expectancy at birth is a useful global measure of population health and illustrates the inequalities across the city. The average life expectancy at birth for males in Brighton and Hove in 2004/2006 was 76.3 years compared with 77.3 years for England. For females the life expectancies were 81.8 years and 81.6 years respectively. The average life expectancy for Brighton males in 1999/2001 was 74.6 years and for females 80.5 years. However as the map below demonstrates there are variations in life expectancy between the different wards across the city. Comparison with the map above clearly links life expectancy with deprivation.

Map 2 Life Expectancy at birth by ward for Brighton and Hove 2003-5



Source BHCPCT Public Health

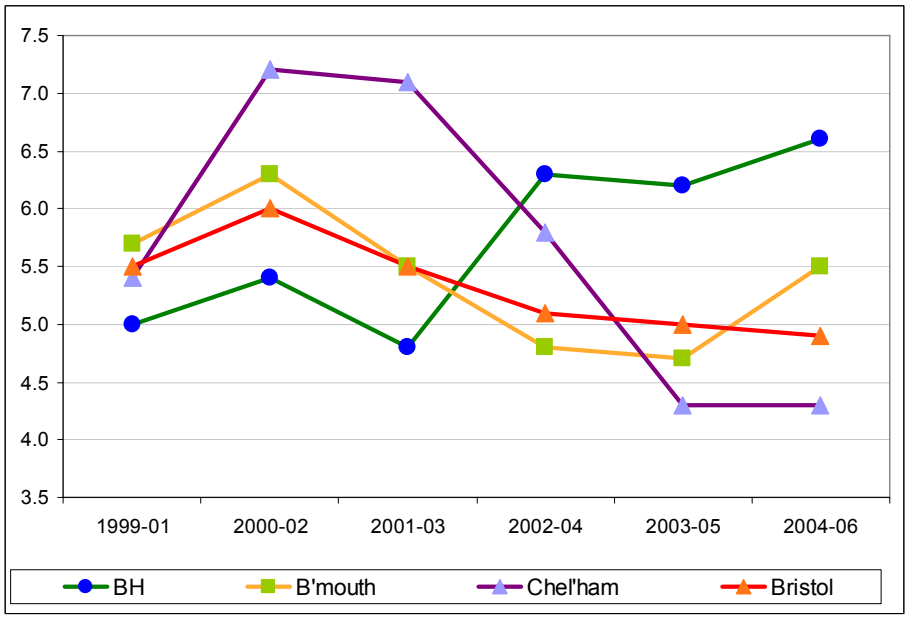
The Department of Health (DH 2007) has identified the key interventions for reducing the gap in life expectancy between the most and least disadvantaged PCTs. These are relevant to reducing health inequalities within Brighton and Hove. The interventions to consider include:

- greatly increasing the capacity of smoking cessation clinics
- increasing the coverage of effective therapies for secondary prevention of cardiovascular diseases in people aged under 75 years
- primary prevention of cardiovascular disease in people of all ages with hypertension through treatment with antihypertensives and statins.
- the early detection of cancer
- reducing mortality from respiratory diseases
- reducing mortality from alcohol related diseases
- reducing infant mortality.

Infant and Child Health

Like life expectancy infant mortality is a measure of a population's overall health. Unlike life expectancy the actual annual number of deaths upon which the rates are based are relatively very few. This has implications for making comparisons between different areas within the same local authority. The figures below compare the trend in infant mortality for the city between 1999/2001 and 2004/06 with the trends for those cities considered to be similar to Brighton and Hove by the Office for National Statistics.

Figure 2 Infant mortality rates 1999/01 to 2004/6 for Brighton and Hove compared with ONS comparator areas.



In general the majority of neonatal deaths are due to immaturity, congenital anomalies and intrapartum asphyxia, anoxia or trauma. Over two-fifths of post-neonatal deaths are due to congenital anomalies and sudden infant deaths. Because of the small number of deaths the causes of death also vary from year to year. In 2005 of the 18 infant deaths 15 were aged under 28 days and seven of the infant deaths were due to extreme immaturity compared with one death in 2004. Regarding Sudden Infant deaths there was one in 2004 and none in 2005. Low birth-weight is an important factor regarding perinatal death. Smoking during pregnancy is more frequent amongst women from lower socio-economic groups and is a contributory factor to low birth weight. The highest rates of low and very low birth-weight babies in Brighton and Hove are seen in the more deprived parts of the city.

Breastfeeding and vaccinations protect children from infectious diseases and other conditions. Breastfeeding initiation rates across the city are high, but the number of babies being breastfed at 6 weeks has been much lower but appears to be improving. The most recent data for the first three months of 2008 showed a breastfeeding rate at 6 weeks of 64%. Across the city the maternal breastfeeding rates between health visiting teams vary from 19% to 60%. This may be due to demographic and cultural factors in the population or differences in expectation or practice.

Childhood immunisation rates in Brighton and Hove are below the national rates. The table below compares the rates of vaccination for selected vaccines at certain ages. Each percentage point represents approximately 30 vaccinated children. Vaccination rates tend to be lower amongst children from more socioeconomically deprived families. Locally it is also considered that the large natural health movement has an impact on uptake.

Table 2

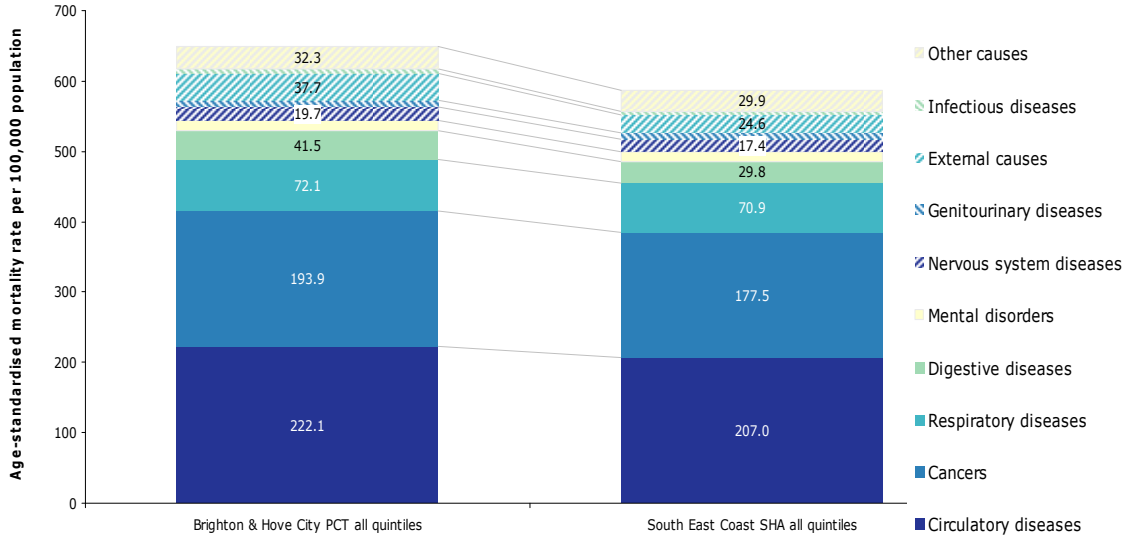
Vaccine	Age	BHCPCT	England
DTaP/IPVB/Hib	% immunised by their first birthday	88	91
MMR	% immunised by their second birthday	79	85
DTaP/IPV Booster	% immunised by their fifth birthday	71	79

In 2005/6 23% of five year olds in Brighton and Hove had active dental decay. This is better than the national figure of 33% but slightly above the SHA rate of 22%. There is however a clear association between increased incidence of dental caries and socio-economic disadvantage. The treatment of diseases of the oral cavity is the most frequent cause of hospital admission for local children, as any dental work requiring general anaesthesia must be carried out in hospital.

Major causes of death for all ages

The figure below shows the main causes of death within Brighton and Hove and compares the rates with those for the SHA as a whole. It clearly shows that the commonest causes of death, cancers, circulatory diseases, respiratory diseases and digestive diseases (which includes liver diseases) are similar but that the Brighton rates are higher for all disease groupings.

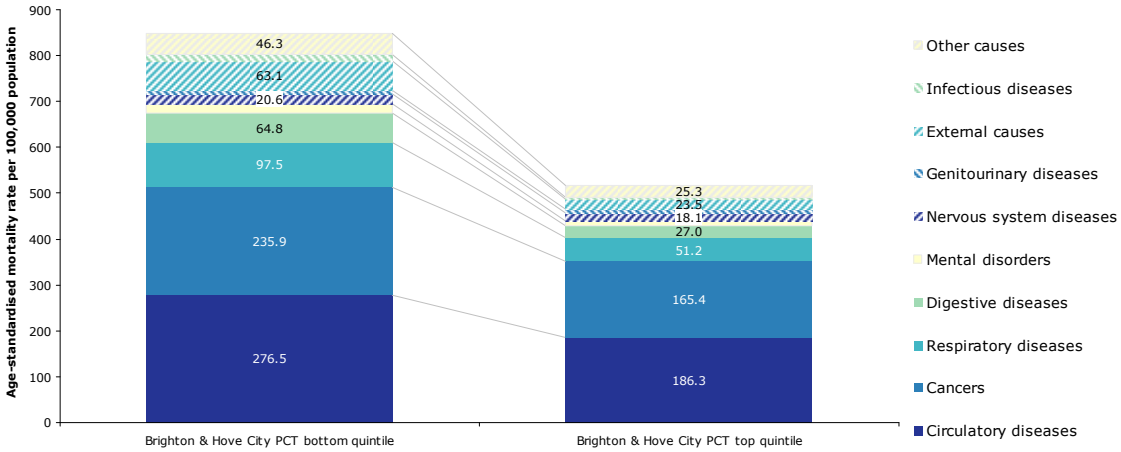
Figure 3 Mortality rate per 100,000 population for the total population of BHCPCT compared with the total population of SEC SHA 2002-6



Source SEPHO Toolkit

The figure below compares the death rates for BHCPCT for 2002-6 for the least deprived quintile of the city's population with the most deprived quintile. Again the commonest causes of death are similar but the rates are clearly much greater in the most deprived quintile.

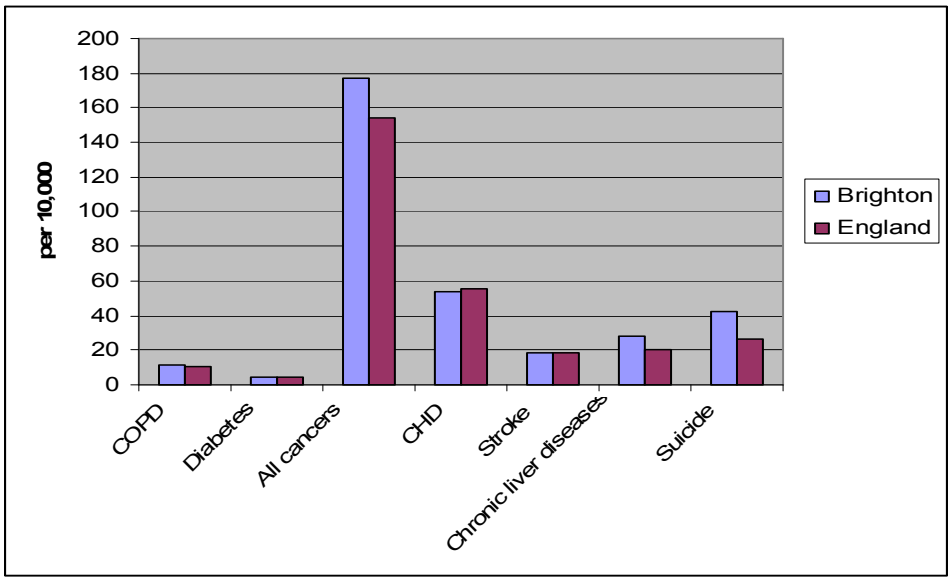
Figure 4 Mortality rate per 100,000 population for the least and most deprived quintiles in BHCPCT 2002-6



Source SEPHO Toolkit

The chart below shows that the same conditions also have the greatest years of life lost, though for suicide and injury undetermined the Brighton rate is relatively much higher than the national one.

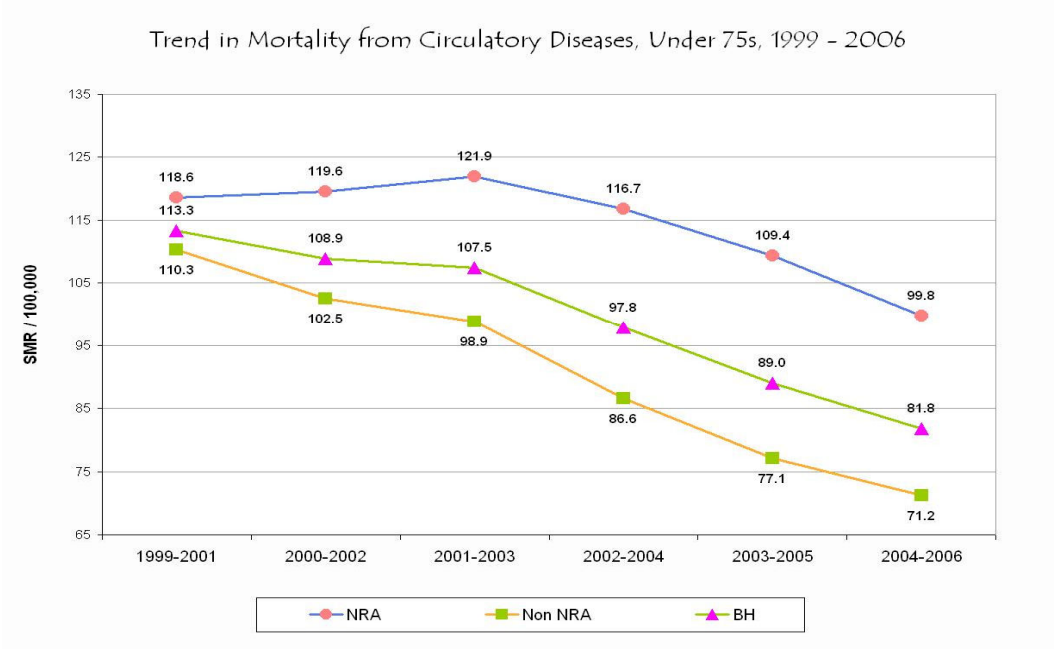
Figure 5 Years of Life Lost per 10,000 population under 75 years for Brighton and Hove and for England 2004-6

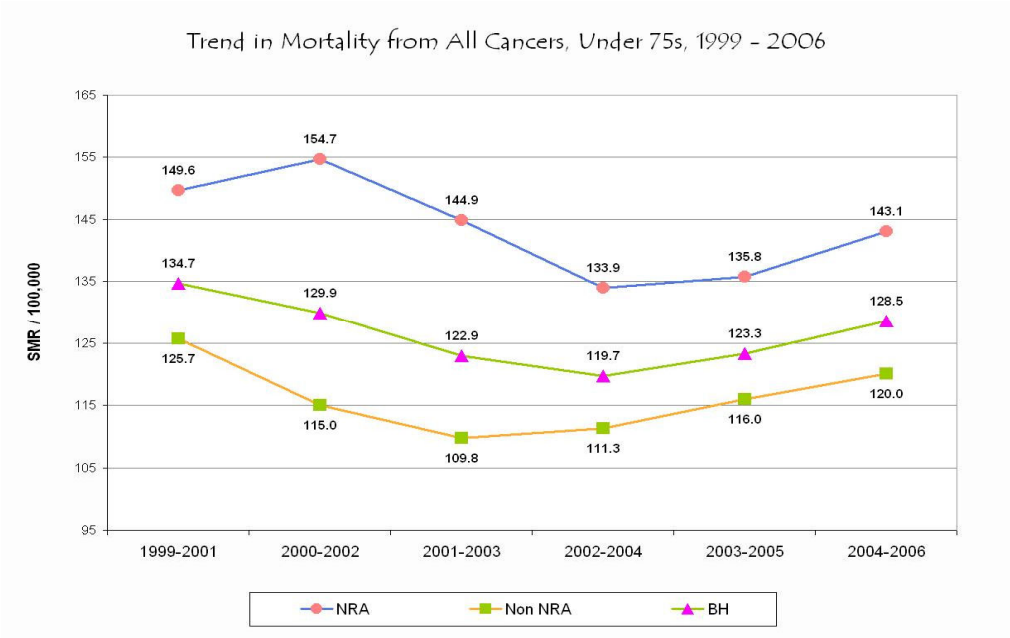


Source: NCHOD

Major causes of death and Health Inequalities

Figure 6 and 7 below show that for the two major killers the recent trend for deaths from circulatory diseases in people aged under 75 years in Brighton and Hove has been downwards whereas for cancers the recent trend is upwards. In addition the rates are higher in those areas of the city which received neighbourhood renewal funding (NRA) and the gap compared with the rest of the city is not reducing.





The recent increase in cancer is being investigated further. The most common cancers showing a significant increase in absolute numbers in recent years are lung and breast cancer, but the trend is not straightforward. Of the 165 male deaths in 2006 in people aged under 75 years, 44 were from lung cancer compared with 35 in 2004 and 47 in 2001. There were 138 female deaths under 75 years in 2006 of which 33 were from lung cancer and 26 from breast cancer. This compares with 23 and 21 in 2004 and 20 and 34 in 2001 respectively. The mortality rate per 100,000 females under 75 years from breast cancer has also fluctuated from 29.9 in 2001 to 18.5 in 2004 and 30.2 in 2007. For males and females combined the rates for lung cancer had

been steadily increasing from 2003 to 2006, but the rate fell slightly in 2007. A similar pattern has been seen for male but not for female deaths.

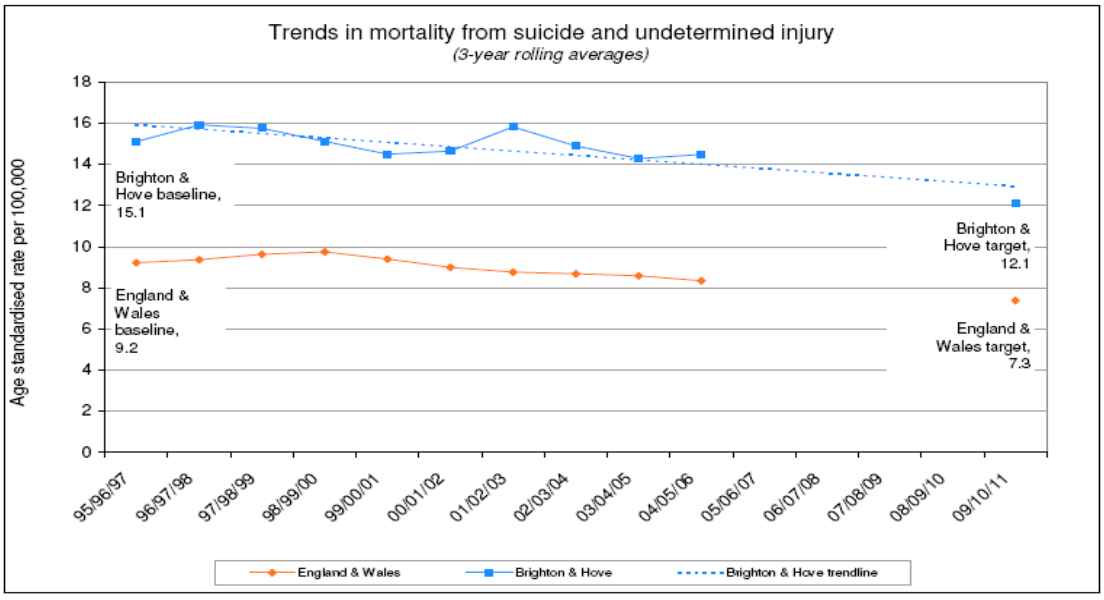
Mental health and substance misuse

Brighton and Hove has a high Mental Health Needs Index score together with a large number of people at increased risk of mental health problems. Based on national survey work 25,000 people in Brighton and Hove aged 16 to 65 suffer from a neurotic disorder at any one time. The most common disorder is mixed anxiety and depression. There are also estimated to be 2000 people with bipolar disorder and 600 with schizophrenia. Schizophrenia is both the most common cause of hospital admission and the condition with the longest average length of stay.

An older people's mental health needs assessment carried out in Brighton and Hove in 2004 found that the two types of mental health problems which affect older people the most are dementia and depression. Applying national prevalence rates to the local population suggests that within the city there are over approximately 3,100-3,200 people aged 65 years and above with dementia. Of these approximately one third will suffer from severe dementia. It is estimated that 10-15% of all older people suffer from depressive symptoms.

As figure 8 shows the suicide rate in Brighton and Hove is much higher than the national average. A local suicide audit of deaths in 2003-5 (based on 119 deaths) showed that 87% of people had had a primary diagnosis of mental illness (of these, 45% had depression, 25% had alcohol/substance dependence), 67% were males, 76% were either single, divorced /separated or widowed, 88% were heterosexual, 51% were aged between 18-44 years and 94% were white.

Figure 8 Mortality rate from suicide and undetermined injury for Brighton and Hove and for England and Wales 1995/7 to 2004/6



Deaths from suicide in people under the age of 20 years are rare: there were 14 suicides in total among 15-19 year olds between 1987 and 2003. However, the number of children with mental health needs is significant. The Children and Young People's Trust estimate that there are over 3000 local children with moderately severe problems and over 800 with complex mental health needs. Mental health issues are more likely amongst children who are looked after, adopted, on the child protection register, have learning difficulties, have suffered traumatic life events or are young offenders. Drug use amongst 11-15 year olds has reduced between 2001 and 2006.

Brighton has relatively high numbers of adult problem drug users including injecting drug-users. Table 3 shows the annual number of drug related deaths in the city. Although not all parts of the country report to the national programme Brighton still has a relatively high proportion of the national total. Heroin or Morphine and alcohol were implicated in a significant number of the deaths.

Table 3 Number of drug related deaths in Brighton & Hove and in England and Wales 2000-2006

	No of Deaths in England and Wales*	Brighton & Hove No of Deaths	Brighton & Hove Rate per 100,000
2000	1319	67	32.56
2001	1774	59	28.51
2002	1684	56	26.85
2003	1659	53	25.30
2004	1472	47	22.32
2005	1382	51	24.22
2006	n/a	38	17.8

(Source : National Programme on Substance Abuse Deaths) * Not all jurisdictions report to the database.

Alcohol misuse including binge drinking is a substantial and growing problem in Brighton and Hove, particularly for men. In 2006 SEPHO ranked Brighton and Hove as the 11th highest of the 67 Local Authorities in the South East for alcohol related hospital admissions. Based on data from 2001-3 Brighton had the second highest alcohol specific death rate for males of all Local authorities in England. For females Brighton and Hove was ranked 62nd. Between the periods 1991/97 and 1998/2004 alcohol specific death rates for men almost doubled whereas in women the death rates were unchanged. Brighton and Hove is also in the top quintile for alcohol related recorded crimes, violent offences and sexual offences. A 2007 systematic review by the National Institute for Mental Health in England found an increased relative risk of alcohol dependence in lesbian, gay and bisexual groups at least 1.5 times higher than the heterosexual population. The relative risk for substance misuse was also increased.

Chronic Disease and Morbidity

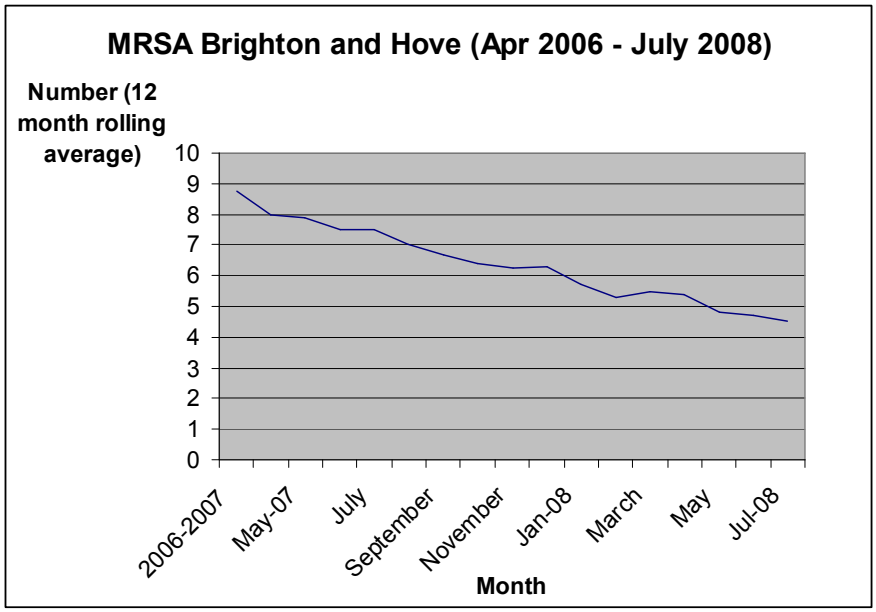
Although a poor indicator of morbidity for some conditions hospital admissions provide some insight to the diseases experienced by the local population. In total in 2007/8 BHCPCT residents spent over 76,000 days as hospital inpatients. This does not include day cases. As the table below shows the majority of hospital bed days are used by people aged 65 years and above.

Table 4 Percentage of total bed days by age and type of admission 2007/8.

Age (years)	Type of admission		
	Elective	Emergency	All
<65	44.9%	41.6%	42.1%
65+	55.1%	58.4%	57.9%
75+	30.8%	46.3%	44.1%
85+	5.1%	23.1%	20.5%

Health care acquired infection, and MRSA and Clostridium difficile (CD) in particular, has become a significant issue in recent years. A great deal of work has been undertaken across the local health economy to address this. The high rates of MRSA infection (bacteraemias) have been falling steadily since 2006 and the monthly average (based on 12 month rolling averages) has fallen from 8.75 in April 2006 to 4.5 in July 2008.

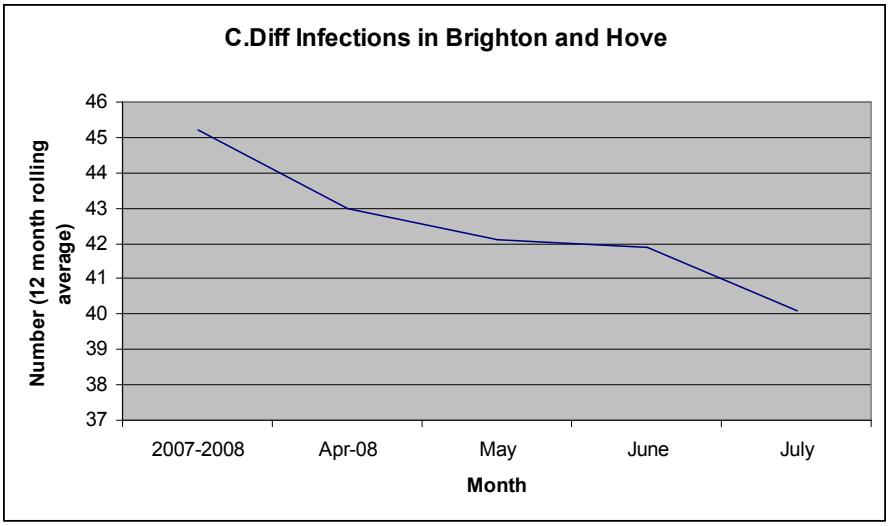
Figure 9 MRSA Bacteraemias in Brighton and Hove, 12 month rolling average



The 2007/8 rate of CD cases in the local community was 14 per 10,000 people, based on 345 cases, which was above the SHA average of 10.4. The PCT target for 2008/9 is for a total of 272 cases falling to 125 in 2010/11.

Figure 10 shows the 12 month rolling average figure from when data first became available (April 2007). While the numbers of infections are higher than MRSA and data recording does not go back as far, there is a suggestion of a similar trend with a reducing rate of infection. Several new initiatives around deep cleaning, a C.Diff ward and a new antibiotic policy across primary and secondary care should have further impact on reducing infection rates.

Figure 10 C.Diff infections in Brighton and Hove, 12 month rolling average



The table below describes by locality within the PCT the prevalence, mortality and admission data for different chronic conditions experienced by local residents. There are some data quality issues about the primary care data from the Quality and Outcomes Framework used to estimate prevalence. The true prevalence is likely to be greater than that presented.

As the table shows the highest mortality rates for cancer and coronary heart disease were in the east locality. This is in keeping with the higher levels of deprivation seen in that part of the city and is likely to reflect increased smoking levels and other variations in lifestyle. The table also clearly shows that the number of hospital admissions for conditions such as diabetes and asthma were relatively few in comparison with the number of people with the condition.

Table 5 Crude prevalence, mortality and admission data for chronic diseases by locality. Data from years 2004 to 2007

Condition	**Locality**	**QOF 2006-7**		**SMR 2004-6**	**Admissions 2005-7**	
					Emergency	**Elective**
		Disease Register Size (No)	**Crude prevalence** (Rate /1000)	(Rate / 100,000)	Avg No. per Yr	Avg No. per Yr

Bronchitis, emphysema and other COPD	Central	689	6.9	4.0	6	1
	East	1,182	12.8	15.9	9	2
	West	1,041	10.4	15.5	14	1
	BH	*2,912*	*9.9*	*13.1*	*29*	*4*
Asthma	Central	5,335	53.3	*	61	0
	East	5,312	57.3	*	126	2
	West	5,456	54.6	*	96	1
	BH	*16,103*	*55.0*	*1.4 (all ages)*	*283*	*3*
CHD	Central	2,009	20.1	26.9	94	12
	East	2,583	27.9	68.6	221	28
	West	2,700	27.0	45.2	210	28
	BH	*7,292*	*24.9*	*47.1*	*525*	*68*
Heart Failure	Central	456	4.6	*	34	2
	East	554	6.0	*	84	4
	West	563	5.6	*	96	5
	BH	*1,573*	*5.4*	5.7	*215*	*11*
Stroke	Central	997	10.0	7.3	86	7
	East	1,141	12.3	14.3	158	9
	West	1,420	14.2	20.1	178	11
	BH	*3,558*	*12.2*	*15.2*	*421*	*27*
Cancer	Central	676	6.7	83.6	127	597
	East	854	9.2	152.3	234	960
	West	829	8.3	129.5	245	1,150
	BH	2,359	8.1	128.9	*606*	*2,706*
Diabetes	Central	2,203	0.0	*	39	22
	East	2,728	0.0	*	83	50
	West	2,908	0.0	*	79	43
	BH	*7,839*	*0.0*	*3.7*	*202*	*114*

* numbers too small to provide meaningful rate

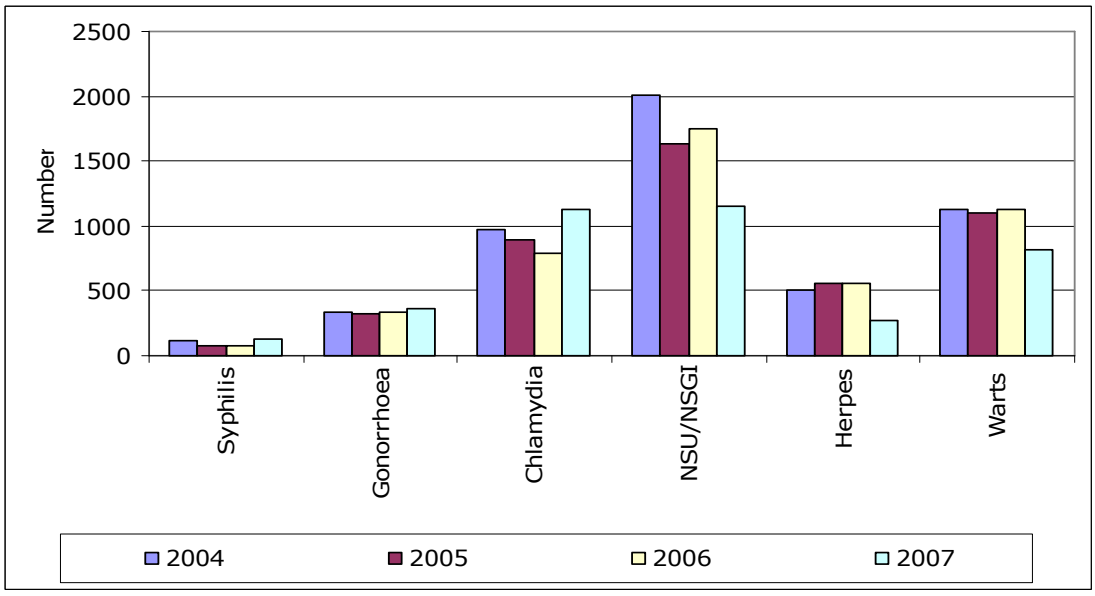
Sexual health

Brighton and Hove has high rates of sexually transmitted infections (STIs), people living with HIV, teenage pregnancy and terminations of pregnancy. It is currently difficult to obtain resident based information about STIs but overall contacts at the main Genito-Urinary Medicine (GUM) clinic in Brighton and Hove remain very high and are increasing year on year. In March 2008 the GUM clinic achieved the national target of offering everyone an appointment to be seen within 48 hours of contacting the service.

Brighton and Hove has high rates of the commonest sexually transmitted infections such as chlamydia but also has very high rates of gonorrhoea and syphilis when compared with national rates. However, unlike the national picture the rates of gonorrhoea cases have not fallen in recent years (Figure

11). The majority of these infections are amongst men who have sex with men.

Figure 11 Number of new contacts seen at Brighton GUM clinic by sexually transmitted infection 2004 – 2007



Source BHCPCT/KC60

During 2007/8 the local chlamydia screening programme screened 4,348 people aged 15-24 year of which 3640, almost 10% of the target population, were eligible for inclusion under the national target. Of the 3640 tests 259 (7%) were positive results. Approximately three quarters of all the tests done and of the positive results were amongst females. The target for 2008/9 is 6355 screening tests completed, which is equivalent to 17% of the target population. A new Local Enhanced Service for primary care including pharmacists is being developed to further increase uptake of the programme. In addition all chlamydia tests carried out, not just those in the screening programme, will be included unless they took place at the GUM clinic.

Brighton has very high rates of people living with HIV compared with the other PCTs in the region. In December 2006 there were 1121 identified people in Brighton and Hove living with HIV, 1019 of whom were males. The total figure for both sexes has been increasing rapidly; in December 2005 it was 1000, and for 2001 it was 633.

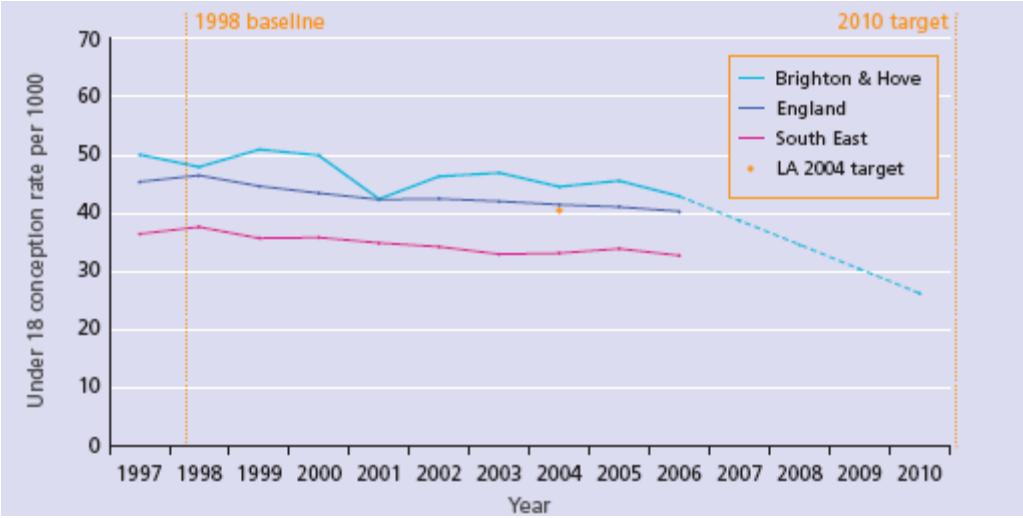
It is estimated that one third of gay men infected with HIV do not know their diagnosis. This is important not only from a prevention perspective but also for ensuring correct monitoring of disease markers to allow treatment to be started as soon as it is required.

As Figure 12 shows the teenage pregnancy rates in Brighton and Hove are above the national average. To achieve the local 2010 target of a 45% reduction will require a significant sustained fall in the rate. It has fallen

10.5% since 1998. The highest rates in the city are seen in the most disadvantaged areas and there is a clear link with educational achievement. In 2004-6 57% of teenage conceptions in Brighton and Hove resulted in abortion compared with 48% nationally.

In the 2007 Health Related Behaviour Survey 45% of boys and 62% of girls knew where they could get free condoms. This compared with 42% and 63% respectively in 2004 and 52% and 63% respectively nationally in 2006. Half the local secondary schools and all the sixth form colleges currently have outreach sexual health and contraceptive service provided by the school nurse team.

Figure 12 Teenage pregnancy rates for Brighton and Hove compared with the rates for England and the South East 1998-2006 (three year rolling average).



Source ONS

Brighton has rates of terminations of pregnancy above the national average for women of all ages. In 2007 the rate per 1000 women resident in Brighton and Hove was 23 for all ages and 22 for women under 18 compared with a national rate of 19 and 20 respectively. The comparable SHA figures were 18 and 17 respectively.

Lifestyle and prevention

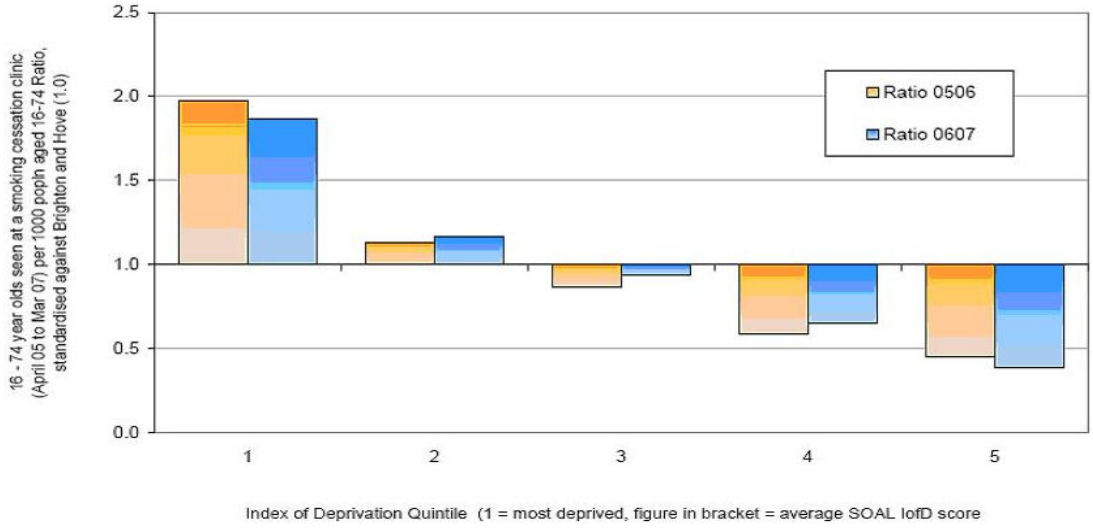
The individual factors influencing the variation in morbidity and mortality can be considered as being either unavoidable such as age, gender and ethnicity or avoidable such as smoking, excessive alcohol consumption, diet, sedentary lifestyle etc. The ability to make healthier choices is influenced by personal circumstances and the broader determinants of health. The latest lifestyle survey of the Brighton and Hove adult population was in 2003.

Smoking is the greatest cause of health inequalities and premature death. In the 2003 survey the number of daily smokers had fallen to 20% from 27% in

1992 with approximately 7% more people being occasional smokers. However, amongst people living in the more deprived parts of the city rates of nearly 50% were recorded from a different household survey at that time. During 2006/8 the local smoking cessation service helped over 4,000 people to quit smoking. However, in 2008/9 there appears to be a reduction in the number of referrals to the service, and the service is planning how it should respond to this change.

One of the possible disadvantages of providing a specialist smoking cessation service is that it may inadvertently widen inequalities as people living in more affluent parts of the city take up the service more readily than those living elsewhere. The figure below shows that in recent years this has not been the case locally and that the specialist service has seen more patients from the more deprived parts of the city.

Figure 13 Referrals to the specialist smoking cessation service per 1000 population by deprivation quintile.



The Health Related Behaviour Survey (HRBS) of 14 -15 year olds in 2007 found that 15% of boys and 25% of girls had smoked at least one cigarette in the previous week. The national figures were 13% and 20% respectively.

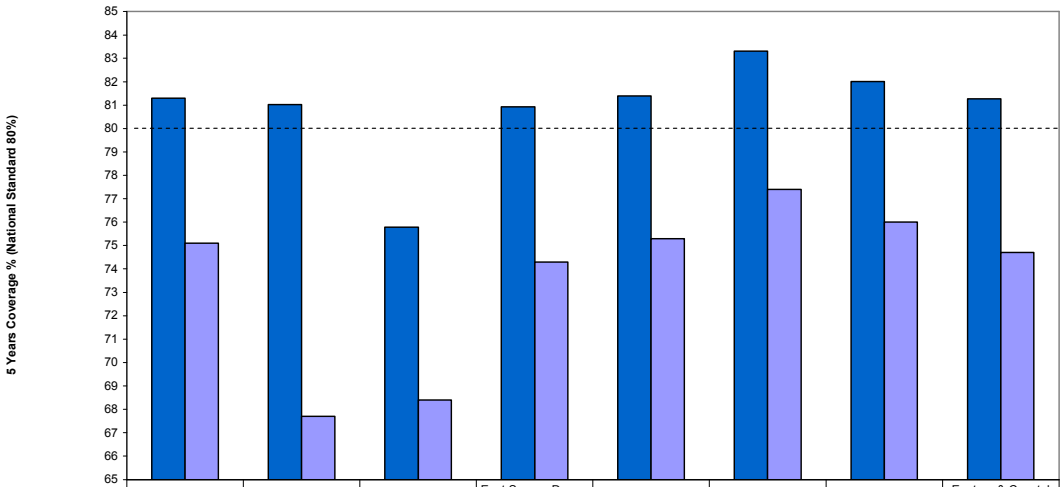
Nationally it is estimated that approximately one in four adults drink above "safe drinking levels". This equates to more than 50,000 adults in Brighton and Hove. Over the period 1992 to 2003 the percentage of adult men consuming above safe levels increased from 165 to 27%. For women the increase was from 8% to 17%. The HRBS found that drinking amongst young people is on the increase with 13% of boys in 2007 reporting drinking at least 14 units of alcohol in the last week compared with 10% in 2004. The figures for girls were 9% and 6% respectively.

Obesity is an increasing concern both for adults and children. Being overweight or obese increases the risk of diabetes, hypertension, heart disease and cancer amongst other diseases. It is estimated that nationally,

without effective action, one fifth of children aged two to ten and one third of adults will be obese by 2010. There is only limited valid local information about obesity. Modelled estimates suggest that in 2005 20.2% of adults in Brighton and Hove were obese. Local data in 2006/7 found 30.2% of year six children were overweight or obese which is similar to the SHA and national picture. Encouragingly the HRBS found that the eating habits of children aged 10-14 are improving as are the levels of physical activity.

The uptake of prevention programmes, such as those addressing the issues outlined above, tends to be greater amongst people from higher socioeconomic groups. This is demonstrated locally by the PCT's cervical cancer screening programme. Overall coverage has been falling over recent years and is now below the national target of 80% (Figure 14). The coverage is particularly low for the 25-34 age group, which is a national issue. However, for all ages local coverage is lowest in the more disadvantaged parts of the city.

Figure 14 Cervical screening coverage for 2006-7 by % target population for BHCPCT and other PCTs within SECSHA.



	Surrey	West Sussex	Brighton & Hove City	East Sussex Downs & Weald	Hastings & Rother	West Kent	Medway	Eastern & Coastal Kent
5 year coverage	81.3	81.0	75.8	80.9	81.4	83.3	82.0	81.3
3.5 year coverage	75.1	67.7	68.4	74.3	75.3	77.4	76.0	74.7

Breast screening coverage has also fallen in recent years. Between 2005/6 and 2006/7 the percentage of women aged 53 to 64 being screened within 36 months fell from 77.1% to 70.1%. The screening service has been unable to recruit adequate numbers of staff to maintain the 36 month screening interval for women. The service is due to move to new premises with modern digital technology in the autumn of 2008 and it is anticipated that this will help to resolve the organisational issues and allow the coverage to return to above national target levels.

Summary

Brighton and Hove PCT is one of the most deprived PCTs in the South East. This together with a relatively large proportion of younger adults results in a population with significant health needs and inequalities. Particular challenges are the low immunisation rates of children, high teenage pregnancy rates, high rates of sexually transmitted infections, high levels of alcohol and drug related morbidity and mortality, increasing cancer mortality and widening inequalities for cancer and cardiovascular diseases. Encouraging healthy lifestyles through reducing smoking and hazardous and harmful drinking together with promoting exercise and healthy eating will help to address some of these issues. Although the population is relatively young by national standards the older population still has the greatest impact on inpatient hospital services.

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