Brent NHS
Teaching Primary Care Trust

Working with our partners for a healthier Brent

Public Health Annual Report 2005/2006

Produced by Brent tPCT
Designed by Anna Sorfova

Contents

Foreword

I am pleased to present my annual report for 2005–6.

This has been an historic year for public health. We have seen the passing of the smoke free legislation and look forward to the positive health impact when this comes into force in July 2007. We have been part of the national casino development debate, resulting from the Licensing Act (2005). Brent was on the shortlist of eight for the “super casino” but withdrew from the contest in August 2006. Nevertheless, gambling remains a growing public health concern.

These legislative changes are illustrative of a growing political focus on the influence of lifestyle on personal and public health.

The 2004 Public Health White Paper, *Choosing Health: Making Healthy Choices Easier* provided the template for the delivery of healthier lifestyles. It is unfortunate that all around the country, money earmarked for Choosing Health has been subsumed into PCT financial deficits. Nevertheless, in Brent we remain optimistic and committed to working with our colleagues in the PCT, the wider NHS and our partners in the statutory and voluntary sector to improve the health of the population and reduce inequalities in health.

Judith Stanton
Director of Public Health

Acknowledgements

Andy Brown
Anjum Fareed
Anna Sorfova
Connie Smith
Cordelle Ofori
David Lawrence
Florence Acquah
Luke Kwamya
Marco Inzani
Mary Joyce
Nahid Chowdhury
Simon Bowen
Sophie Flanagan
Sunita Sidhu
Tony Ellam

Executive Summary

This is the fourth Annual Public Health Report for Brent Teaching Primary Care Trust (tPCT). The focus of this report is on gambling, sexual health and drugs (including smoking and alcohol). These areas have been chosen because they are important and significant areas of health with a large burden of preventable disease. They are also areas where there are major legislative changes taking place which are likely to impact on health in the future.

The Health and People of Brent

Brent has an ethnically and culturally diverse population and there are great variations in wealth across the borough. Black and minority ethnic groups (BME) in Brent now make up the majority of the population at 54.7%. This is the second highest of all the London Boroughs after Newham. Ranked 81st on the national deprivation league table, there is a north south divide with an affluent north and a generally poorer south.

There are significant health inequalities, closely linked to deprivation. The most deprived wards in the South of the borough have a higher death rate and lower life expectancy than the less deprived wards in the North of the borough. The differences in health within Brent are dramatically illustrated by examining male life expectancy along the Bakerloo line. A journey of 3.5 miles takes you from Harlesden, which has the lowest life expectancy for men (71.8) and women (78.4), to South Kenton, where male life expectancy is 11.1 years higher, at 82.9 years. The difference is 7.5 years in females, between Harlesden (78.4) and Dudden Hill (85.9). It is a major concern that the gap in life expectancy between the most deprived and the most affluent of Brent’s residents is increasing.

Overall the mortality rate in Brent (570/100,000) is lower than that of England and Wales (628/100,000). Circulatory disease, including heart disease and stroke and cancers are the commonest cause of death. The mortality rate from these causes has reduced significantly over the last decade.

Executive Summary

There are areas where the burden of ill health is higher in Brent than England and Wales. There are high and increasing numbers of people with diabetes, HIV and tuberculosis. Teenage pregnancy rates also are high and diagnoses of sexually transmitted infections are increasing.

The performance of preventive services is mixed in Brent. There have been marked improvements in recent years in the uptake of MMR and flu vaccinations. The number of smoking quitters has also increased considerably. However Brent is not yet meeting its smoking cessation targets. The uptake of breast and cervical screening is low.

Gambling

The consideration of a possible 'super casino' in Brent over the last year has focused attention on the health impacts of gambling. It is estimated that there are approximately 2220 problem gamblers in Brent, a number that is likely to increase. A literature review carried out by the PCT highlighted the scale and severity of potential health impacts affecting problem gamblers, their families and the broader society. The potential health impacts include stress, depression, anxiety, family and child neglect, relationship breakdown, suicide and drug and alcohol addiction.

The social and health impacts of a casino in Brent would have been considerable. The decision by the council not to proceed with the casino means that neither the benefits nor the costs will now take place. However it is possible that the number of regional casinos will be extended in the future and that a casino in Brent is once again proposed in Brent. In the meantime, the changes brought about by the Gambling Act will greatly increase the accessibility and promotion of gambling, resulting in more people gambling and greater numbers of problem gamblers.

Sexual Health

Sexual health is one of the key national priorities in the Choosing Health White paper. Within Brent the number of teenage pregnancies and sexually transmitted infections (STIs) including HIV are increasing. The teenage pregnancy rate in Brent has increased by 11.7%, from 47.8 per 1,000 in 1998 to 53.4 per 1,000 in 2004. This is despite a national target to reduce the teenage pregnancy rate by 50% by 2010. Two fifths of teenage pregnancies in Brent occur in 4 wards. There were 2463 terminations of pregnancies to Brent residents in 2004. This is more than double the national rate.

There were 665 people diagnosed with HIV living in Brent in 2004 and receiving treatment and care, an increase of 37% since 2001. There has also been an increase in diagnoses of other sexually transmitted infections in Genito-Urinary Medicine (GUM) clinics in Brent in recent years, although the increase has not been as high as for the rest of London and the UK. The largest increase has been in Chlamydia diagnoses. This in part reflects increased Chlamydia testing and improved diagnostic techniques in laboratories. Young people, gay men, and people of black ethnic groups are disproportionately affected by STIs and HIV.

Smoking

Smoking is the single greatest cause of illness and premature death in Brent today.[1] Smoking kills an estimated 310 people per year in Brent and 86,500 people nationally (one in six deaths) accounting for a third of all cancer and a seventh of all cardiovascular deaths. The personal costs and the cost to the NHS are considerable. In 2001 in Brent an estimated 1020 hospital admissions were caused by smoking, at a cost to the NHS of £1.8 million.

Approximately one in four people in Brent smoke, similar to the number nationally. The national ban on smoking in public places will come into effect on 1st July 2007. Smoking will not be allowed in places such as pubs, cinemas, offices, factories and public transport. The smoking ban represents a considerable opportunity to reduce the health impacts of smoking in Brent.

1 Department of Health: Delivering Choosing Health: making healthy choices easier. Department of Health

Executive Summary

Alcohol

One in ten people in Brent are estimated to be binge drinkers. This is 8% lower than the national estimated prevalence. Alcohol consumption contributes to twelve months of life lost in men in Brent and four and half months of life lost in females. One in eighteen deaths in Brent are attributable to alcohol. There were also 1438 alcohol related admissions in Brent at a rate of 734 and 354 per 100,000 in men and women respectively.

Nationally alcohol misuse is estimated to cost £7.3 billion in crime and anti-social behaviour every year.[2] Each year around half (1.2 million) of all violent crimes and around one third (360,000) of all domestic violence incidents are linked to alcohol misuse.[3] The North West Public Health Observatory (NWLPHO) estimate that there were 4439 crimes attributable to alcohol in Brent in 2005/06 at a rate of 16.58 per 100,000, nearly double the rate for London and 60% higher than for England. Two thirds of these crimes (3059) were violent crimes against people.

Drugs

Drug misuse has a detrimental impact on both physical and mental health. Health consequences include HIV and Hepatitis B and C transmission in injecting drug users and the mortality associated with accidental and intentional overdoses. There were 24 deaths from drug misuse in 1999-2003, half the number that occurred between 1994 and 1998. The prevalence of HIV and hepatitis B and C in injecting drug users in London is higher than elsewhere in the country and the uptake of hepatitis B vaccinations amongst injecting drug users remains low.

The drug treatment rate in Brent (623 people per 100,000 population) is lower than for London (784 per 100,000 population) and nationally (768 per 100,000 population). Three fifths of users discharged from treatment had been in treatment for more than 12 weeks, this was slightly higher than the national rate of 56%.

2 Cabinet Office. Prime Minister's Strategy Unit. The Alcohol Harm Reduction Strategy for England. London: Cabinet Office, 2004. is available on the internet at: http://www.strategy.gov.uk/output/page3669.asp
3 Cabinet Office. Prime Minister's Strategy Unit. The Alcohol Harm Reduction Strategy for England. London: Cabinet Office, 2004. is available on the internet at: http://www.strategy.gov.uk/output/page3669.asp

Recommendations

- **Work with the Local Authority to develop Brent's health and wellbeing strategy (2007 – 2017) to reduce health inequalities**
- **Increase the uptake of Chlamydia screening through integration with existing services, e.g. termination of pregnancies.**
- **Build on existing success to increase the number of drug users in treatment & successfully completing treatment programmes**
- **Increase the coverage of hepatitis B vaccination amongst injecting drug users**
- **Increase the number of people who quit smoking and increase the proportion of smokers successfully quitting as a result of contact with smoking cessation services**
- **Work with the Local Authority to maximize the impact of the smoking ban (July 2007)**

Introduction

This is the fourth Annual Public Health Report for Brent Primary Care Trust (PCT). The focus of this report is on gambling, sexual health, and drugs (including smoking and alcohol). These areas have been chosen because they contribute to a significant burden of preventable disease. They are also areas where there have been major legislative changes which are likely to impact on health in the future. These include the liberalisation of alcohol and gambling regulations and the restrictions on tobacco consumption.

Aim

The aim of this public health report is to assess the health of the population in Brent with a particular focus on sexual health, drugs and gambling. The report collates local information on these factors, highlighting the populations most affected, comparing and contrasting with the national picture and assessing the likely impact of legislative changes. This will highlight where efforts to improve health and reduce health inequalities should be focused.

Objectives

- To describe the population and health of Brent using routine sources in relation to births, deaths and disease surveillance data.
- To compare Brent with England and Wales to identify the major health issues and highlight the similarities and differences with England and Wales.
- To compare different areas and populations within Brent so as to identify the variations in health and health inequalities within the borough
- To assess the likely impact of legislative changes
- To update the information provided about key health statistics
- To make recommendations for addressing the health issues identified
- To present the main findings from this work in a clear, concise and accessible report
- To present the report to the PCT Board and to other partners and fora.

Structure of the Report

This report is divided into five chapters. In this chapter we introduce the report and set out its aims. Chapter 2 describes the population of Brent and summarises information about the overall health of the people in Brent. Chapters 3, 4 and 5 present specific information about gambling, sexual health and drugs. Finally there are several appendices containing more detailed information for those who are interested.

This report accompanies an online resource found at www.phar.org.uk

The People and Health of Brent

Key Facts

Population

- 278,560 resident population, 347,541 registered population in 2006
- 54.7% of residents are from black and minority ethnic communities
- Over 130 different languages are now spoken in our schools
- The population is relatively young with 43% of residents under 30 years of age
- Over 30,000 people are over the age of 65
- 81st most deprived borough
- 17 out of 21 wards are in the most deprived half of all wards in England

Health and Health Inequalities

- Brent is a diverse Borough and this diversity is reflected in marked health inequalities
- Highlighting and tackling health inequalities is an important part of public health work
- There is a gap of 11.1 years in male life expectancy between wards with the best and worst life expectancy

Lifestyle and Behaviour

- A quarter of Brent's population are estimated to smoke
- The percentage of smokers is higher in more deprived wards
- Two thirds of Brent residents do not eat the recommended five portions of fruit or vegetables per day
- Approximately 20% of Brent residents are obese

Burden of Ill Health

- 70% of Brent residents report their health as good in the past year
- Life expectancy is 76.6 years for males and 82.3 years for females
- Circulatory disease and cancer are the biggest killers
- Mortality rates for CHD and cancer vary across Brent
- There is a high prevalence of diabetes and TB
- There are high and increasing rates of HIV, teenage pregnancy and sexually transmitted infections
- Mortality from diabetes, infectious disease and liver disease in men is higher in Brent than the rest of the country
- The uptake of some preventative services such as breast and cervical cancer screening and smoking cessation is low

The People and Health of Brent

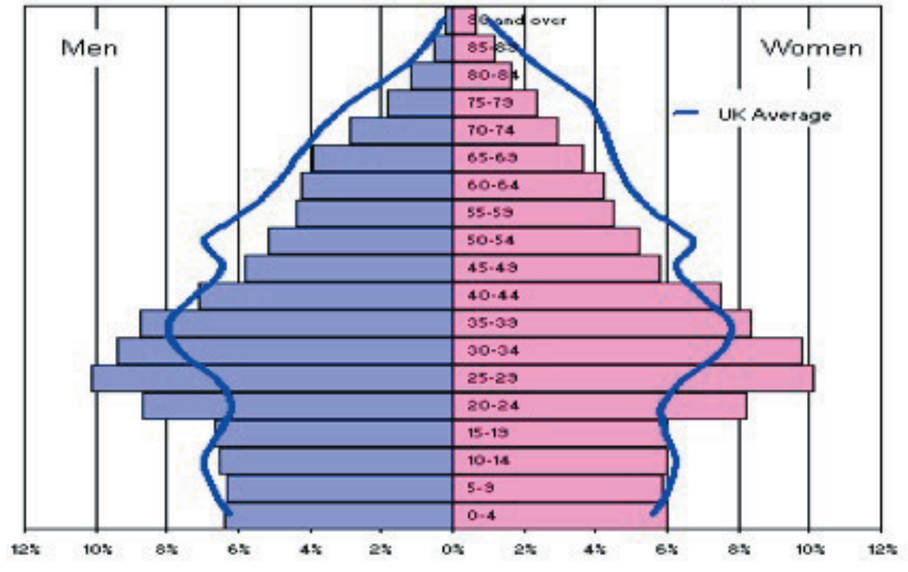
Population

Brent has an ethnically and culturally diverse population and there are great variations in wealth across the borough. Ranked 81st on the national deprivation league table, there is a north south divide with an affluent north and a generally poorer south. There are 5 locality areas (clusters of wards) within the borough – Harlesden, Kilburn, Kingsbury, Wembley and Willesden – each with its own distinct socio-demographic characteristics and health profile.

Population Structure

The population structure of Brent is shown in the population pyramid, figure 1. The dark blue line shows the structure of the UK population. The population of Brent is younger than the rest of England and Wales, where the estimated percentage of the population over 50 years of age is 34%. In Brent 25 % of the population is over 50 years old.

Figure 1: Population Pyramid



Source: 2001 Census

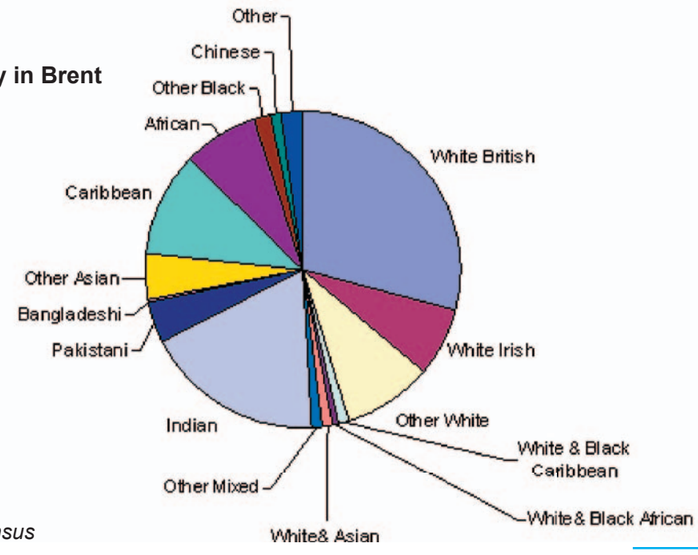
Population Change

The 2001 census found that 263,464 people were living in Brent, however, the population changes due to the number of births, deaths and net migration flow. The Office of National Statistics (ONS) produces population estimates based on known trends for these factors. The latest estimate for 2006 for the population of Brent was 270,100. In addition, the Greater London Authority (GLA) produces annual population projections for all London boroughs. The GLA estimate for the population of Brent in mid 2006 was 278,560. The number of people registered with a GP in Brent at the start of 2006 was 347,551. The true population of Brent probably lies somewhere between these figures.

Ethnicity

Brent is a highly ethnically diverse borough. Black and minority ethnic groups (BME) in Brent now make up the majority of the population at 54.7%, according to the 2001 census. This is the second highest of all the London Boroughs after Newham. By comparison, BME groups make up an estimated 40% of the population of London and 12% of the population of England and Wales. Figure 2 shows the different ethnic groups represented in the population of Brent, as defined by the ONS.

Figure 2:
Ethnic Diversity in Brent



Source: 2001 Census

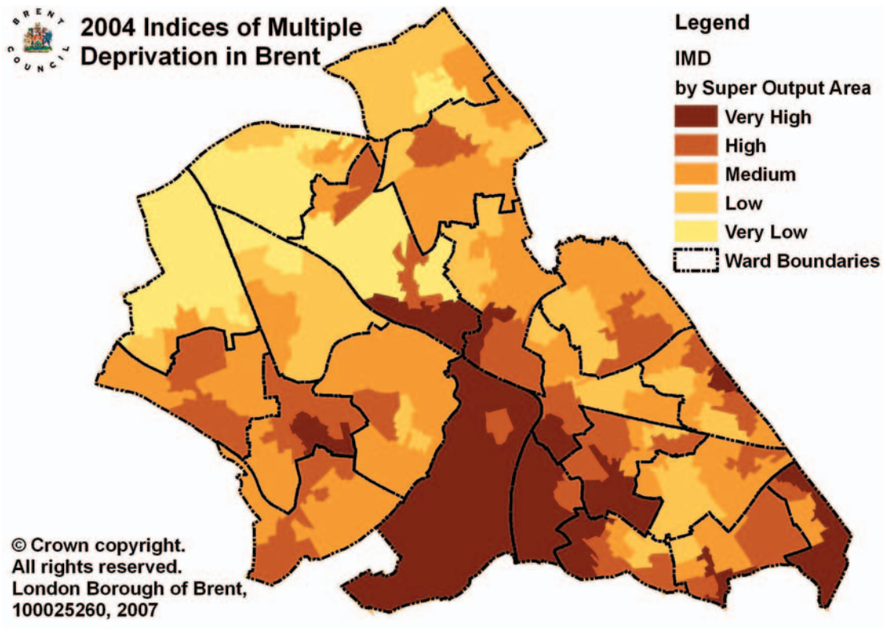
The People and Health of Brent

Deprivation

Deprivation is strongly associated with poor health. Seventeen out of twenty one wards in Brent are in the most deprived half of all wards in England. The Government measures deprivation using the Index of Multiple Deprivation (IMD) of 2004, which is derived from seven variables: income, employment, health and disability, education and training, housing, access to services and crime. Brent has an IMD score of 25.95, which means that it ranks 81st out of the 354 boroughs in the country, ie. it is in the 25% most deprived local authorities in the country. Brent is ranked the fourth most deprived borough in Outer London.

Brent is a borough of contrasts. The North of the borough is largely affluent suburbia, whilst in the South, wards such as Harlesden, Stonebridge, Kilburn and Kensal Green rank within the top 10% most deprived wards nationally, according to the IMD 2004. This is illustrated in figure 3.

Figure 3 Indices of Deprivation 2004 in Brent, by Ward



At borough level, incomes are lower than the London and national averages and unemployment is higher. 9.7% of the Brent households have an income below £15,000 per annum, rising to 32.5% in Stonebridge ward and 27.6% in Harlesden.[4] Within these wards job seeker allowance claimant counts stand at 7.9% and 8.7% respectively compared to the Brent average of 4.3% and a national average of 2.6%.[5] Unemployment is higher among ethnic minority populations.

Health and Health Inequalities

Overall health in Brent is very close to the average for London. In some cases it is better. However there are wide variations in health within Brent which mirror the distribution of deprivation. Health inequalities are undesirable differences in health status between different population groups. Health inequalities are determined by a number of factors – demographic, genetic, and environmental. A key factor is poverty. People living in more deprived areas have a higher death rate and lower life expectancy. People on low incomes or lower socio-economic groups have higher rates of most causes of death and are more likely to smoke, have a poorer diet and exercise less. Action to reduce health inequalities needs both to improve the health of the deprived and to reduce poverty.

Health inequalities are reflected in marked variations in several important measures of health, including life expectancy. The Government's key national targets on reducing health inequalities focus on infant mortality and life expectancy. Life expectancy is a sensitive way of comparing the health of Brent with the rest of England and Wales and comparing health within Brent. Infant mortality is an important measure of the health of a population but it is less useful for comparing health within Brent.

Life Expectancy

Life expectancy is an estimate of the number of years a new-born baby would survive, were he or she to experience the particular area's age-specific mortality rates for that time period throughout his or her life. The Government's national health inequalities target for life expectancy is:

4 Income Statistics produced by CACI Ltd, 2005.

5 Office for National Statistics, Labour Market Statistics 2006.

The People and Health of Brent

Starting with Local Authorities, by 2010 to reduce by at least 10% the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole.

For 2002-2004 the average life expectancy for males in Brent was 76.6 years. Life expectancy is 5.7 years higher among females at 82.3 years. Nationally, life expectancy for males is 76.45 years and for females is 80.8 years (2002-04). Since 1991-93, average life expectancy in Brent has increased by 3.2 years for males and 2.6 years for females.

Life expectancy by ward is shown in figure 4 below. The differences in health within Brent are dramatically illustrated by examining male life expectancy along the Bakerloo line, as shown in figure 5. A journey of 3.5 miles takes you from Harlesden, which has the lowest life expectancy for men and women, to South Kenton, where male life expectancy is 11.1 years higher, at 82.9 years. The difference is 7.5 years in females, between Harlesden (78.4) and Dudden Hill (85.9). It is a major concern that the gap in life expectancy between the most deprived and the most affluent of Brent's residents is increasing.

Figure 4: Life Expectancy at Birth by Ward, 2000-2004. Source: London Health Observatory

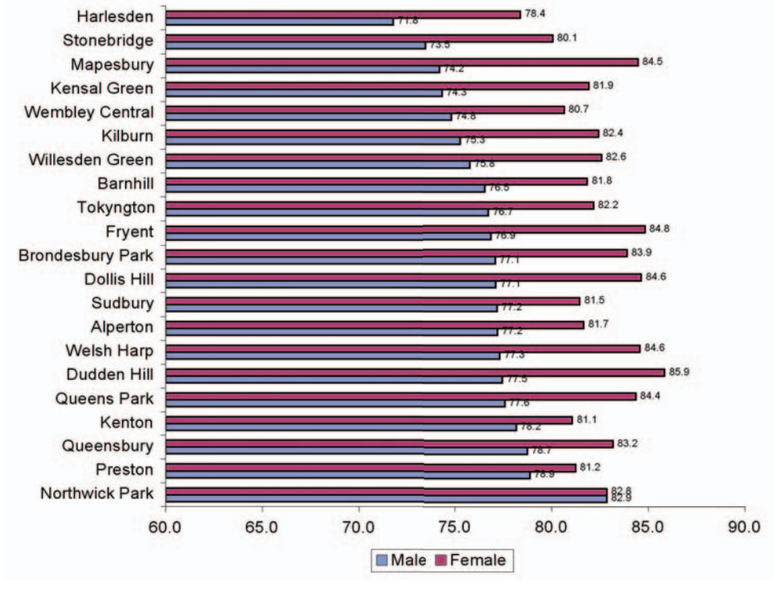
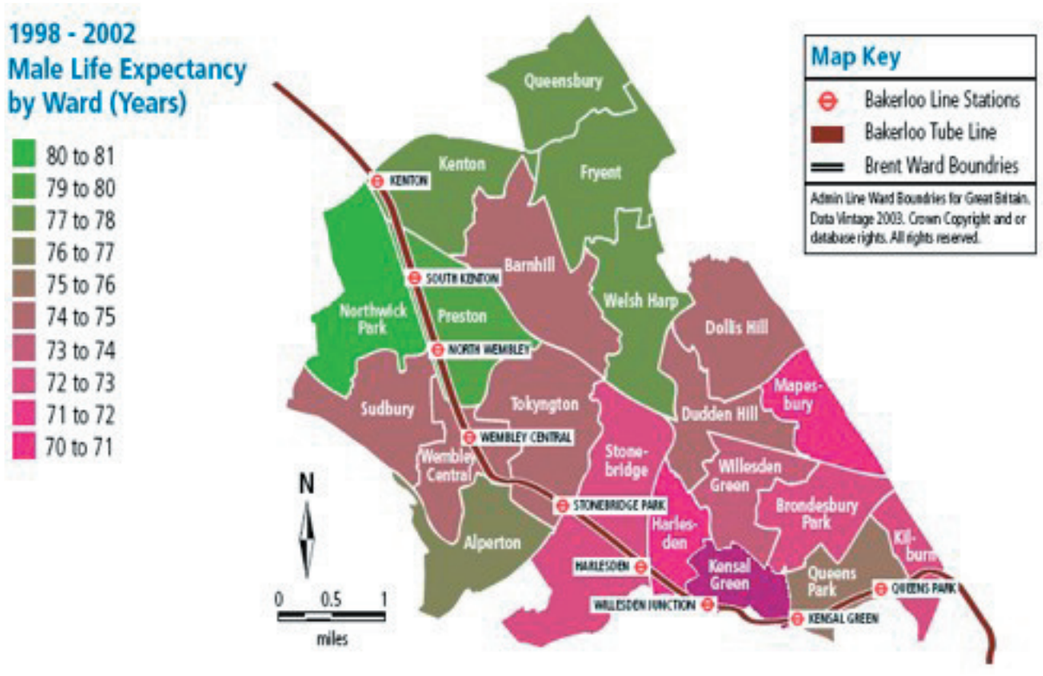


Figure 5: Change in Male Life Expectancy From Harlesden to South Kenton Along the Bakerloo Line



Infant Mortality

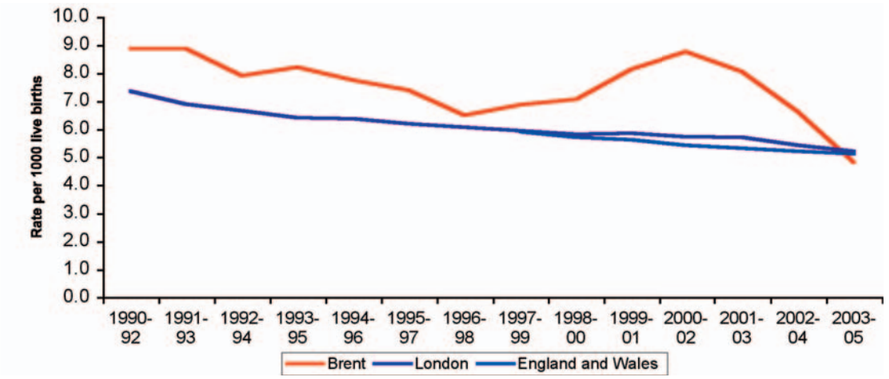
Infant mortality is a measure of death in the first year of life, described as a rate per 1000 births. The Government has set a national health inequalities target for infant mortality:

Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between manual groups and the population as a whole

The People and Health of Brent

Nationally there were 3217 infant deaths in 2005, including 2205 deaths at <28 days, in total 5.0 deaths per 1,000 births. The annual number of infant deaths in any Local Authority is relatively small and there is substantial year on year fluctuation, so it is difficult to use infant mortality as a measure of health inequalities within Brent. In Brent there were 22 infant deaths in 2005, of these 14 were within 28 days of birth, in total 4.9 deaths per 1,000 births. Figure 6 below shows trends in infant mortality and compares Brent with London. Infant mortality in Brent increased substantially between 1996-98 and 2000-02 but has reduced in the last couple of years.

Figure 6: Three Year Average Infant Mortality rate per 1000 live Births for London and Brent, 1990-2005



Source: National Centre for Health Outcomes Development

Self-Reporting of Health in Brent

The 2001 census included a question on general health. People were asked whether over the previous twelve months their health had generally been good, fairly good or not good. Poor self-rated health has been shown to be a strong predictor of subsequent mortality and gives information about the burden of ill health in different areas.[6]

Table 1: Self Reporting of Health. Source: 2001 Census, ONS

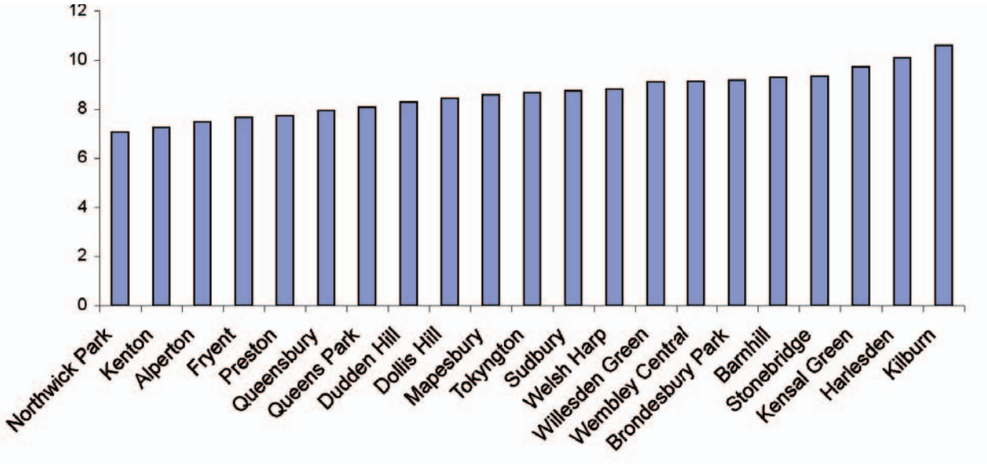
	Good	Not Good
Brent	70%	8.6%
London	70.8%	8.3%
England and Wales	68.8%	9.2%

Overall, 70% of Brent residents reported their health as ‘good’ over the preceding twelve months. This compares favourably with the rest of England and is similar to the figure for London. 8.6% of Brent residents reported that their health had been ‘not good’ in the past year. This is slightly higher than the percentage in London but was lower than the rest of England.

As with other measures of health, the overall figures for self-reporting of health in Brent mask significant variability within the borough at ward level. Figure 7 shows the percentages of people in different wards in Brent who reported their health as ‘not good’. It illustrates the unequal burden of ill health in different areas. The range is from 10.6% in Kilburn, to 7% in Northwick Park.

6 Burström et al, J Epidemiol Community Health 2001;55:836-840 (November)

Figure 7: Percentage of People in Brent Reporting 'not good' Health Over the Past Year, 2001 Census.



Lifestyle and Behaviour

The lifestyle factors that have the greatest impact on the health of the population are smoking, diet and physical activity. We do not have routine data about the numbers of people in Brent who smoke, or how many people have a healthy diet and take regular exercise. However, the National Centre for Social Research (NCSR) has produced estimates of these important lifestyle choices based on the Household Survey of England, 2001. The estimates tell us about the expected prevalence of smoking, healthy diet and obesity levels and how these compare to the rest of the country.

Table 2: Estimates of Health Behaviours in Brent, National Centre for Social Research, 2005

Behaviour	Brent	England and Wales
Current cigarette smoking	25.7%	25.8%
Binge drinking	10.0%	18.2%
Obesity	19.6%	22.1%
Adult fruit & vegetable consumption	33.8%	23.7%
Child fruit & vegetable consumption	52.3%	37.5%

In addition, in 2001 the London Borough of Brent commissioned an independent and confidential survey of residents living in the four most deprived neighbourhoods in the borough, namely: St Raphael's/Brentfield, Harlesden, Church End and Stonebridge. 2,828 interviews where conducted and residents were asked about smoking, diet, alcohol, exercise and overall health. Information from this survey provides a snap shot of the health behaviour of residents. When compared with the average for the UK, residents' ratings of their own health were lower within the four neighbourhoods. This is shown in table 3.

Table 3: Self Reporting of health by Brent Residents

Rating Of Health	% - 4 neighbourhoods	% - UK average*
Good	54%	59%
Fair	28%	27%
Poor/not good	18%	13%

Source: 2001 General Household Survey, Office for National Statistics and Kwest Resident's survey, London Borough of Brent, 2001

The People and Health of Brent

Smoking

Given the characteristics of the population of Brent, it is estimated that 25.7% of the population are smokers. This is similar to the percentage of smokers in the rest of England (25%).

The 2001 survey of St Raphael's/ Brentfield, Harlesden, Church End and Stonebridge residents found that 30% of residents smoke cigarettes, the majority of these smoke between 1 and 20 cigarettes per day. White British/ Irish and Other White ethnic respondents are most likely to say that they smoke, whilst Asian/Asian British-Indian and Black/Black British-African respondents are the least likely to smoke. Men are more likely to smoke than women. Harlesden has the largest proportion of smokers.

Nationally levels of smoking have declined significantly since the 1970s and have continued to decline. The proportion of men who were smokers declined from 28% in 1993 to 22% in 2004. The proportion of women who were current smokers decreased between 1993 and 2004, falling from 26% to 23%. As well as a decline in the numbers of adults smoking cigarettes there has also been an overall decline in the average number of cigarettes smoked.[7]

Diet and Exercise

The NCSR estimate that 33.8% of Brent's adult population eats the recommended five portions of fruit and vegetables per day. Although Brent compares favourably with an estimated 23.7% of the population of England who eat a healthy diet, two thirds of Brent residents do not eat the recommended amount of fruit and vegetables. The figures for children are better in Brent, with approximately 52.3% of children eating enough fruit and vegetables, compared to 37.5% in the country as a whole.

7 Health Survey for England, 2004

The 2001 residents survey suggests that fewer people in St Raphael's/ Brentfield, Harlesden, Church End and Stonebridge eat a healthy diet. Only 10% of respondents eat 30 or more portions of fruit or vegetables a week. The survey found that women generally eat more portions of fruit and vegetables and home owners and people who rent their home from private landlords generally eat more fruit and vegetables than council or housing association tenants. Asian/Asian, British-Indian respondents and Other White respondents generally eat more fruit and vegetables than respondents of other ethnic groups.

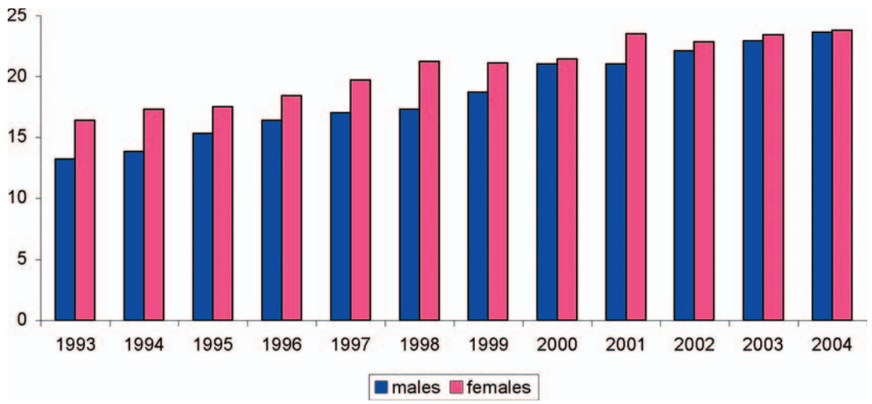
The 2001 survey also asked residents of the four neighbourhoods about exercise. Half of the people interviewed take part in some form of physical exercise or sport to keep fit. 41% take part at least once a week whilst the remainder exercise once a month or less often (9%). People who rent privately or own their home are more likely than Council and housing association tenants to exercise regularly. Residents in Stonebridge generally exercise more frequently than those in other neighbourhoods, whilst those in Harlesden typically do the least amount.

Obesity

The combination of low levels of physical activity and poor diet is contributing to an increasing proportion of the population who are overweight or obese, figure 8. In England about 45.7% of men and 34.7% of women are overweight (a BMI of 25-30 kg/m2), and an additional 23.6% of men and 23.8% of women are obese (a BMI of more than 30 kg/m2). The percentage of adults aged 16-64 years in England who are obese has more than doubled since the mid 1980's. This increase in obesity is particularly marked in men, among whom rates have tripled since the mid 1980's, with men now as likely to be obese as women.

The NCSR estimates that approximately 19.6% of Brent's population are obese (BMI of >30). This is similar to the figure of 22.1% for the rest of England. In addition, some of the population will also be in the overweight category, (BMI of 25-30).

Figure 8: Prevalence of Obesity in Adults Aged 16 and over in England, 1993-2004



Source: Health Survey for England

Forecasting Obesity to 2010, a recent report published by the Department of Health predicts the levels of obesity in the UK by 2010 if current trends continue.[8] Obesity in adults is expected to rise by approximately one third in men and one fifth in women. Obesity in children is also expected to rise approximately 10% in boys and by 25% in girls.

Of particular concern in Brent is that the predicted increase in obesity levels is not evenly distributed across social classes. For example, the predicted increase in obesity levels in male children in the UK as a whole is in children from manual households. In contrast, obesity in boys form non-manual households is expected to fall by 2010. In girls, obesity is expected to rise in all social classes, though more in girls from manual households. A disproportionate increase in obesity in manual households will worsen health inequalities in Brent and the rest of the UK.

8 Zaninotto, P.; Wardle, H.; Stamatakis, E.; Mindell, J.; and Head, J.; Forecasting Obesity to 2010. Department of Health, 2006.

Burden of Ill Health

Prevalence of Key Diseases

Since 2004 there has been a central collection of information from GPs about how many of their registered patients have certain conditions as part of the Quality and Outcomes Framework (QOF). This provides information about the prevalence of key conditions in Brent and compares it to similar information for the rest of NWL Strategic Health Authority and the rest of the country. There are limitations to the data. It should be remembered that not everyone with these conditions will be registered with a GP and, of those that are, not all will be reported by the GP's practice. In some conditions, such as diabetes, the true prevalence will be higher than the QOF data suggests because many people have the disease for some time before they develop symptoms and are diagnosed.

Table 4: Unadjusted Disease Prevalence from the Quality and Outcomes Framework (QOF) for April 2005 - March 2006,

Condition	PCT (No.)	PCT (%)	SHA (%)	National (%)
CHD	7149	2.1	2.3	3.6
LVD	793	0.2	0.3	0.4
Stroke	3118	0.9	1.0	1.6
Hypertension	36424	10.5	10.1	12
Diabetes	16158	4.6	3.8	3.6
COPD	2127	0.6	0.8	1.4
Epilepsy	1367	0.4	0.4	0.6
Hypo-thyroidism	4623	1.3%	1.7	2.4
Cancer	1620	0.5%	0.5	0.7
Mental health	3071	0.9	0.9	0.6
Asthma	15863	4.6	4.6	5.8

Infectious Diseases

Getting Ahead of the Curve [9] sets out a national strategy for combating infectious diseases and strengthening health protection services. The strategy, which was published in January 2002, is a response to current challenges including the rising incidence of healthcare associated infection, BSE, E Coli 0157 outbreaks and the rising prevalence of HIV and AIDS.

Infectious diseases are notified to the Health Protection Unit on a regular basis by GPs, chest clinics, hospital doctors and environmental health officers. Although this notification is a statutory requirement, diseases are not always reported such that the numbers of notification are less than the true incidence. Moreover, not all patients with an infectious disease (e.g. food poisoning) present to their GP. Despite this, notification of these diseases gives a reflection of what is going on in the community and thus enables appropriate preventive measures to be undertaken.

Tuberculosis

Tuberculosis, or TB, is a disease caused by a germ called the tubercle bacterium or Mycobacterium tuberculosis. TB usually affects the lungs but can affect other parts of the body such as the lymph nodes, the bones and (rarely) the brain. TB used to be common in England and Wales. For example, in the mid-1930s, over 50,000 cases of TB were notified each year. These days it is much less common, although since the early 1990s the number of TB cases notified in the UK has been increasing. Nearly 7000 cases were reported in the UK in 2002 and 44% of these were in London.

Brent has the highest TB rate in the country and the numbers - 288 cases in 2005 - continue to increase. Table 5 presents data on the number of notifications of TB in Brent between 2002 and 2005 per 100,000 population. The increase reflects a combination of factors. This includes migration of people from countries where tuberculosis is common, HIV co-infection and improvements in case reporting following the introduction of Enhanced Tuberculosis Surveillance, which has improved reporting and recording of information since it was established in 1999.

9 Getting Ahead of the Curve - A Strategy for Infectious Diseases, Department of Health, 2002,

The majority of cases of TB in London are in people who were born outside the UK. TB rates are increasing in this population and remain static in the UK born population.

Table 5: Tuberculosis notifications rates per 100.000, 2002-2005

	2002	2003	2004	2005
Brent	80.3	81.0	87.4	105.52
NWL	55.8	55.3	59.8	68.9
London	38.4	37.2	34.7	42.9

Source: London TB Register, Health Protection Agency

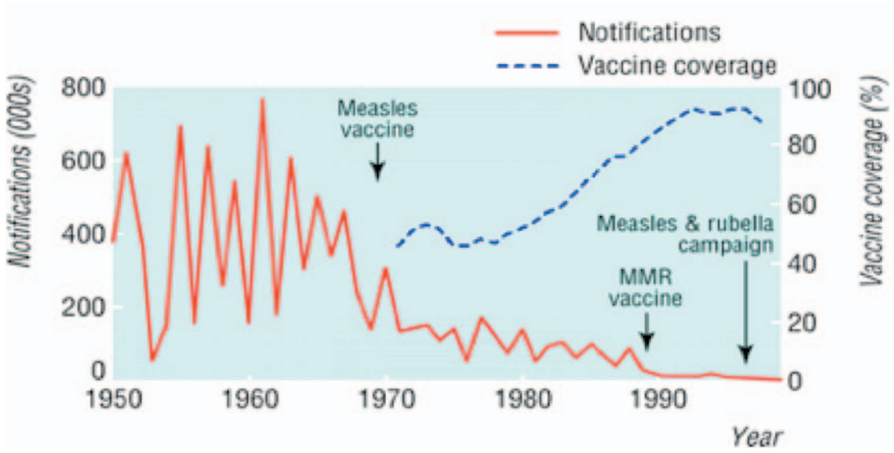
Measles

Measles is an acute, highly infectious viral illness transmitted by aerosols, so is an airborne infection. It is characterised by a prodomal illness lasting 2-3 days characterised by a cough, coryza and conjunctivitis, before the rash appears, which spreads over the body. Complications are common and these may include pneumonia or bronchiolitis. It is estimated that worldwide 1 million children die each year from measles, mostly in developing countries.

Measles vaccine is one of the components of MMR vaccine. The vaccine is highly effective and its introduction in 1988 led to a dramatic fall in the number of measles cases. In recent years an unfounded controversy over the safety of the MMR vaccine contributed to declining uptake and, as a result, measles has reappeared in the United Kingdom. There have been 449 confirmed cases in the UK to the end of May 2006 compared with 77 in 2005 and the first death since 1992. Figure 9 shows the trend in measles notifications and percentage of people vaccinated against measles in England and Wales since 1950.

There was an outbreak of measles in Brent in 2006, with six members of staff at Central Middlesex hospital becoming infected. There were no cases of measels confirmed in Brent in 2005. In 2006 so far to the end of October, there have been 25 confirmed cases. Table 6 shows the number of notified cases of measles in Brent between 1984 and 2004.

Figure 9: Annual measles notifications and vaccine coverage in England and Wales 1950-99 [10]



Mumps

Mumps is an acute viral illness transmitted by direct contact with saliva or droplets from the saliva of an infected person. Symptoms begin with a headache and fever for a day or two before the disease which is characterised by swelling of the parotid glands near the jaw. In young children at least 30% of cases have no symptoms. Complications of symptomatic mumps include swelling of the ovaries (oophoritis), swelling of the testes (orchitis) and deafness.

Mumps vaccine is also one of the components of MMR vaccine. The introduction of MMR vaccine in 1988 was very effective in reducing cases of mumps infection. The notified cases of mumps in Brent between 1989 and 2004 are shown in table 6.

10 Asaria P., MacMahon, E., Measles in the United Kingdom: can we eradicate it by 2010? British Medical Journal 2006;333:890-895.

Meningitis

Meningitis is an inflammation of the lining of the brain and spinal cord. Septicaemia is the blood poisoning form of the disease. These two conditions have different symptoms and may occur separately or together. They may be caused by a variety of different organisms including bacteria, viruses and fungi. When caused by the bacterium called Neisseria meningitidis, these two conditions together are known as meningococcal disease. It is a particularly serious cause of illness and is a notifiable disease.

The UK was the first country in the world to introduce vaccination for one type of meningococcal meningitis (Group C) in everybody under 25 years of age. The number of cases of this type of disease have significantly reduced since the vaccination was introduced in the age groups that were targeted. The numbers of cases of meningitis reported in Brent since 1984 are shown in table 6.

However, the vaccine only protects against one type of meningococcal infection, so it is very important that there is good public awareness of the signs and symptoms of meningococcal disease because prompt treatment is essential.

Table 6: Notifications of Measles, Mumps and Meningitis in Brent, All Ages, 1984-2004.

Year	Measles	Mumps	Meningitis	
			Meningococcal meningitis and septicaemia	All meningitis
1984	146	No data available	2	6
1985	267	No data available	4	7
1986	197	"	2	7
1987	151	"	6	9
1988	113	"	6	10
1989	52	51	8	13
1990	29	11	4	4
1991	39	14	6	10
1992	32	12	6	11
1993	35	8	5	7
1994	33	4	7	10
1995	45	3	5	5
1996	33	11	8	5
1997	4	7	7	5
1998	5	5	15	11
1999	7	6	7	7
2000	6	4	7	9
2001	8	7	2	2
2002	6	4	3	4
2003	15	7	1	4
2004	14	4	1	1

Source: Health Protection Agency Notification of Infectious Diseases (NOIDS) data

Methicillin Resistant Staphylococus Aureus (MRSA)

Staphylococcus aureus is a bacterium that lives on the skin of about a third of healthy people and usually causes no health problems. However, Staphylococcus aureus can cause disease particularly if there is an opportunity for the bacteria to enter the body or the immune system is weakened. Illnesses such as skin and wound infections, urinary tract infections, pneumonia and bacteraemia (blood stream infection) may then develop.

Most strains of this bacterium are sensitive to a number of antibiotics and infections can be effectively treated. However, some S. aureus bacteria have developed resistance to the antibiotic methicillin, and are called methicillin-resistant Staphylococcus aureus (MRSA). MRSA is hard to treat because the choice of antibiotics that can be used is limited.

MRSA in North West London Hospitals

Data on the number of patients diagnosed with MRSA bacteraemias in North West London Hospitals NHS Trust (NWLHT) is collected as part of the mandatory national MRSA bacteraemia surveillance programme (www.dh.gov.uk/publicationsandstatistics). Information on the number of bacteraemias and the rate per 1000 bed days is given in figure 10 below. Between April 2004 and March 2005 the NWLHT rate was 0.17 cases of MRSA bacteraemia per 1000 bed days. This compares to 0.09 per 1000 bed days at the Liverpool Women's Hospital NHS Trust, which has the lowest rate of MRSA bacteraemias of all specialist hospitals in England. The highest rate of MRSA bacteraemias found in a specialist hospital in England in the same time period was 0.43 cases per 1000 bed days. Overall, NWLHT sits 14th in a national prevalence table of the 45 specialist hospitals.

In response to increasing concerns over MRSA, the Department of Health has issued targets for reduction in total MRSA bacteraemia figures to all acute trusts. NWLHT has been issued with a challenging target of 22 MRSA bacteraemias infections per annum by 2007/8. To put this into context, its total for 2003/4 was 55 cases.

Figure 10: Number and Rate per 1000 bed-days of MRSA Bacteraemias in North West London Hospitals NHS Trust, April 2001 to September 2005

MRSA in Brent PCT Community Inpatient Beds

Between August and November 2006 a survey was carried out in Brent PCT community beds over three months to assess how many patients were carrying MRSA and the extent of environmental contamination. From a potential sample of 125 patients who were eligible for inclusion within the project, 105 (84%) patients were screened for MRSA and 25% tested positive for MRSA carriage. Of these patients 31% showed clinical signs of infection, all within wounds. The rest had no symptoms. All patients were treated to eliminate MRSA carriage. There was no evidence of transmission of MRSA within the community inpatients' areas during the period of the project. Contamination levels of the environment were also found to be very low, with only 2% of samples found to be positive for MRSA. This was removed with targeted cleaning. There have been no recorded cases of MRSA bacteraemia in Brent community beds.

Despite a lack of published comparable data for similar community in-patient areas, these prevalence rates for carriage amongst admissions are considered to be high. As a result of the MRSA survey several important changes have been made to reduce the amount of MRSA carriage in Brent community beds. All patients are now screened for carriage on admission and treated to eliminate carriage if found to have MRSA. Enhanced infection control measures have been introduced. Cleaning procedures have been strengthened on the wards and regular MRSA sampling of the environment has been commenced.

Hepatitis A, B, and C

Hepatitis is an inflammation or swelling of the liver. Viruses are the commonest cause but other causes include non-viral causes, such as alcohol excess. There are several viruses which can cause hepatitis. The main difference between the viruses is how they are spread and the effects they have on health. Hepatitis A, B and C are the most common in the UK.

Most people recover from hepatitis A with no lasting liver damage but Hepatitis B and C both cause long term liver disease, leading to possible cirrhosis and liver cancer. In many cases there are no early warning symptoms until liver damage is far advanced. The number of notified cases of viral hepatitis in Brent since 1987 are shown in table 7.

Table 7: Number of Notified Cases of Viral Hepatitis in Brent, 1987-2004.

Year	All viral Hepatitis	Hepatitis A	Hepatitis B	Hepatitis non A non B/ C
1987	27	20	3	2
1988	26	14	1	0
1989	18	15	1	0
1990	23	19	2	0
1991	22	10	4	0
1992	26	19	3	0
1993	21	12	1	2
1994	23	23	1	0
1995	23	19	2	1
1996	21	10	6	1
1997	25	21	1	2
1998	22	11	3	1
1999	8	6	0	1
2000	14	13	4	0
2001	6	6	0	2
2002	5	5	1	0
2003	6	2	4	0
2004	4	3	1	0

Source: Health Protection Agency, Notification of Infectious Diseases (NOIDS) data

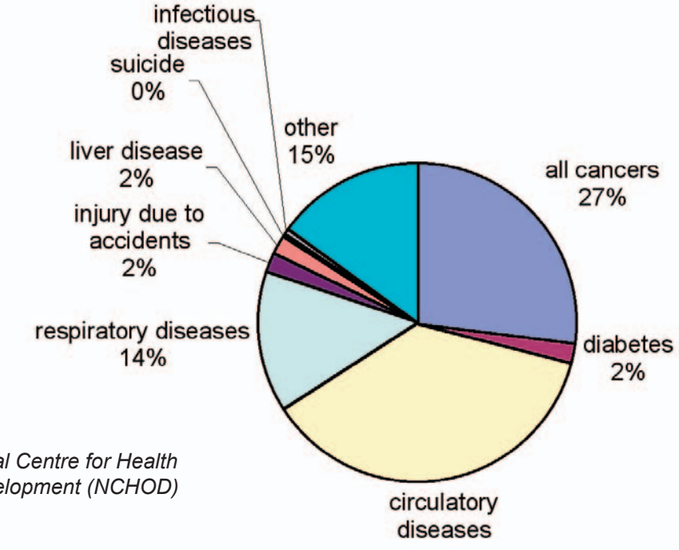
The People and Health of Brent

Main Causes of Death

There were 1636 deaths of Brent residents in 2004. The age and sex standardised mortality rate for all causes was 570.17 per 100,000. This is lower than the rate for England and Wales of 628.35 per 100,000.

The proportion of deaths by cause is shown in figure 11. The most common cause of death was circulatory disease accounting for 600 deaths (37%) of which 284 were from coronary heart disease. Cancer was the second most common cause of death accounting for 449 deaths (27%).

Figure 11: Main Causes of Death in Brent in 2004



Source: National Centre for Health Outcomes Development (NCHOD)

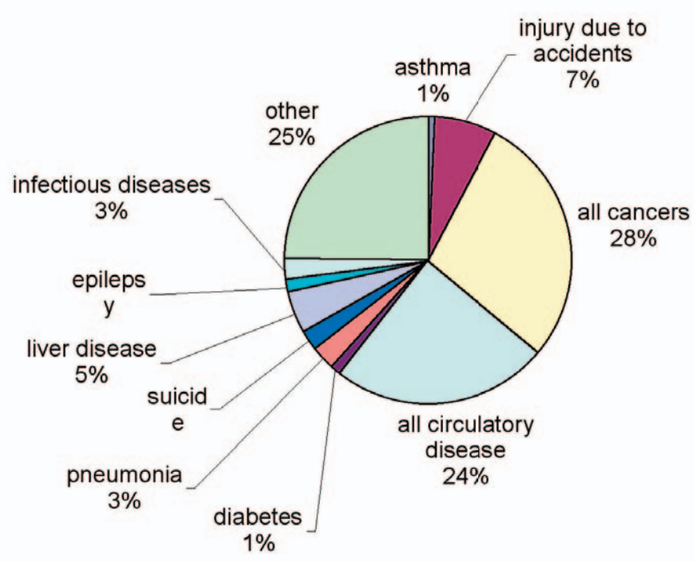
Years of Life Lost

Another way of assessing the burden of specific causes of mortality on the population is to look at the years of life lost. This shows the greater impact of causes of mortality that occur at an earlier age. In total there were 33,398 premature years of life lost amongst Brent residents between 2002-2004, at a standardised rate of 442.5 per 10,000. This is slightly lower than the England and Wales standardised rate of 498.3 per 10,000. The male standardised rate of 570.7 was nearly twice as high as the female rate of 311.1.

When the causes of years of life lost are compared to the main causes of death, shown in figure 11, it can be seen that causes of death which have a greater burden amongst younger people, such as cancers, injury and liver disease, contribute proportionally more to the burden of years of life lost.

Figure 12 shows the proportion of years of life lost contributed by different causes of death and figure 13 compares this with England and Wales. Circulatory diseases and cancer still account for the greatest years of life lost but the impact of other causes such as accidents, suicide and undetermined injury is greater.

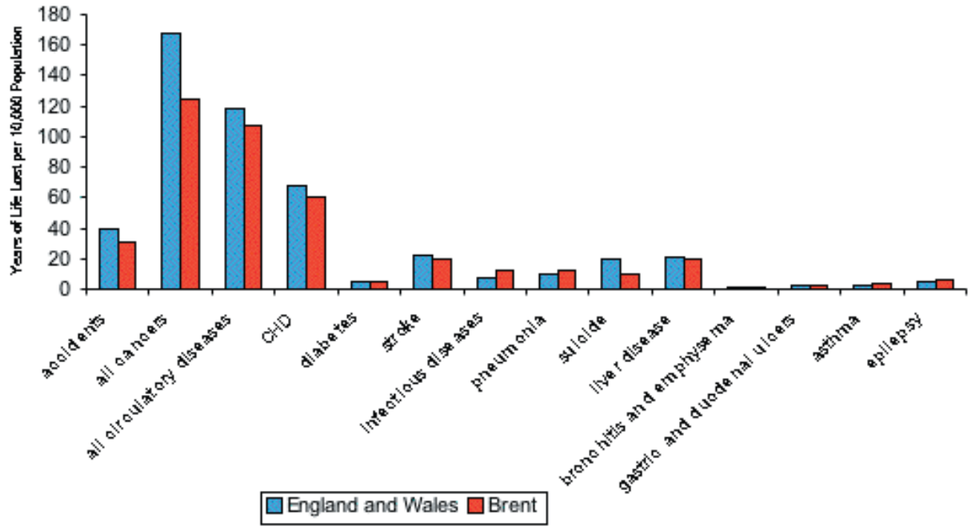
Figure 12: Causes of Years of Life Lost up to Age 75 in Brent, 2002-04



Source: National Centre for Health Outcomes Development (NCHOD)

The People and Health of Brent

Figure 13: Rate of Years of Life Lost in England and Wales and Brent in 2002-04 per 10,000 Population

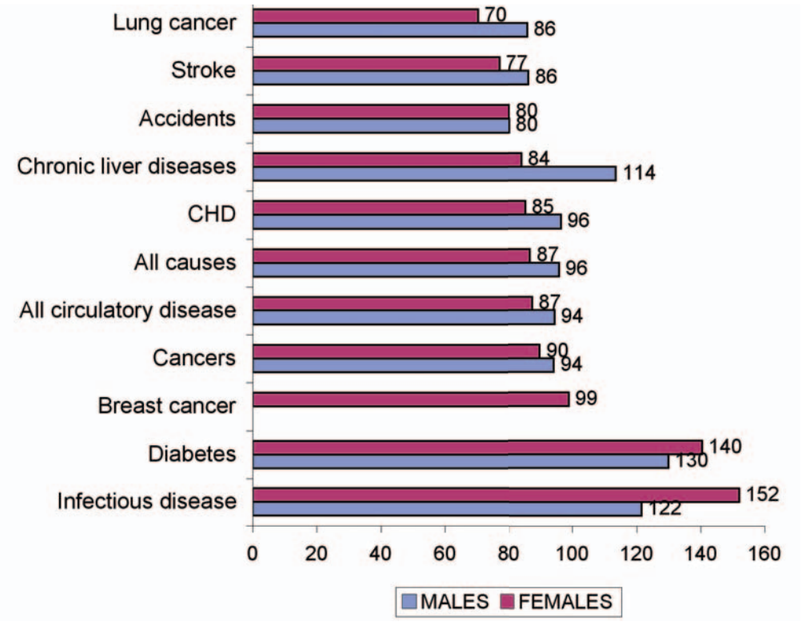


Source: National Centre for Health Outcomes Development (NCHOD)

Standardised Mortality Ratios

A standardised mortality ratio (SMR) is a ratio of the actual number of deaths in an area to the number expected if the area had the same age specific mortality rates as England multiplied by 100. A value of 100 indicates that there is no difference in mortality compared to the rest of England. A higher value suggests that mortality is higher than England and vice versa. Figure 14 shows SMRs for a number of significant causes of death in Brent.

Figure 14: SMRs For Males and Females for Main Causes of Death in Brent, 2002-04

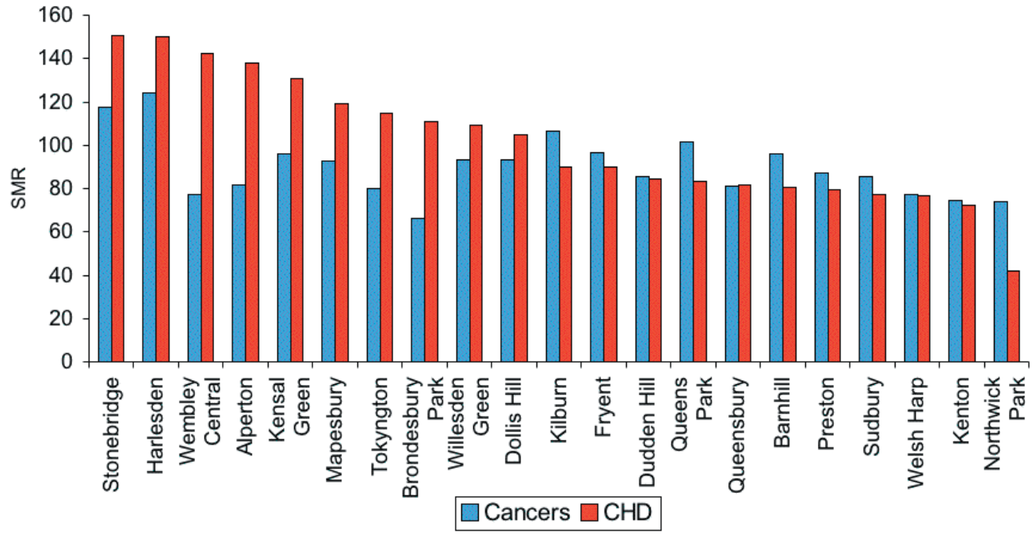


Source: National Centre for Health Outcomes Development (NCHOD)

The figure shows that SMRs in Brent are particularly high for infectious diseases and diabetes in men and women and liver disease and cirrhosis in men. SMRs for circulatory diseases and cancers are close to 100. SMRs for these conditions are higher in males than in females. The number of deaths from diseases with high SMRs is relatively small compared to cancer and circulatory diseases.

The SMR figures for the whole of Brent mask significant variation in mortality from the major killers in different areas within the Borough. This is shown in the graph of SMRs for cancer and CHD in Brent's wards, figure 15. For example, the SMR for CHD in Northwick Park is 50.4, well below the standard for the rest of the country. By contrast, the CHD SMR in Wembley Central is 130.5. This inequality is also seen in the SMRs for cancer, which are also lowest in Northwick Park, at 79.5, and highest in Stonebridge at 117.5.

Figure 15: Ward level SMRs for cancers and CHD, under 75s, 2000-2004

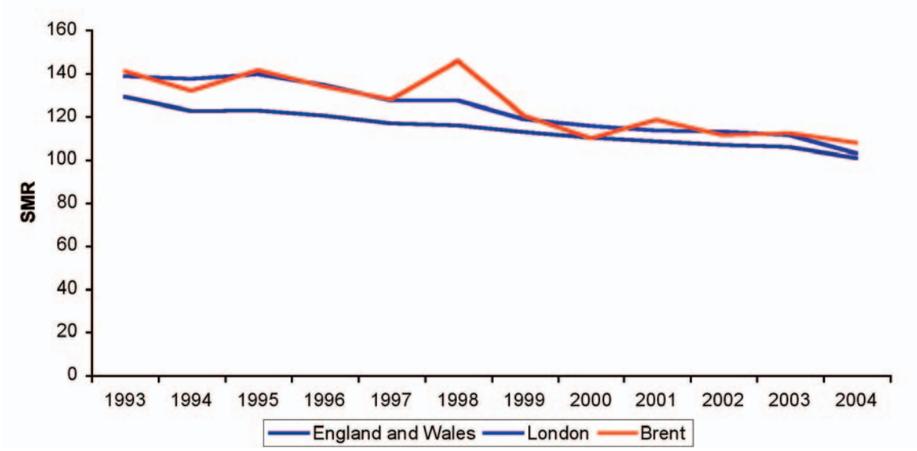


Source: London Health Observatory

Trends in SMRs

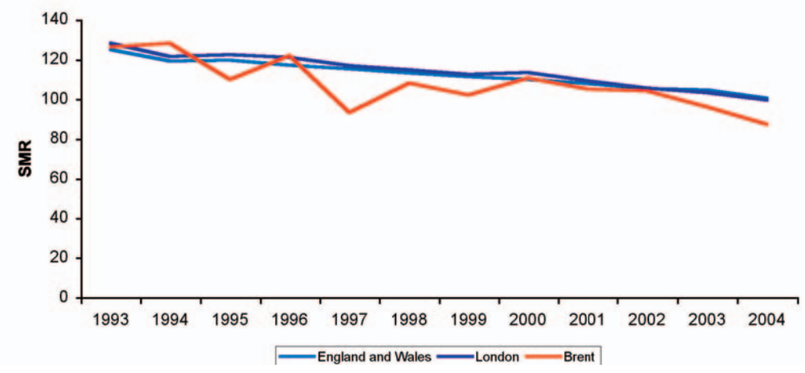
Figures 16 and 17 compare standardised mortality ratios over time for the male and female population aged 15-64 of Brent with London and England and Wales. The SMR for both males and females has improved considerably. The male SMR has decreased from 141 in 1993 to 108 in 2004. In 2004 the female SMR in Brent was 87. This means that female mortality in Brent is slightly better than for England and Wales as a whole.

Figure 16: Trends in SMRs in Males, Aged 15-64 in Brent, London and England and Wales, 1993-2004



Source: National Centre for Health Outcomes Development (NCHOD)

Figure 17: Trends in SMRs in Females, aged 15-64 in Brent, London and England and Wales, 1993-2004

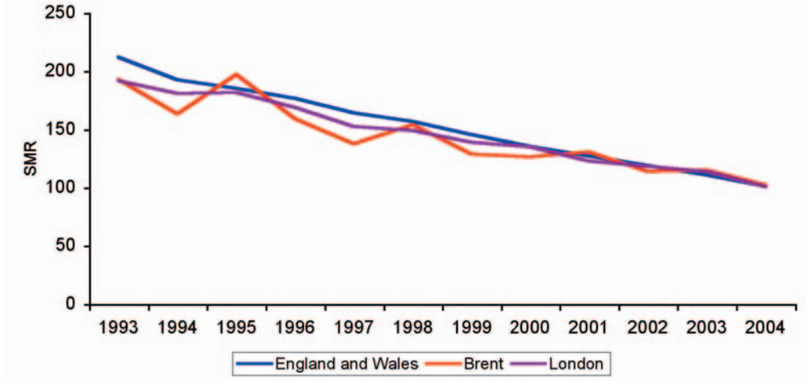


Source: National Centre for Health Outcomes Development (NCHOD)

The People and Health of Brent

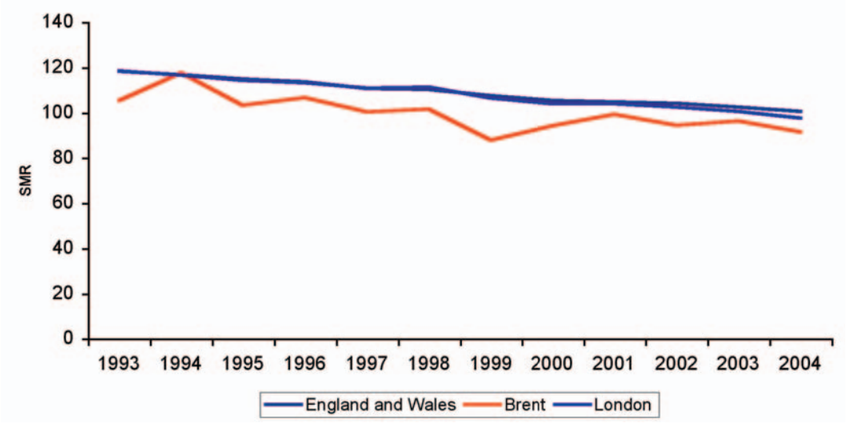
Mortality is improving for all the main causes of death. Figures 18 and 19 show the trends in SMRs for the two major causes of death, CHD and cancer. Mortality rates for both these disease groups have declined in Brent in line with Department of Health targets.

Figure 18: Trends in SMR due to Coronary Heart Disease, all ages, in Brent, London and England and Wales, 1993-2004



Source: National Centre for Health Outcomes Development (NCHOD)

Figure 19: Trends in SMR for Cancers in Brent, all ages, London and England and Wales, 1993-2004



Source: National Centre for Health Outcomes Development (NCHOD)

Performance on Healthcare Targets

There are some areas in which Brent is performing well against healthcare targets. Mortality rates from cardiovascular disease, which is the main cause of death in Brent, have improved in people under 75 years of age ahead of local development plan targets. Cancer mortality rates have also improved, although Brent received an 'amber' rating, because the reduced rate of 109.3 per 100,000 in 2002-04 was slightly above the target of 108.3.

Access to genitourinary medicine (GUM) services in Brent is good. Swift access to a GUM clinic is important in improving the sexual health of a population. The 2005-08 Local Delivery Plan (LDP) states that the percentage of patients attending GUM clinics that are seen within 48 hours of contacting a service should increase over time. During May 2006, the percentage in Brent was 80.1% which is ahead of the LDP target of 62.0%.

There are a number of areas where Brent performs poorly compared to the targets. These include breast and cervical screening, smoking cessation and teenage pregnancy. Teenage pregnancy is discussed in more detail in Chapter 3: Sexual Health and HIV. Smoking and smoking cessation is discussed in more detail in Chapter 4: Smoking Drugs and Alcohol.

The UK target for breast screening coverage is that 70% of women aged 53-64 should have been screened within 3 years since their last adequate test. In 2004/05 in Brent coverage was 59% and has been relatively constant over recent years. Across London, coverage ranged from 37.8% in Tower Hamlets to 79.1% in Havering. Brent PCT has a screening action group to improve coverage and uptake.

The people and health of Brent

The national target for cervical screening is that 80% percent of women aged 25-64 should be screened within 5 years since their last adequate test. In 2004/05 in London, coverage ranged from 68.5% in Hammersmith & Fulham to 83.8% in Bexley. In Brent, coverage has been relatively constant over recent years. The coverage in 2004/05 was behind the national target, at 72.5%.

By 2005/06 in Brent the cumulative number of 4-week smoking quitters was 3618, which was behind the target of 5244. However, there have been recent improvements in this area and Brent is now meeting its target quarter on quarter. Brent is still behind its smoking during pregnancy target which states that the percentage of mothers smoking at the date of delivery is to decrease by 1% each year between 2003/04 and 2007/08. During 2005/06 in Brent, the percentage of mothers smoking during pregnancy was 8.4%. This is behind the LDP target of 5.0%.

Teenage pregnancy rates are another area of concern within Brent. The 2005-08 Local Delivery Plan states that teenage conception rates (number of conceptions per 1000 among those aged 15-17) are to be reduced by 40% between 1998 and 2010. During 2004 the rate was 53.4 per 1,000 which was behind the LDP target of 45.9 per 1,000. Of particular concern is that teenage pregnancy rates are increasing in Brent.

Gambling and health

Gambling Key Facts

- There are an estimated 2220 problem gamblers in Brent
- As many as 15 times this number (21,000) may be affected by problem gambling
- The 2005 Gambling Act considerably lessens the restrictions on the availability of premises and types of gambling allowed
- Brent was shortlisted as one of 8 possible sites for a regional casino but the council decided not to proceed with its application
- The key impacts of the Wembley casino would have included:
  - An additional 1500 jobs, 1250 of which would have been for Brent residents
  - An additional 6m visitors per annum to Brent
  - An increase of 800 - 1200 problem gamblers
  - An additional 8000 car journeys per day contributing to traffic congestion, parking problems, noise and pollution.
- Government action to limit the availability and accessibility of gambling opportunities using technological innovation does not seem to be adequate to limit the impact of recent deregulation on the individuals and communities most at risk.

Introduction

Brent was shortlisted as one of 8 potential sites for a regional casino in the UK. The council decided to withdraw its bid on the basis that it was not convinced that the potential benefits of the casino would outweigh the negative effects. However it is possible that the number of regional casinos will be extended in the future and that a casino is once again proposed in Brent. In the meantime, the changes brought about by the Gambling Act will greatly increase the accessibility and promotion of gambling, resulting in more people gambling and greater numbers of problem gamblers. This chapter considers the economic, social and health impacts of gambling in the overall context of the proposal for the casino in Brent.

Gambling and Health

Definition of Gambling

Gambling, according to Korn (1999)[11] is to risk something of value on the outcome of an event when the probability of winning or losing is determined by chance. Two points are clear, that there are major health consequences for some people, and their families, who gamble more than they can afford and that governments and organisations, both legal and illegal, make vast revenues from gambling. There is no doubt that a great deal of gambling activity is idiosyncratic 'small change' raffles, sweepstakes etc but this report concentrates on the impact of ongoing and persistent use of any gambling in licensed premises and/or with licensed or registered gambling operators in the UK.

Gambling forms a spectrum of activities ranging from non problem to problem and pathological gambling. Healthy gambling, is characterised by informed choice on the probability of winning, wagering in sensible amounts, resulting in a pleasurable gambling experience. As such healthy gambling may sustain or enhance a gamblers state of well being. Problem gambling by contrast can be seen as a pathological illness, as a progressive disorder in which an individual has a psychologically uncontrolled preoccupation and urge to gamble. This results in excess gambling, the outcome of which compromises, disrupts or destroys the gambler's personal life, family relationships and vocational pursuits.

The first national survey of gambling behaviour in Britain found that 72% of the population participates in at least one gambling activity each year and that 65% play the National Lottery.[12] The survey estimates that 0.8% of the population are problem gamblers (95% confidence interval 0.6% to 1.0%). This equates to about a third of a million people. In Brent this would represent almost 2224 adult problem gamblers. Gamcare, the UK charity that deals with problem gambling, estimate that 1% of all gamblers develop an addiction and that for each problem gambler around fifteen other people in their families, at work and in the community are affected by their gambling.

11 Korn. D., and Shaffer., H., Gambling and the Health of the Public: Adopting a Public Health Perspective, Journal of Gambling Studies vol 15: 4 1999
12 Sproston K, Erens B, Orford J. Gambling behaviour in Britain: results from the gambling prevalence survey. London: National Centre for Social Research, 2000.

Context

Gambling in the UK is governed by legislation, most recently the 2005 Act. This act considerably lessens the restrictions on the availability of premises and types of gambling allowed in an attempt to maintain control over existing forms and develop some control over the booming areas of internet casinos and web based gambling. The latter two are currently illegal in the UK and operate offshore. This Act will allow them to become legal and register on the mainland and become liable for tax.

The Gambling Act will allow three new types of casinos to operate in Britain. One "regional casino" will be permitted, along with eight large and eight small casinos.

- The regional casino will have a minimum total customer area of 5,000m^2, and be permitted up to 1,250 Category A limited jackpot gaming machines.
- The one regional and eight large casinos will be permitted to offer bingo. All three categories will be permitted to offer betting.
- The Government expects that a regional casino will be a major development, offering clear potential for regeneration.
- It may include hotel accommodation, conference facilities, restaurants, bars, areas for live entertainment and other leisure attractions.

Economic benefits

NERA Economic Consulting undertook an Economic Impact Assessment of the casino in Brent.[13] The study identified the following economic impacts:

- A 55% increase in the number of visitors to Wembley, bringing an additional 6,145,000 people per year into the Borough.
- 75% of these people would be 'day visitors' (ie. they would not stay overnight in a hotel), and a majority of these would be 'diverted' from existing day visits to London, which as a whole receives 340,000,000 day visitors a year.

13 NERA Economic Consulting, Economic Impact of a Casino in the Wembley Development Area – A Final Report for Brent Policy and Regeneration Unit. December 2005

Gambling and Health

- 1.6 million visitors would be new overnight visitors, most of whom will be foreign tourists. This would generate substantial additional expenditure in the local area and would provide an opportunity to maximise linked visits to other local facilities.
- 2000 jobs created, 1500 of which would be new jobs and 1250 of these would go to Brent residents.
- Most of the new jobs would be in casino, food / catering and security operations
- Average salaries for each of these occupations would likely to be as follows:
- Casino (Gaming) – 760 jobs – average salary: £21,450
- Food / Catering – 557 jobs – average salary: £16,080
- Security – 484 jobs – average salary: £23,107

The report recognised that there would be an increase in problem gamblers and that there would also be policing and transport issues associated with the casino but no economic cost was assigned to these. These are considered more fully in the next section.

Social and Health Impacts

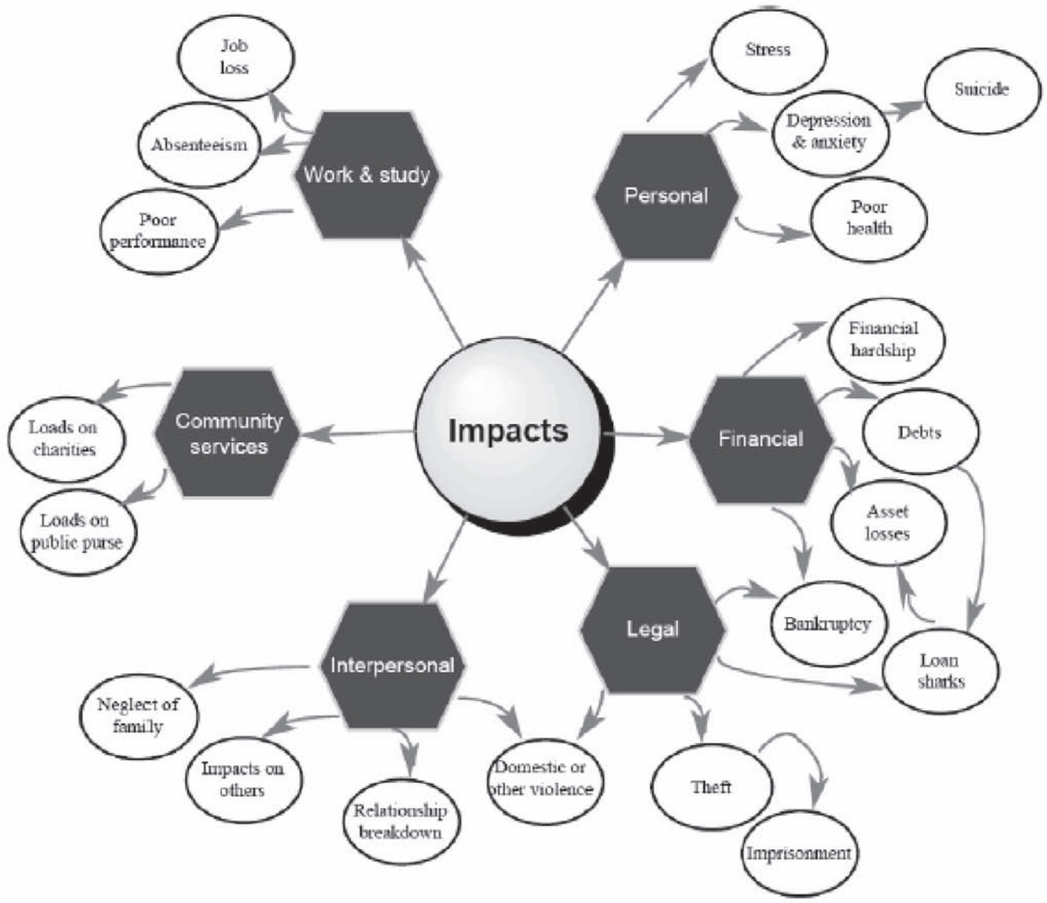
A Social Impact Assessment was undertaken by EDAW – a firm of regeneration consultants.[14] The reports key findings are as follows.

- A new regional casino would directly increase levels of problem gambling.
- There would be up to 600 casino related problem gamblers in the area which when adjusted to reflect Brent's 'vulnerability' profile could increase to between 800 and 1200.
- Negative impacts are felt disproportionately amongst those with low incomes, poorer than average qualifications and amongst non-white groups.
- Proximity to the casino in general would increase the likelihood of negative impacts.
- The potential health impacts of problem gambling include stress, depression, anxiety, family and child neglect and suicide.

14 EDAW, Social impact of a Casino in the Wembley Regeneration Area. March 2006

- There are also strong links between problem gambling and mental health problems, anti-social behaviour and relationship breakdowns.
- Significant numbers of problem gamblers also have other addictions and psychological disorders.

The broad range of social and health impacts are shown in the diagram below



Source: Australian Productivity Commission, 1999

Gambling and Health

- There is limited evidence that some elements of criminal activity rise in areas close to casinos
- 8000 additional car journeys per day (55% of journeys to the casino) contributing to traffic congestion, parking problems, noise and pollution.
- There may also be a number of environmental improvements resulting from the casino development as the operators invest in the area in terms of physical improvements, better public transport and road infrastructure and better security to prevent anti-social behaviour.

A literature review carried out by the PCT highlighted the scale and severity of potential health impacts affecting problem gamblers, their families and the broader society. For instance:

- Stress related symptoms include insomnia, irritable bowel syndrome, hypertension, migraines
- Physical ill health – heart disease and high blood pressure, (NORC/ Lewin/ Gemini, 1988)[15] depression (60%) and suicide (9%) (Productivity Commission, 1999)[16]
- One in five report alcoholism or other dependencies (Dickerson et al, 1996) [17]
- On average 15 other people are affected by problem gambling
- Spouses suffer from headaches, breathing difficulties, anger, depression and isolation (Lorenz and Yaffe, 1988) [18]
- Children of problem gamblers are five times more likely to describe unhappy childhoods and 3 times more likely to use drugs and alcohol
- 22% of problem gamblers income is spent on gambling
- 18-28% of males gamblers had declared bankruptcy (Lorenz, 1983)[19]

15 NORC/Lewin/Gemini, Report to the National Impact Gambling Impact Study Commission. 1988
16 Productivity Commission, Australia's gambling industries. Canberra: Commonwealth of Australia, 1999.
17 Dickerson, M., Baron, E., Hong., S. and Cottrell, D. 1996, 'Estimating the extent and degree of gambling related problems in the Australian population: a national survey',Journal of Gambling Studies, 12: 2, 1996.
18 Lorenz V., and Yaffe R.A., Pathological Gambling: Psychosomatic, emotional and marital difficulties as reported by the spouse. Journal of Gambling Behaviour. 1988 4:13-26
19 Lorenz, V., and Shuttleworth. The impact of pathological gambling on the spouse of the gambler, Journal of community Psychology. 1983, 11:66-67.

- Greater indebtedness - compulsive gamblers are 25% higher than low risk gamblers and 120% higher than non gamblers
- The availability of a casino within 50 miles (30 minute drive) doubles the rate of problem gambling (Gerstein et al, 1999) [20]
- There are a wide range of estimates of the cost of problem gambling but a widely quoted study estimates the social cost of problem gambling to be US$13,586 (£8761) per problem gambler per year (Goodman, 1995) [21]

The literature review also identified a number of particular health impacts affecting casino employees including higher levels of pathological gambling among casino employees (Shaffer et al, 2002)[22], increased drug and alcohol use and depression and the adverse health impacts of working long hours at night.

Of particular concern in Brent is the impact that gambling has on people from low socio-economic groups. Although gambling rates increase with household income, low-income households spend proportionally more of their money in gambling. Gambling can therefore be viewed as a form of regressive taxation. Poverty brings additional risks to people who gamble as it increases the financial risk taking with the perception of a greater potential to change their lives with a gambling win.

Studies in Australia, the Netherlands, Sweden, the United States and New Zealand (Abbot 2000) [23] national survey data show that gambling is disproportionately higher among people with lower levels of education, among people in lower status occupations, among people with lower income and with indigenous people, as well as these being significant risk factors for problem gambling.

20 Gerstein, D., et al, Gambling impact and behaviour study: Report to the national Gambling Impact Study Commission. Chicago: National Opinion Research Centre, 1999.
21 Goodman, R., The luck business: the devastating consequences and broken promises of America's gambling explosion. New York: The Free Press, 1995.
22 Schaffer, H., Bilt, J., and Hall, M., Gambling, Drinking, Smoking and Other Health Risk Activities Among Casino Employees. American Journal of Industrial Medicine 36:365-174, 1999.
23 Abbott, M.W., and Volberg Gambling and problem gambling in the community: an international overview and critique. Report Number one of the National Gaming Survey Wellington. Department of Internal Affairs, 1999.

Gambling and Health

Heath impact assessment

Brent tPCT ran a Health Impact Assessment workshop on the 27th June 2006 to assess the social and heath impacts of the proposed regional Casino in Wembley. Participants came from a wide range of backgrounds including school nurses, drug and alcohol services, the community, the local authority and a schoolboy on work experience.

Those attending recognised the potential employment, regeneration and economic benefits that a casino could bring but raised concerns about a number of other areas. These included:

- Increased problem gambling resulting in problems with mental health, drugs and alcohol, family dysfunction and domestic violence
- Transport, pollution, and the environment - particularly in the context of significant congestion currently around the Wembley site with further expansion planned
- Short term consequences of construction in terms of the influx of workers and the associated health & safety issues
- Income stress on families with low incomes
- Increases in crime
- Further strain on services and local resources which are already under pressure

Participants emphasised the racial, cultural, and religious diversity within Brent. Brent is, for instance, one of 2 white minority boroughs in the UK. Brent is also relatively deprived with stark differences between the most affluent and deprived areas and similarly significant inequalities in health and social outcomes. The ethnic diversity and deprivation within Brent mean that certain sectors of Brent's population could be disproportionately affected by the adverse impacts of the casino. The development of a regional casino in Brent would have been at odds with the religious, cultural and faith beliefs of substantial portions of the community.

Measures to minimise the impacts of Problem Gambling

From an extensive list of possible mitigation measures, five specific measures were identified as being particularly appropriate to the proposed casino development in Brent. These are outlined below:

Employee Training Schemes – Several operators of gambling venues across the UK, the US, Australia and New Zealand have incorporated intensive training schemes for their employees which involves training floor staff of all descriptions to recognise symptoms and triggers of problem gambling. Employees are also equipped with the right information to enable them to signpost individuals to further support or to alert an appropriate official as appropriate. As part of this measure, it is also essential that operators themselves receive training to ensure that they operate in a socially responsible manner. Currently, the National Association for Gambling Care (Gamcare) provides a comprehensive programme of social responsibility training. It was recommended that further consideration of this measure should be discussed with them.

Public Awareness Campaigns – Evidence from around the world indicates that raising the public's awareness of problem gambling, its dangers and symptoms, can have a significant impact in reducing the incidence of problem gambling. Such campaigns can also encourage an individual to recognise their problem and access help at an earlier stage, helping to reduce the long-term impacts. Any campaign of this nature should also involve clearly displayed information about the probabilities of winning both outside and within the casino. This is also linked to the curtailing of advertising/promotion to ensure the casino experience is not marketed as overly glamorous or inviting.

Immediate Access to Help – As part of Gamcare's guidelines for social responsibility in the gambling industry, it is strongly recommended that operators ensure that an individual can access some form of help immediately when they need it. This help can come in many forms but can be as basic as a leaflet or poster clearly displayed within the venue which directs people to help-lines etc. For Brent it is essential that these materials are also culturally appropriate and available in different languages. Evidence from international literature has shown that problems with language have been found to be a barrier to some individuals accessing help.

Self-Exclusion and Compulsory Exclusion – Gamcare currently works with operators of gambling venues across the UK to establish systems to enable problem gamblers to exclude themselves from the venue for a set period of time (currently the minimum recommended is six months). In other countries, operators have also chosen to employ compulsory exclusion measures in which a recognised problem gambler is excluded by the operator themselves. This information also needs to be shared across different local gambling venues to reduce the accessibility of gambling to the troubled individual.

Licensing Regulations - Drawing mainly upon the experience of existing casinos across the UK, it is suggested that encouraging higher-end casinos, who use pricing policies to attract wealthier clientele, may restrict access to the more vulnerable (i.e. lower income). This would also include over-pricing and capping the number of all gaming machines in casinos which have been found to provide the greatest risk of problem gambling.

Source: EDAW

Net Economic Impact

Calculating the net economic impact from the casino in Brent is a complex task. It involves calculating the value of any positive effects or benefits and subtracting the value of any costs. Table 8 shows the range of benefits, costs and transfers identified by NERA in their economic assessment.

Table 8: Benefits, Costs and transfers of a Casino

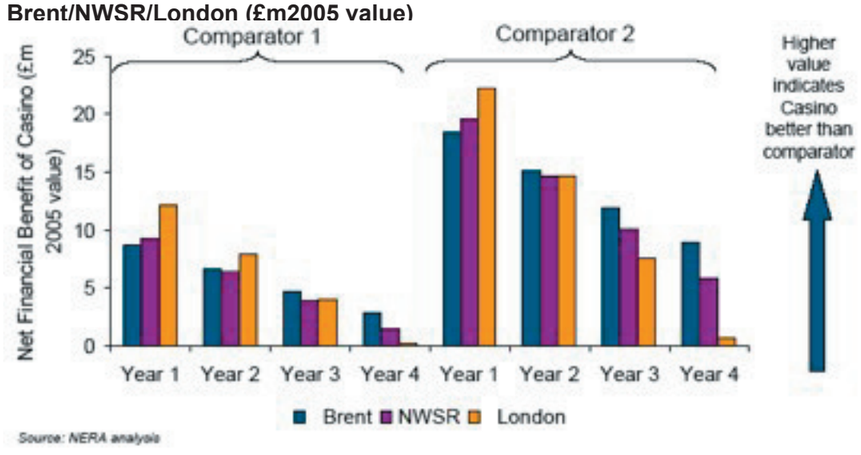
Benefits	Costs	Transfers
Direct		
Employment: ***Construction*** ***Casino workers***	Problem gambling	**Tax revenue**
Casino spending: *Residents of Brent* *Non-residents of Brent*	Litter, policing	Substitution of spending away from substitute industries (e.g. betting, horse racing)
Investment	**Congestion** & pollution	
Indirect		
Additional Employment: ***Complementary and other industries***	Crime	**Substitution of employment**
Additional Income: ***Personal*** ***Complementary and other industries***	Property value decreases*	Substitution of income
Additional Investment: *Complementary and other industries*		Substitution of investment
Property value increases*		**Unemployment benefit avoided**

*Source: NERA, adapted from Felsenstein and Freeman (1998); Rose (2001); National Institute of Economics and Industry Research (2003); Gazel (1998); Henriksson (2001); Grinols and Mustard (2001) Note: * it is unclear from the literature the likely direction of impact on property values*

In order to assess the economic impact of a casino NERA compared a possible casino development with two alternative scenarios. Comparator 1 is a development in line with what is planned for the Stage 1 Wembley development. This includes land allocated to restaurants and bars (food and beverage), retail, office space, residential and non-residential institutions (eg nursing homes and day centres), student accommodation, assembly and leisure (eg sports centre), and dwellings. Comparator 2 is a more cautious version of comparator 1 where the office development and hotel has been excluded.

NERA calculated the net economic impact by adding in the economic benefits of the additional employment and subtracting the economic costs of the additional congestion. NERA concluded that the casino would be superior to both of the comparators across most years as shown in figure 20. The net economic effect of the casino compared to comparator 1 was £8m in the first year reducing to £2.5m in year 4. The net economic effect of the casino compared to comparator 2 was £18m in the first year, reducing to £9m in year 4.

Figure 20: Net Benefit of the Casino Compared to Comparators, Year 1 – 4, Brent/NWSR/London (£m2005 value)



A critical omission of the NERA work however, is that they do not quantify the economic impact from the increased number of problem gamblers or from increased crime. The cost of problem gambling was not quantified in this assessment. Using the widely quoted figure of $13,586 per problem gambler per year would give a cost of problem gambling of between £7m –£10.5m.

This would make the casino less economically beneficial than comparator 1 across all years and less economically beneficial than comparator 2 by the 4th year. The figure of $13,586 is likely to be a conservative estimate that was based on research prior to 2001. It is also likely, given the public health and welfare system in the UK, that a greater proportion of these costs would be picked up by the taxpayer in the UK compared to the US.

There are a number of calculations of the net economic impact of gambling in the literature using different methodologies. These range from a positive net effect to a negative net effect. A selection of these is shown in the table below. Negative numbers are shown in brackets.

Table 9: Range of Calculations of the Net Economic Impact of Gambling

Location	Costs	Benefits	Net effect
Florida, 1994	$2.7 - 3.8b	$536m	($2.1b) – ($3.2b)
Australia, 1999	$4.3 – 6b	$1.8 – 4.2b	($1.2b) – 4.2b
Wisconsin, 1996	$138m	$326m	$188m

Service Provision

There are virtually no dedicated local services to deal with problem gambling although some work may be done by addiction staff, social workers and debt management staff both statutory and voluntary. There are a number of national services available, many modelled on the Alcoholics Anonymous, and some linked to residential clinical services.

Boswell, in the Lanarkshire Annual Public Health Report 2006, says that what is required is a combination of the roles to be offered by the Voluntary Sector, the NHS and the Local Authority to promote a coherent and multi-disciplinary response to the range of problems that impact on individuals, families and communities. He goes on to suggest that such an approach could include:

- Staff training for specific and generic support
- Gambling guidelines for the general public
- Mechanisms and referral systems for the early identification of gambling problems
- Non judgemental moderation and abstinence goals for problem gambling
- System(s) of monitoring and reporting gambling related participation trends
- Incidence and prevalence of gambling, and the burden of gambling related ill health and inequalities.
- Exclusion procedures for minors and voluntary exclusion provisions for people who have a problem with gambling

Gambling and Health

- Restricted access to ATMs at gambling premises
- Restrictions on advertising and availability of premises for gambling

Conclusion

Problem gambling has clear health related consequences, particularly for the most vulnerable within our communities. It thus represents a serious public health concern and the impact of gambling on health requires a framework of services and policies to deal with the issues.

The decision by the council not to proceed with the casino means that neither the benefits nor the costs will now take place. However it is possible that the number of regional casinos will be extended in the future and that a casino in Brent may be once again proposed. In the meantime the changes bought about by the Gambling Act will greatly increase the accessibility and promotion of gambling resulting in more people gambling and greater numbers of problem gamblers.

Government action to limit the availability and accessibility of gambling opportunities using technological innovation does not seem to be adequate to limit the impact of recent deregulation on the individuals and communities most at risk.

Action is required at both local and national level to raise the issue up the agenda, allocate the necessary resources and ensure a coherent unified approach to reduce, rather than create, more opportunities for people to get into problems over gambling. That joint approach will help to stop the anticipated health harm, reduce actual harm and rehabilitate those who have experienced harm.

Sexual Health and HIV

Sexual Health Key Facts

Teenage Pregnancy

- Brent's teenage pregnancy rate is higher than the national rate and increasing. This is in contrast to the national rate which is decreasing
- Two fifths of teenage pregnancies occur in the four wards with the highest numbers of teenage pregnancies
- The teenage pregnancy rate in the ward with the highest rate is 15 times higher than the ward with the lowest rate

Termination of pregnancy

- There were 2463 terminations of pregnancies in Brent in 2004. This is more than double the national rate of 30.8 per 1000 women aged 15-44
- 74% of the abortions were performed at 4-9 weeks of gestation compared to 60% nationally
- 58.3% of teenage pregnancies in Brent are aborted, compared to 45.6% in England and Wales

HIV

- 665 people were living with HIV in Brent in 2004. This number has increased by 37% since 2001
- Another 245 people may be living with HIV in Brent but be undiagnosed
- The biggest rise in HIV in recent years has been through heterosexual intercourse. Nearly all these infections have been among Black Africans, three quarters of which were most likely acquired in Africa
- Men who have sex with men continue to be disproportionately affected by HIV

Sexual Health and HIV

Sexually Transmitted Infections (STIs)

- STIs diagnosed in GUM clinics in Brent have increased in recent years, although the increase has not been as high as for the rest of London and the UK
- Chlamydia is the most common diagnosed STI. As many as 1 in 10 young people are likely to be infected
- The number of diagnoses of Chlamydia increased by a third between 2002 and 2004.
- The introduction of a Chlamydia screening programme in 2005 means that diagnoses of Chlamydia are likely to continue to increase
- Young people, gay men and people of black ethnic groups suffer disproportionately from sexually transmitted infections
- 80% of GUM patients are seen within 48 hours in Brent compared to 54% in England

Introduction

Sexual health has been identified as one of the key national priorities for action in the White Paper 'Choosing Health' and its importance in Brent is reflected in the Brent Sexual Health Strategy. The key objectives set out in the strategy are shown in the box below.

"Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be maintained, the sexual rights of all persons must be respected, protected and fulfilled"

Source: World Health Organisation

Objectives of Brent tPCT's Sexual Health Strategy

- To reduce transmission of HIV and STIs and to reduce the prevalence of undiagnosed HIV and STIs
- To ensure appropriate levels of service and service uptake for high risk and underserved groups
- To improve health and social care for people living with/ affected by HIV
- To reduce the stigma associated with HIV and STIs and normalise access to sexual health services
- To reduce unintended pregnancy
- To improve the sexual health of young people

Fertility

In 2004, there were 4,326 live births in Brent and the general fertility rate (number of live births per 1000 women aged 15-45) was 66.5 per 1000. This was higher than the fertility rate for London (62.5) and England (58.4).

Table 10: Fertility Rate per 1000 women in Brent, NW London, and England and Wales, 2004

	2001	2002	2003	2004
Brent	57.86	61.98	66.6	66.5
North West London	55.86	55.82	61	58.4
Eng & Wales	54.82	54.64	56.8	58.2

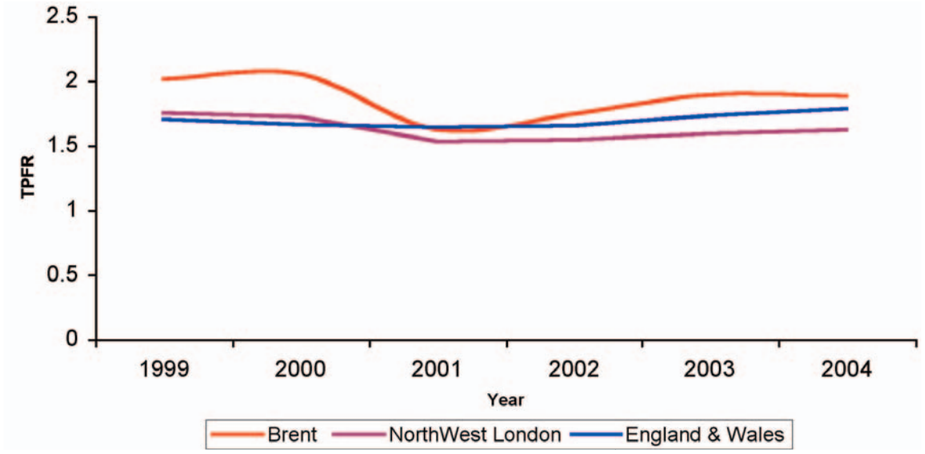
Source: National Centre for Health Outcomes Development (NCHOD)

Total Period Fertility Rate (TPFR)

The Total Period Fertility Rate (TPFR) is the average number of children per woman living in a particular area, if all women experienced the current age specific rate throughout their childbearing years i.e. between ages 15 and 44. The TPFR in Brent, 1.88 in 2004, is significantly higher than both London and national rates. There was a fall in TPFR between 2000 and 2001, almost equal to the national rate but the rate is now gradually increasing (Figure 21).

Sexual Health and HIV

Figure 21: Total Period Fertility Rate, 1999 - 2004



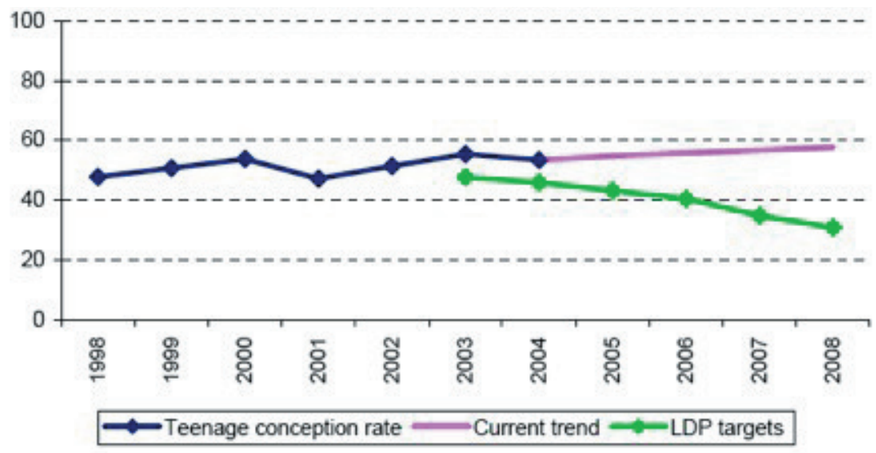
Source: National Centre for Health Outcomes Development (NCHOD)

Teenage Pregnancy

A teenage pregnancy is a conception to a girl aged less than 18. Teenage pregnancy has adverse consequences for many girls. It is often difficult to continue education, which makes it harder to find employment later in life and can lead to social exclusion. Babies born to teenage mothers are at increased risk of prematurity, cot death and accidental injury in early life. They are also at higher risk of becoming teenage parents themselves. The national teenage pregnancy strategy aims to reduce conceptions among under 18 year olds in England by 50% by 2010. The NHS plan also set an interim target of achieving a 15 % reduction in this rate by 2004.

There were 236 teenage conceptions in Brent in 2004 at a rate of 53.4 per 1000 females aged 15-17. In calculating teenage conception rates the female population aged 15 – 17 years is used as the denominator. Nationally the under 18 conception rate has fallen since 1998. However this trend is reversed in Brent. The under 18 conception rate in Brent has increased from 47.8 in 1998 to 53.4 in 2004 – an increase of 11.7%.

Figure 22: Conception for females under 18 per 1000 females 15-17 in Brent 1998-2004



Source: London Health Observatory Public Health Performance Reports Q4 2005/06.

There is considerable variation in the number and rates of conception at ward level within Brent. The four wards (Harlesden, Kilburn, Willesden Green, and Stonebridge) with the highest rates are in the south east of the borough, 38% of teenage conceptions between 2000-2002 were in these wards. Conversely wards with the lowest number of conceptions tend to be in the North of the borough (Kenton, Fryent and Dollis Hill).

Table 11: Conceptions for females under 18 in Brent by Ward (2000 –2002)

	Number	Rate per 1000 females 15-17
Harlesden	91	126
Kilburn	59	98
Willesden Green	48	95
Stonebridge	89	78
Queens Park	31	68
Wembley Central	48	65
Barnhill	42	50
Dudden Hill	34	47
Mapesbury	23	46
Tokyngton	39	44

Sexual Health and HIV

	Number	Rate per 1000 females 15-17
Sudbury	28	44
Kensal Green	25	42
Welsh Harp	29	42
Preston	27	36
Northwick Park	25	35
Brondesbury Park	20	35
Queensbury	26	29
Alperton	21	27
Dollis Hill	19	25
Fryent	18	23
Kenton	6	8
All	**748**	

Source: Office for National Statistics

Brent's Teenage Pregnancy Strategy

A range of initiatives have been developed within Brent to reduce teenage pregnancy and to support teenage parents. These include:

- Personal Social and Health Education (PSHE) Team in place to oversee the development of Sex and Relationships Education (SRE) in all schools through supported training of teachers
- School and community nurses are trained to deliver SRE
- Open door sessions for teenagers are run by school nurses
- 1:1 counselling is provided for secondary school pupils in the early evening
- Brent Linx – an organisation for young people aged between 13-18 years who have disrupted home lives and/or not regularly attending or excluded from school
- Support programmes specifically for young people providing advice and guidance on issues including sexuality and access to contraceptive services
- A condom distribution scheme
- Dr Foster – distribution of sexual health magazine to male/female teenagers
- Boys 2 Men – sexual health programme targeting young men
- Teens and toddlers programme, a programme that works with individuals that are seen as vulnerable and placing them in supervised nursery settings so that they can gain an understanding of the needs and demands of young children
- Sex and Drugs young persons training coordinator
- Black African Men's Campaign – 'Not another statistic'
- Outreach sexual health post - Brent Centre for Young People offers training, outreach, support, advocacy, information and advice
- Theatre into Education
- Peer education projects

Analysis of the social, economic and cultural characteristics of teenagers in Brent who became pregnant during 1998 – 2004 was carried out by Experian Mosaic UK[24]. A generic classification system, which segments postcodes and households based on their characteristics, was appended to the postcodes of each teenager. According to the report two mosaic groups, 'Ties of Community' and 'Welfare Border line', and two mosaic types, 'Metro Multi culture' and 'Settled Minorities' are more likely to become pregnant teenagers.

Characteristically, these Mosaic types are more deprived than the UK average and are more likely to be from a lone parent family. Teenagers belonging to 'Ties of Community' mosaic group are more likely to choose to give birth, whereas those belonging to 'welfare border line' are more likely to choose an abortion. Geographically there is a concentration of the 'welfare borderline' groups around Harlesden and Kilburn and there is a concentration of the 'Ties of Community' group around Harlesden, Willesden and Neasden.

Contraceptive Services

Contraceptive services are one of the NHS's most cost effective services. For every £1 invested in contraceptive services, including screening, there is a saving of at least £11 on associated NHS costs.[25] Contraceptive services are provided by GPs, Brent family planning clinics, walk in centres and community pharmacists. There is no single database nationally, or in Brent, that collates comprehensive information about contraceptive use.

24 "Teenage pregnancy and Abortion Analysis", Experian March 2005
25 Department of Health, Delivering Choosing Health: Making Healthy Choices Easier. Department of Health, 2005.

Sexual Health and HIV

Westside Contraceptive Services provides 29 contraceptive sessions across 11 sites in Brent. It runs a dedicated young person's session and provides cervical screening and referral to termination of pregnancy services. In 2002/03 the service received 9,760 first visits to the service and 17,411 total visits.

Table 12 shows the number of contraceptives items prescribed by GPs. The number of items prescribed has been fairly consistent over the last three years. The most common prescription written is for oral contraceptives (OCP), which makes up 85 % of the contraceptive items prescribed in 2005. Injectable contraceptives and emergency contraceptives (EHC) constitute 8% and 6% of all the contraceptives prescribed. The uptake of intrauterine devices (IUCD) is less than 1%.

Table 12: Trend of Prescription of Contraceptive Items by GP Practices in Brent (February 2003 – January 2006)

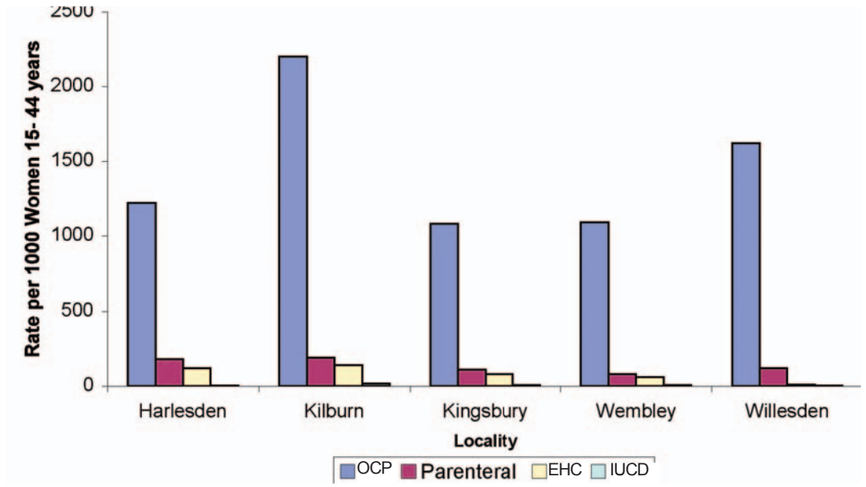
	Feb 03-Jan 04	%	Feb 04-Jan 05	%	Feb 05-Jan 06	%
Oral Contraceptives	31,074	85	30,471	84	30,451	85
Intra –Uterine Progestogen –only device	132	0.37	171	0.47	190	0.53
Injectable						
Contraceptives	3,104	8	3,313	9	2,998	8
Emergency Hormonal Contraceptives	2,320	6	2,199	6	2,120	6

Source: Pricing Prescription Authority

There is wide variation in the prescribing pattern across practices in Brent. On average, for every 1000 women of 15- 44 years, each practice prescribes 1426 items of oral contraceptives (range 179 – 6015); 126 items of injectable contraceptive (0- 635); 6.5 items of IUD (range 0- 51.47) and 30.5 items of emergency contraceptives (range 0- 141). In 2005, the highest number of oral contraceptive items was prescribed in Kilburn followed by Willesden and Harlesden. The highest number of injectable contraceptive items was prescribed in Kilburn, followed by Harlesden and Willesden.

Emergency Contraception items were more commonly prescribed in Kilburn and Harlesden followed by Kingsbury and Wembley (Fig 23).

Figure 23: Contraceptive Prescriptions by Locality in Brent, 2005



Source: Pricing Prescription Authority

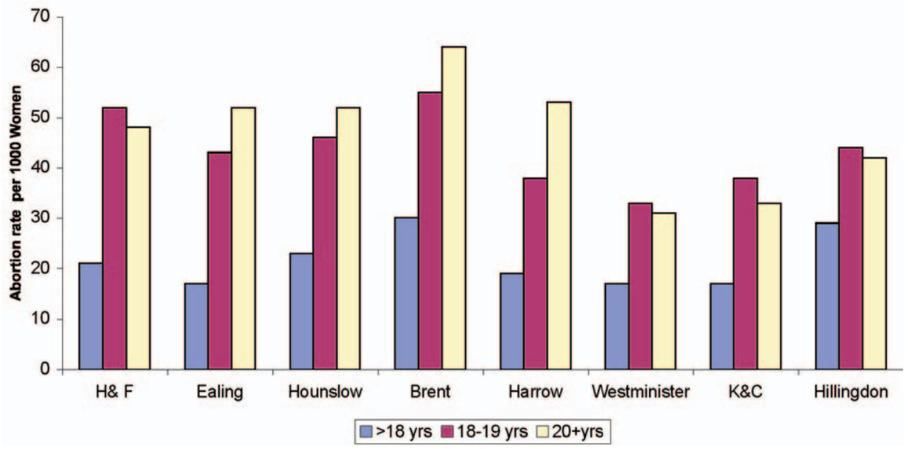
Termination of Pregnancy

Access to appropriate, timely abortion services is important. The earlier an abortion is performed, the lower the risk of complications. Brent has historically had relatively well funded services and access to services compares favorably to other PCTs in London and the UK.

In 2004, the total number of abortions performed in Brent was 2,463, which is 6.2 % less than that in 2003. The age – standardised abortion rate for Brent was 30.8 per 1000 women resident aged 15-44. This was the highest in North West London. The distribution of terminations by age group shows the number of abortions was highest amongst younger women (Figure 24).

Sexual Health and HIV

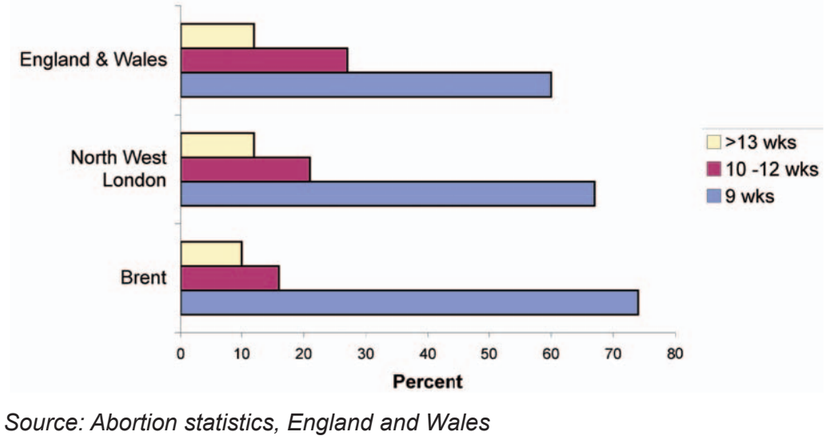
Figure 24: Abortion Rate in Different Age groups in North West London Boroughs, 2004



Source: Abortion statistics, England and Wales

The proportion of terminations provided to 10 weeks gestation is an NHS performance indicator used to measure access to termination of pregnancy services. In Brent early abortion is the norm. In 2004, 74 % of the abortions were performed at 4-9 weeks of gestation and 16 % were performed at 10-12 weeks gestation. 60% of the abortions in England and Wales, and 67% percent of that of North West London were performed at less than 9 weeks gestation (Figure 25).

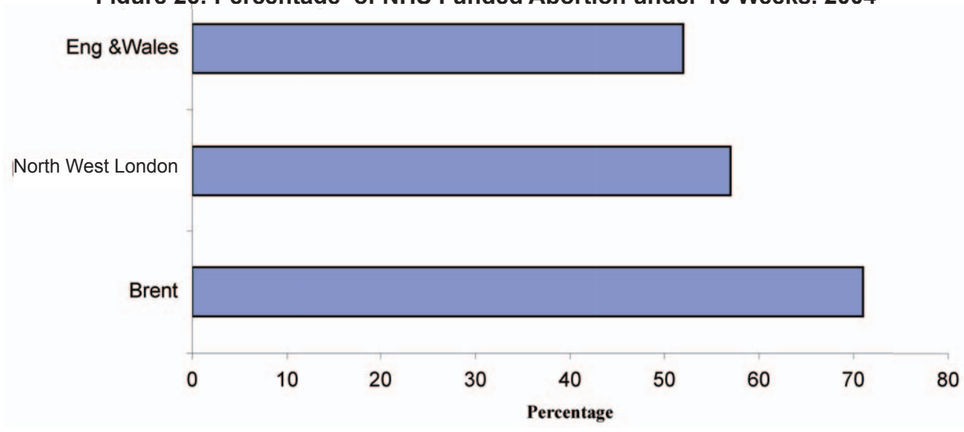
Figure 25: Percentage of Abortions by Gestation in Brent, North West London, England and Wales, 2004



Source: Abortion statistics, England and Wales

The proportion of termination of pregnancies purchased by the NHS is another way of measuring access to services. 71% of the total terminations for Brent residents under 10 weeks gestation in 2004 were NHS funded. This was considerably higher than North West London (57%) and England and Wales (52%) (Figure 26).

Figure 26: Percentage of NHS Funded Abortion under 10 Weeks, 2004



Source: Abortion statistics, England and Wales

Sexual Health and HIV

Different methods may be used to terminate a pregnancy, depending on the duration of gestation and other circumstances relating to the individual woman. Vacuum aspiration is most commonly used in pregnancy under 15 weeks gestation. Where gestation is above 15 weeks or greater, dilatation and evacuation is recommended. Use of the abortion drug mifegyne (mifepristone) is slowly increasing in England and Wales. In 2004 it accounted for 19% of all abortions compared with 17% in 2003.[26]

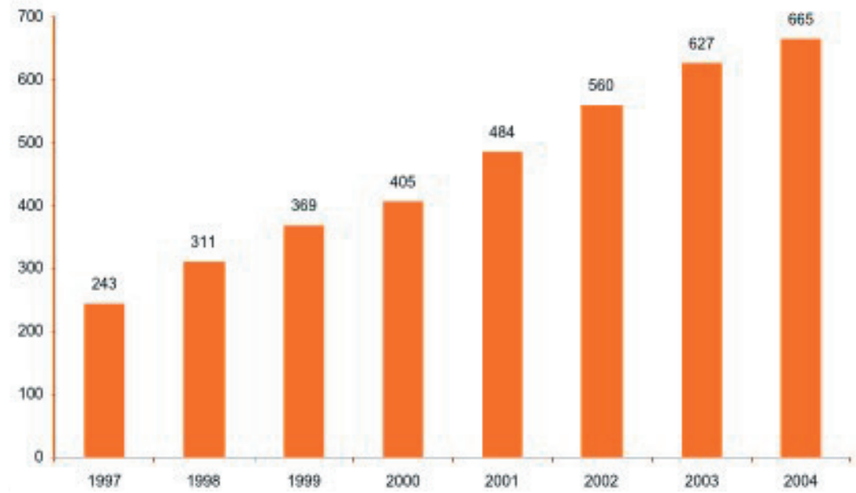
The new abortion form allows for recording whether Chlamydia screening was offered. This is a key component of the Department of the Health's Sexual Health Strategy. In England and Wales, 69 % of the women undergoing abortion were offered Chlamydia screening in 2004, compared to 64% in 2003. In Brent chlamydia screening for women undergoing abortion will be introduced in 2006.

HIV

There were 665 people diagnosed with HIV living in Brent in 2004 and receiving treatment and care (Figure 27). The number of people living with HIV in Brent has grown rapidly in recent years and increased by 37% between 2001 and 2004. Based on anonymous surveys of GUM attenders and mothers giving birth, it is estimated that about 27% of all HIV infections may be undiagnosed. Therefore it is possible that there are a further 245 Brent residents who are HIV positive but unaware of their status.

26 Statistical Bulletin, Abortion Statistics, England & Wales, 2004. Crown Copy right 2005

Figure 27: Number of People with HIV diagnosed in Brent 1997- 2004



Source: SOPHID (Survey of Prevalent HIV infections Diagnosed)

Mode of Transmission and Ethnicity

Heterosexual transmission is the most common route of infection (62%) in Brent. In 2004, 28% of HIV infections occurred through sex between men. Mother to child transmission accounted for 5% of cases and intravenous drug use was the route of infection in 2% of cases. In North West London, 53% of transmission occurred through sex between men (Table 13).

Table 13: Mode of transmission of HIV Infection in Northwest London & Brent, 2004

	North West London	Brent
Route	**%**	**%**
Sex between men	53	28
Injecting drug use	3	2
Sex between men and women	37	62
Blood /blood product recipient	3	1
Mother to child transmission	3	5
Other /not known	3	2
Total	100	100

Source: SOPHID (Survey of Prevalent HIV infections Diagnosed)

Sexual Health and HIV

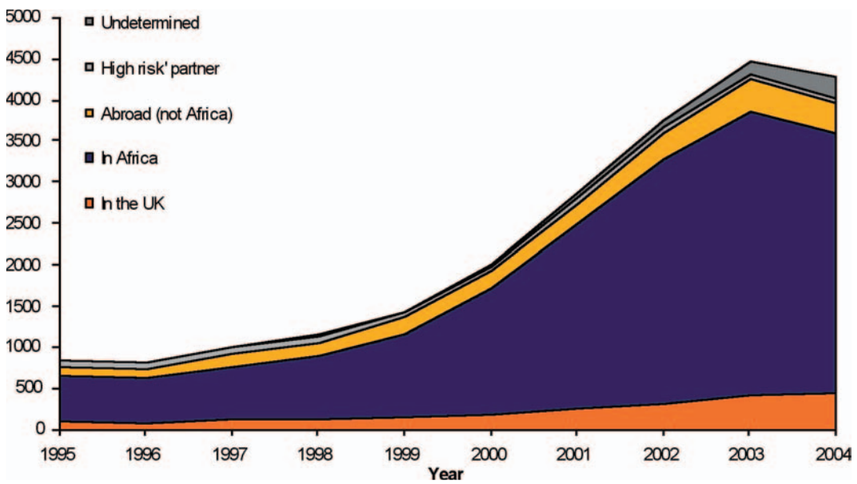
The distribution of infection among various ethnic groups has remained the same over the last three years. In 2004, the highest rate of HIV infection is found among people of Black African ethnic group (47%). The second largest ethnic group most affected by HIV epidemic is the white population (27%).

Table 13: People living with HIV in Brent by Ethnicity, 2002- 2004

	2002	2003	2004
Ethnic group	**%**	**%**	**%**
White	29	28	27
Black Caribbean	7	8	8
Black African	46	48	47
Black other	3	1	2
Indian/Pakistani/Bangladeshi	4	5	5
Other/mixed	7	4	5
Other Asian/oriental	1	2	2
Not known	3	4	4
Total	100	100	100

Source: SOPHID (Survey of Prevalent HIV infections Diagnosed)

Fig 28: HIV diagnoses in the UK acquired through heterosexual contact by sub-category



Source: Health Protection Agency, HIV/AIDS diagnoses reports, United Kingdom.

Age distribution of HIV cases

According to the Survey of Prevalent HIV Infections Diagnosed (SOPHID), the age profile of people living with HIV and AIDS shows that the highest proportion was among the 25- 39 age group (49.9%) in 2004. However, the population with HIV is living longer as a result of combination therapy and there is therefore an increasing proportion of people in the 40-54 age group.

Table 14: Age profile of people living with HIV in Brent, 2002 - 2004

Age group	2002		2003		2004	
	No	%	No	%	No	%
0 -14	20	4	26	4.2	31	4.7
15- 24	25	5	22	3.5	27	4.1
25 -39	298	53	339	54	332	49.9
40 -54	187	33	194	31	232	34.9
>55	30	5	46	7.3	43	6.5
Total	560	100	627	100	665	100.0

Sourse: SOPHID (Survey of Prevalent HIV infections Diagnosed)

Access to treatment, Undiagnosed HIV, and Uptake of HIV testing

Of the 665 diagnosed HIV cases, 57% received triple therapy and 10.4% received quadruple therapy. 30.2% of the diagnosed HIV cases did not receive any anti-retroviral treatment. As stated above it is estimated that about 27% of all people with HIV in London may be undiagnosed and therefore unable to benefit from treatment[27]. Increasing the uptake of voluntary confidential HIV testing is a critical strategy to reduce the number of People living with HIV/AIDS (PLWHA) whose HIV status is undiagnosed.

The promotion of voluntary confidential HIV testing can prevent further HIV transmission because an HIV diagnosis allows access to antiretroviral therapy, reducing viral load and provides the opportunity for changing behaviours. In 2002, the implementation of an action plan for England's National Strategy for Sexual Health and HIV set a standard for GUM clinics to offer voluntary confidential testing to all people attending the clinic on their first screening for STIs, and subsequently according to the risk.

27 London HIV Strategy 2005

Sexual Health and HIV

Overall uptake of voluntary confidential testing among men who have sex with men has increased from 47% in 1998 to 64% in 2003, and among heterosexuals from 27% in 1998 to 55% in 2003.[28]

Sexually Transmitted Infections

There has been an increase in diagnoses of sexually transmitted infections in GUM clinics in Brent in recent years, although the increase has not been as high as for the rest of London and the UK. The largest increase has been in Chlamydia diagnoses. This, in part, reflects increased Chlamydia testing and improved diagnostic techniques in laboratories. In spite of the overall increase in sexually transmitted infections there has been a reduction in diagnoses of gonorrhoea. Rates of STIs are particularly high in young people, gay men and people of black ethnic group.

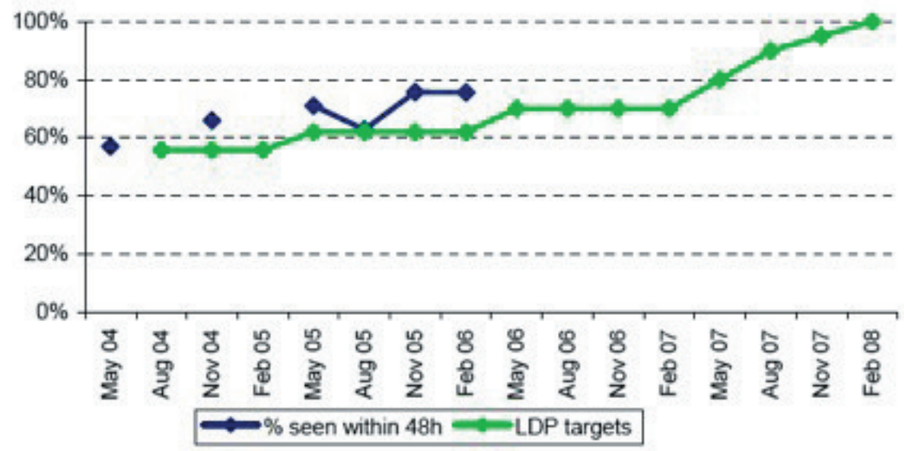
Information from the *National Survey of Sexual Attitudes and Lifestyles*[29] indicates that Londoners have higher number of partners and are more likely to have unprotected sex. A higher number of heterosexual partners were reported by men (4.5 partners) and women (2.7 partners) in London than elsewhere in Britain, (3.7 and 2.3 partners respectively). The proportion of men who had a homosexual partner in the last 5 years was also higher in London (5.5%) compared with the rest of Britain (2.1%).

Ensuring timely access to GUM clinics is important to treat infections and minimise the spread of infections. In the White Paper “Choosing Health” the government set a 48 hour maximum waiting time target for genitourinary medicine (GUM) clinics by March 2008. This target was included in Primary Care Trust’s (PCTs) Local Delivery Plans (LDPs) from April 2005 and access to GUM services is a PCT performance indicator.

The Health Protection Agency (HPA) has been undertaking national audits of waiting times for GUM clinics in England since May 2004. The percentage of Brent patients seen within 48 hours has been consistently improving. 81% of Brent patients attending were seen within 48 hours in May 2006. This was among the highest percentages of PCTs in London. The percentage seen within Central Middlesex hospital (79%) was higher than Northwick Park (56%). Performance was particularly good at St Mary’s hospital (95%) where a large number of Brent residents also attend.

28 HIV and other Sexually Transmitted Infections In the United Kingdom in 2003.
29 Erens B et al. National survey of sexual attitudes and lifestyles II: Reference tables and summary report.National Centre for Social Research 2003.

Figure 29: Percentage of Brent patients seen within 48 hours



Source: London Health Observatory, Q4 05/06 Public Health Performance Report

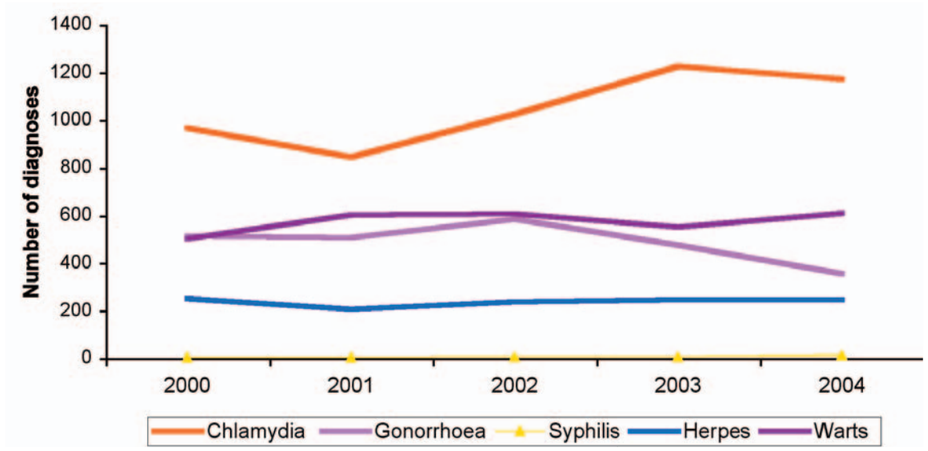
Information on sexually transmitted infections is based on the KC60 returns from the GUM clinics of Central Middlesex and Northwick Park Hospital. It measures the workload of the GUM clinics of these two hospitals rather than the incidence of sexually transmitted infections of Brent residents. Information concerns the number of diagnoses of five key infections: chlamydia, gonorrhoea, herpes simplex virus and ano-genital warts. In Brent, there were 11,745 cases of these STI’s recorded amongst all ages in the 5 year period between 2000 and 2004, the majority of which were recorded amongst under 25s.

The most commonly recorded infection was Chlamydia (44% of infections reported overall). The prevalence of Chlamydia is high in both men and women, with up to 10% of young people in London likely to be infected.[30] The number of diagnoses of Chlamydia increased by 34% between 2002 and 2004. A chlamydia screening programme was established in Brent in 2005. The screening programme offers opportunistic screening to asymptomatic sexually active men and women under 25 years of age. It is therefore likely that the number of Chlamydia diagnoses will continue to increase.

30 London-Wide Sexual Health Framework

Sexual Health and HIV

Figure 30: Number of new diagnoses of STIs from Central Middlesex and Northwick Park GUMs 2000-2004



Source: Health Protection Agency, HIV and Sexually Transmitted Infections Department

The number of gonorrhoea diagnoses decreased by 30% over the five year period although one out of every five sexually transmitted infections diagnosed is of gonorrhoea. The incidence of gonorrhoea is higher among men than women. A high proportion of diagnoses of gonorrhoea are amongst men who have sex with men (9%). This is also true of herpes where 8% of diagnoses were amongst men who have sex with men.

The least recorded sexually transmitted infection was syphilis, with only 29 cases recorded in the five-year period. There was an increase in the number of diagnoses of syphilis in 2004 (11 compared to 4 or 5 in previous years). There have been outbreaks recently of syphilis elsewhere in London and the UK, particularly amongst men who have sex with men.

Information about the prevalence of STIs by ethnic group is not available at PCT level. Studies conducted in London however indicate that the incidence of STIs is particularly high in some ethnic groups. In 20 – 24 year old Black Caribbean and Black African men the incidence of gonorrhoea and chlamydia is higher than in the general population.[31] National survey information shows that Black Caribbean and Black African men report the highest number of lifetime sexual partners of all ethnic groups. [32] Just over a quarter and a third respectively had concurrent sexual partners.

Brent Chlamydia Screening Programme

- The Brent and Harrow PCT Chlamydia Screening Programme was set up in September of 2004.
- The overall aim of the programme is to implement and monitor opportunistic screening for genital Chlamydia infection
- Chlamydia screening is offered to sexually active men and women between the ages 16 and 24
- Chlamydia screening is offered in family planning clinics, GP surgeries, universities, colleges, secondary schools, outreach programmes, voluntary organizations and at health promotion events
- 5049 young men and women have so far been screened as part of the Brent and Harrow Chlamydia screening programme

31 Nicola Low, Jonathan A C Sterne and David Barlow. Inequalities in rates of gonorrhoea and chlamydia between black ethnic groups in south east London: cross sectional study
32 Fenton KA et al. Ethnic variations in sexual behaviour in Great Britain and risk of sexually transmitted infections: a probability survey. Lancet 2005. 365:1246-55

Smoking, Drugs and Alcohol

Smoking, Drugs and Alcohol Key Facts

Smoking

- Smoking is the leading cause of preventable ill health
- One in four people smoke in Brent, similar to the national rate
- There are marked social inequalities in smoking rates between the most affluent, who smoke least, and the least affluent, who are more likely to smoke
- Ethnic inequalities are even greater and there are major gender differentials within many ethnic groups
- Smoking causes 1020 hospital admissions in Brent and accounts for 19 beds occupied per day
- One in six deaths are due to smoking
- The number of smoking quitters in Brent increased substantially in 2005-2006
- The percentage of people contacting smoking cessation services who quit successfully in 2005/06 was 37% which is lower than the national average (53%)
- The national smoking ban in 2007 provides a major opportunity to reduce the burden of smoking in Brent

Alcohol

- One in ten people in Brent are estimated to be binge drinkers. This
- is 8% lower than the national estimated prevalence
- People from many ethnic minority groups are more likely to be non drinkers and less likely to drink above sensible levels
- Alcohol misuse and its health consequences are generally more common in men than in women
- The percentage of women binge drinking nationally had been on the increase however this trend has reversed since 2002
- Admissions for alcohol related conditions have increased in recent years as have the number of ambulance call outs
- Three times as many men as women suffer from alcohol related problems
- One in 18 deaths in Brent are attributable to alcohol
- Mortality rates from diseases caused by alcohol are nearly four times higher in unskilled working men compared to those from professional groups
- Nearly half the victims of violent crime described their assailant as being under the influence of alcohol at the time

Drugs

- Health consequences of drug misuse include HIV and Hepatitis B and C transmission and the mortality associated with accidental and intentional overdoses
- 933 Brent residents were in treatment for drug use in 2005/06
- The drug treatment rate in Brent (623 people per 100,000 population) is lower that for London (784 per 100,000 population) and nationally (768 per 100,000 population)
- 60% of users discharged from treatment had been in treatment for more than 12 weeks. This was slightly higher than the national rate of 56%
- Black and Asian people are under-represented in treatment services
- Heroin is the most commonly used substance by Brent residents in treatment services
- There were 24 deaths from drug misuse in 1999-2003. This was half the number between 1994-1998
- The prevalence of HIV and hepatitis B +C in injecting drug users in London is higher than elsewhere in the country
- The uptake of hepatitis B vaccinations amongst injecting drug users is low

Smoking, Drugs and Alcohol

Smoking

Smoking is the single greatest cause of illness and premature death in England today[33]. It kills an estimated 310 people per year in Brent and 86,500 people nationally (one in six deaths), accounting for a third of all cancer and a seventh of all cardiovascular deaths. Over 80% of all lung cancer deaths are the direct result of smoking.

The personal costs and the cost to the NHS are considerable. In 2001 in Brent an estimated 1020 hospital admissions (at a cost to the NHS of £1.8 million) were caused by smoking. The national ban on smoking in public places will come into effect on 1st July 2007. Smoking will not be allowed in places such as pubs, cinemas, offices, factories and public transport.

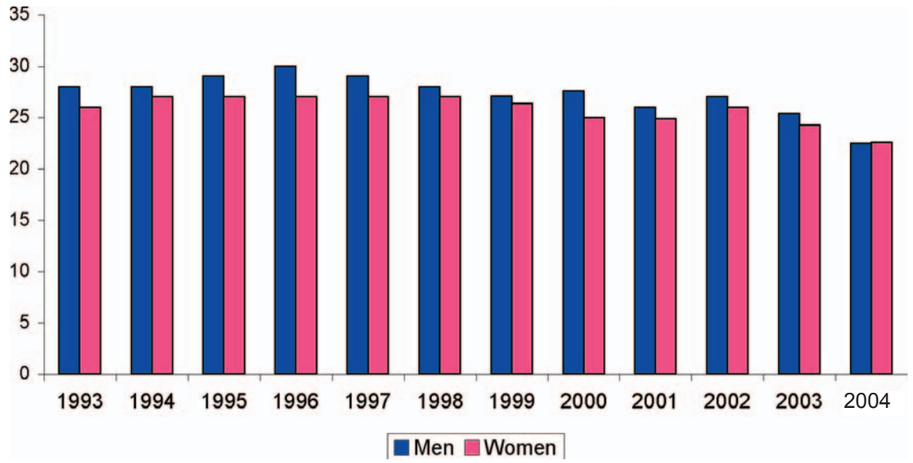
In spite of reductions in the number of people smoking nationally, one in four people continue to smoke in Brent. The estimated prevalence of smoking in Brent based on the characteristics of the local population is 25.7% (CI 22.8-29.6). [34] This is similar to the percentage of smokers nationally of 25%.

The 2001 survey of St Raphael's/Brentfield, Harlesden, Church End and Stonebridge residents found that 30% of residents smoke cigarettes. The majority of these smoke between 1 and 20 cigarettes per day. White British/ Irish and Other White ethnic respondents are most likely to say that they smoke, whilst Asian/Asian, British-Indian, Black/Black and British-African respondents are the least likely to smoke. Men are more likely to smoke than women. Harlesden has the largest proportion of smokers.

Nationally levels of smoking have declined significantly since the 1970s. The proportion of men who were smokers declined from 28% in 1993 to 26% in 2004. The proportion of women who were current smokers decreased between 1993 and 2004, falling from 26% to 23%. As well as a decline in the numbers of adults smoking cigarettes there has also been an overall decline in the average number of cigarettes smoked (Health Survey for England, 2004).

33 Department of Health: Delivering Choosing Health: making healthy choices easier. Department of Health
34 National Centre for Social Research, Synthetic Estimates of Healthy Lifestyle Behaviours at PCO Level, 2000-2002

Figure 31: Cigarette Smoking in England Among Adults Aged 16 and over, 1993-2004



Source: Health Survey for England

Smoking disproportionately affects the least well off with 31% of manual groups smoking compared to 20% among non-manual groups.

Overall smoking prevalence among ethnic minorities tends to be slightly lower than in the general population. However there are some differences between men and women of specific communities. The populations with higher than average proportions of male smokers in 2004 were Bangladeshi (40%), Irish (30%) and Pakistani (29%) compared to the national average for men of 24%.

In women rates were higher in Black Caribbean (24%) and Irish (26%) populations with the national average being 23%. The difference between smoking rates in men and women is much bigger among the Asian communities than the general population, with less than 10% of Asian women reporting smoking.

Smoking, Drugs and Alcohol

Tobacco Reduction in Brent

- A smoking cessation service for children and young people age 12 years and upwards will be offered through the Monks Park Young People Service.
- Development of PCT smoke-free policy – leading by example
- Supporting businesses through process of policy development
- Alliance of key stakeholders to develop Brent-wide strategy for the implementation of new smoke-free legislation (Health Bill 2006)
- Joint work with Environmental Health in development of business fora addressing range of workplace health issues including smoking
- Joint work with Brent Council Food Safety officers to address issues of food hygiene & smoking
- Maintenance of key partnership with the Smoking Cessation Team to ensure support for smokers wishing to quit is integral to policy development

Smoking related harm

In Brent in 2001 there were an estimated 1020 hospital admissions for diseases caused by smoking at a cost of £1.8 million. One in six deaths (18%, 310 deaths) in Brent were caused by smoking. One in four deaths (22%, 200 deaths) amongst men and one in eight deaths (13%, 110 deaths) amongst women were caused by smoking.

Table 15: Hospital admissions, and beds per day for disease caused by smoking in Brent, North West London SHA and London 2001.

	Number of admissions			
	Men	**Women**	**All**	**Beds per day**
Brent	720	290	1,020	19
North West SHA	7,030	3,570	10,600	250
London	29,930	16,100	46,040	1,133

Source: Tobacco in London; The preventable burden [35]

35 Christine Callum and Patti White: Tobacco in London; The preventable burden Published by SmokeFree London March 2004

Table 16: Hospital admissions, beds per day and costs for disease caused by smoking in Brent, North West London SHA and London 2001

	Cancer		Respiratory disease		Circulatory disease		% of admissions			Total cost (£s)
	Admissions	Beds per day	Admissions	Beds per day	Admissions	Beds per day	Cancer	Respiratory	Circulatory	
Brent	310	4	140	5	480	10	11	11	21	1,873,000
North West SHA	3,690	60	2,240	79	3,770	100	14	16	18	23,616,000
London	15,560	269	10,960	362	15,780	433	14	16	17	103,355,000

Source: Tobacco in London; The preventable burden [36]

Effects of Second Hand Smoke

The 2002 Annual Public Health Report of the Chief Medical Officer [37] highlighted the harm caused by exposure to other people's cigarette smoke (second-hand smoke or passive smoking). This includes:

- increased risks of contracting smoking related diseases such as cancer and heart disease;
- extra stress on the heart and affect the body's ability to take in and use oxygen;
- trigger asthma attacks;
- increased chances of sudden infant death syndrome (SIDS); and
- greater effects on children and babies than adults.

Second-hand smoke increases the risk of lung cancer by 20-30% and heart disease by around 25% in people who live with smokers.

Second-hand smoke from parents is causally linked to sudden infant death syndrome (a doubling of risk), lower respiratory illness (a 50% increase in risk), asthma (a 50% increase in risk), and middle ear disease (a 40% increase in risk).

36 Christine Callum and Patti White: Tobacco in London; The preventable burden Published by SmokeFree London March 2004
37 Donaldson L., On the State of Public Health – CMO's Annual Report. Department of Health 2002.

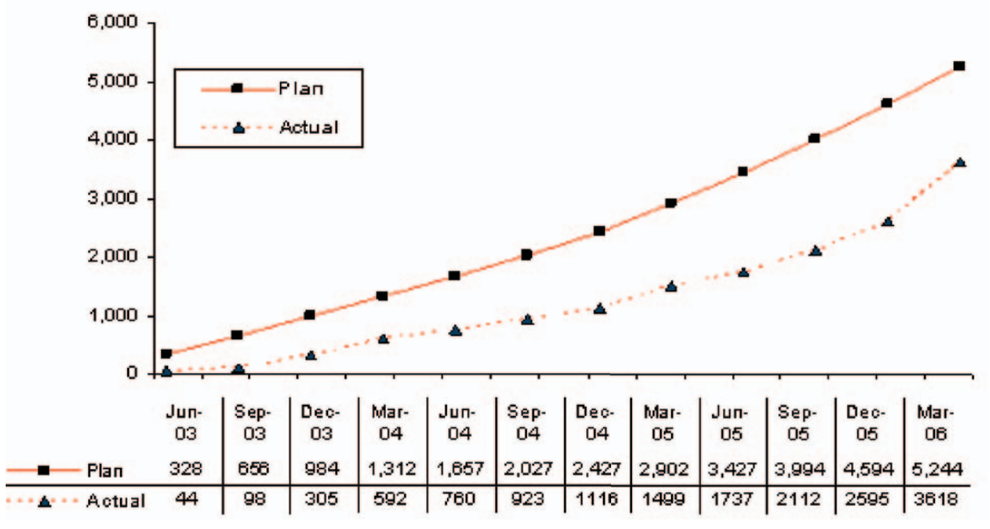
Smoking, Drugs and Alcohol

Smoking Cessation Services in Brent

The Brent Stop Smoking Service was established in its current format in September 2003. It is now well established with strong links in the community through community advisors, GP surgeries and local pharmacists. This is reflected in the yearly increase in smoking quitters (Figure 32).

Within 2003-06 and 2005-08 Local Delivery Plans (LDP), each PCT has targets for the cumulative number of 4-week smoking quitters who attended NHS Stop Smoking Services. The 3 year target for Brent for 2003-06 was 5244 smoking quitters. 69% of this target was achieved. The percentage of the target achieved for 2003/05 was 52%. The percentage of the target achieved has increased by 17% since last year. In 2005-06 there was an increase in the number quitting in each successive quarter.

Figure 32: Cumulative number of 4-week quitters in Brent, performance against local delivery plan, 2003 - 2006



	Jun-03	Sep-03	Dec-03	Mar-04	Jun-04	Sep-04	Dec-04	Mar-05	Jun-05	Sep-05	Dec-05	Mar-06
Plan	328	656	984	1,312	1,657	2,027	2,427	2,902	3,427	3,994	4,594	5,244
Actual	44	98	305	592	760	923	1116	1499	1737	2112	2595	3618

Source: Brent tPCT Performance Monitoring Report

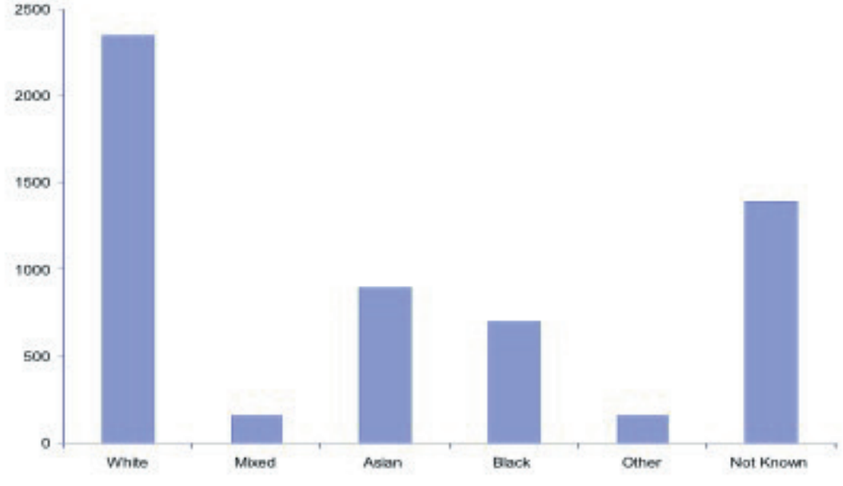
5673 people set a quit date in the period April 2005 to March 2006 of which 37.4% (2119) quit successfully and 25.5% (1448) were lost to follow up.

The percentage of people setting a quit date with smoking cessation services who quit successfully in Brent was 16% lower than the national average (53%). This is clearly an area for improvement. Table 17 shows the quit rates for different types of service in Brent. There is little difference between the successes of the services used.

Table 17: Quit rate and type of service Brent PCT 2005

Treatment Provider	Number of referrals	Number of interventions	Number Quit	% Quit (of interventions)
Pharmacy	1,628	1,624	612	38
Community advisers	555	553	207	37
Groups	41	31	12	39
Drop in 1 to 1	65	64	21	33
Workplaces	0	0	0	0
Telephone	0	0	0	0
Other	8	8	2	25

Figure 33: Ethnicity Profile of Smoking Cessation Service Users in Brent, 2005/06



Source: Stop Smoking Report for North West London.

Smoking, Drugs and Alcohol

The ethnicity profile of smoking cessation service users in Brent probably reflects the generally lower prevalence of smoking in the non-White population. However the accessibility to or uptake of smoking cessation services by minority ethnic groups should also be considered. National statistics suggest that men from the Black Caribbean and Irish groups should be targeted for smoking cessation and they may well be under-represented in smoking cessation services in Brent.

The Brent Stop Smoking Service is planning further local initiatives including working with the St Raphael's Estate to promote stop smoking cessation in relation to the Health Living Bid. It will also be doing targeted work in Neighbourhood Renewal Funding areas.

Implications of the Tobacco Ban

A national ban on smoking in public places will come into effect on 1st July 2007. Smoking will not be allowed in places such as pubs, cinemas, offices, factories and public transport. This should cause a reduction in morbidity due to passive smoking which has been shown to cause disease and deaths. It also presents an opportunity to have an impact on the prevalence of smoking in general and smoking related disease. The introduction of a smoking ban in other countries including New Zealand (Thompson-George and Wilson-Nick 2006)[38] , Ireland (Fong et al. 2006)[39] and Italy (Gallus et al. 2006)[40] has consistently resulted in an increase in public support for smoke free policies.

In a study conducted following the implementation of a work-place smoke-free law in Ireland in 2004, 46% of Irish smokers reported that the law had made them more likely to quit (Fong et al. 2006).

38 Thomson,G., Wilson, N., One year of smokefree bars and restaurants in New Zealand: impacts and responses. BMC Public Health (electronic resource), 2006 (epub), vol. 6, p. 64,
39 Fong-G-T, Hyland-A, Borland-R, Hammond-D, Hastings-G, McNeill-A, Anderson-S, Cummings-K-M, Allwright-S, Mulcahy-M, Howell-F, Clancy-L, Thompson-M-E, Connolly-G,Driezen-P. Reductions in tobacco smoke pollution and increases in support for smoke-free public places following the implementation of comprehensive smoke-free workplace legislation in the Republic of Ireland: findings from the ITC Ireland/UK Survey. Tobacco Control 2006, vol. 15 Suppl 3, p. iii51-8.
40 Gallus-S, Zuccaro-P, Colombo-P, Apolone-G, Pacifici-R, Garattini-S, La-Vecchia-C. Effects of new smoking regulations in Italy. Annals of Oncology: Official Journal of the European Society for Medical Oncology. 2006 vol. 17, no. 2, p. 346-7.

In Norway there was a significant decrease in five respiratory symptoms in 1526 employees in the hospitality business five months following a total ban on smoking in restaurants and other hospitality business premises (Eagan and AarØ 2006).[41] In Italy it has been estimated that smoke-free policies accounted for an 8% decrease in cigarette consumption in the short-term and the policies did not seem to have an unfavourable affect on the business of restaurants or cafes (Gallus et al. 2006). Recommendations from experience in Los Angeles to maximise adherence to the ban include education campaigns to counter perceptions of lost revenue, rigorous enforcement and severe penalties such as alcohol license revocation (Weber et al. 2003).[42]

Big Wins identified in the 'Choosing Health' Delivery Plan

- **Reducing exposure to second-hand smoke**: establishing a smoke-free NHS; ending smoking in work places and public areas via local agreements; and targeted support for NHS employees to stop smoking.
- **Communications and education**: new campaigns on second-hand smoke; health risks of tobacco products; motivating people to quit; and helping people who want to quit, with particular attention to manual working groups.
- **Support for smoking cessation**: more accessible and responsive stop smoking services and making Nicotine Replacement Therapy much more widely available, particularly to manual groups e.g. through pharmacies and GPs and other community outlets, including sports clubs, hospitals, leisure centres, places of worship and shops.
- **Using new technology** e.g. developing pilots on using the electronic booking system to trigger advice for smokers, targeting manual groups in particular.
- **Enforcement of regulations**: Local Authority enforcement of regulations against advertising and promotion, and clamping down on illegal sales.

41 Eagan-T-M-L, Hetland-J, Aarø-L-E. Decline in respiratory symptoms in service workers five months after a public smoking ban. Tobacco Control. 2006, vol. 15, no. 3, p. 242-6.
42 Weber-M-D, Bagwell-D-A-S, Fielding-J-E, Glantz-S-A Long term compliance with California's Smoke-Free Workplace Law among bars and restaurants in Los Angeles County. Tobacco Control. 2003, vol. 12, no. 3, p. 269-73.

Smoking, Drugs and Alcohol

Alcohol

Consuming more than the recommended amount of alcohol is likely to have adverse affects on health. It can cause medical problems such as alcoholic liver disease, gastritis (inflammation of the stomach) and associated bleeding, cancers of the liver and the oesophagus, hypertension (high blood pressure) and psychiatric problems such as depression. Reducing alcohol related harm has been identified as one of the key national priorities for action in the Public Health White Paper 'Choosing Health'.

The Licensing Act 2003 came into effect in November 2005. These new licensing laws related to the supply of alcohol, the provision of regulated entertainment and the provision of late night refreshment. Changes included the eradication of the 11pm curfew and an end to fixed closing times in order to prevent the increase in disorder that occurs around the times of 11pm and 2am. The penalties for selling alcohol to under 18s were also increased and the police were given tougher closure powers to deal with problem premises.

Current guidelines advise against regular drinking of 4 or more units a day for men (2 pints of beer or 4 small glasses of wine or 4 small glasses of sherry), or 3 or more a day for women – see the box below.

Definitions: Levels of Drinking:

Sensible drinking - No more than 3-4 units a day for men, and no more than 2-3 units a day for women.

Binge drinking - 8 or more units of alcohol for men, and 6 or more units of alcohol for women on their heaviest drinking day in the past week.

Hazardous drinking - Drinking above recognised 'sensible' levels but not yet experiencing harm.

Harmful drinking - Drinking above 'sensible' levels and experiencing harm.

Alcohol dependence -Drinking above 'sensible' levels and experiencing harm and symptoms of dependence.

What is a unit of alcohol?

A unit of alcohol is 10ml of pure alcohol.
The list below shows the number of units of alcohol in common drinks:
- A pint of ordinary strength lager (3.5%) (Carling Black Label, Fosters) - 2 units
- A pint of strong lager (Stella Artois, Kronenbourg 1664) - 3 units
- A pint of bitter (John Smith's, Boddingtons) - 2 units
- A pint of ordinary strength cider (Dry Blackthorn, Strongbow) - 2 units
- A 175ml glass of red or white wine - around 2 units
- A pub measure of spirits - 1 unit
- An alcopop (eg Smirnoff Ice, Bacardi Breezer, WKD, Reef) - around 1.5 units

(Adapted from Department of Health website)

Data on the prevalence of drinking is not currently available at a Local Authority or PCT level. In England two fifths of men (40%) and a fifth of women drink more than the recommended levels on at least one day in the preceding week according to the 2003 General Household Survey. In London the numbers are slightly lower with a third of men (32%) and one in 6 women (15%) drinking more than the recommended levels.

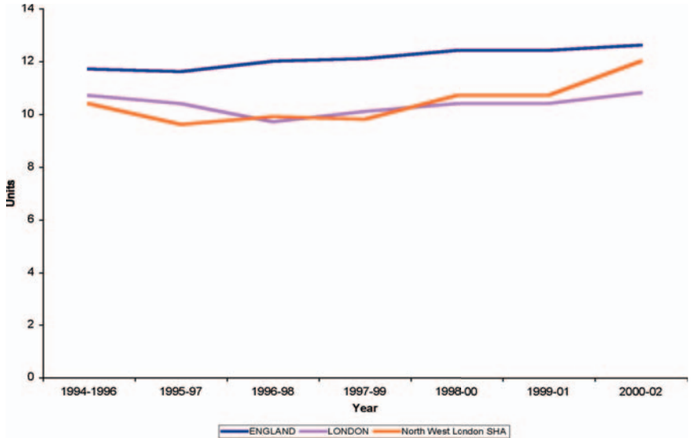
People from many ethnic minority groups are more likely to be non drinkers and less likely to drink above sensible levels. In the Health Survey for England, both men and women from ethnic minority groups, other than Irish, had lower than average alcohol consumption levels and a higher than average proportion that never drink. More than 90% of Pakistani and Bangladeshi people say they never drink compared with more than 40% of Black Caribbean, Indian and Chinese people. Less than a quarter of white Londoners never drink alcohol.

Alcohol consumption in the UK increased substantially in the early 1970s. Average consumption of pure alcohol per person aged over 15 years increased from around 6 litres per year in 1969 to around 9.5 litres per year in 1976. Figure 34 shows the age-standardised mean weekly alcohol consumption in the North West Strategic Health Authority, London and England from 1994 to 2002. The overall trend is of increasing alcohol consumption over time.

Smoking, Drugs and Alcohol

Brent is in the North West London Strategic Health Authority where the mean alcohol consumption was significantly lower than the national average.

Figure 34: Standardised Mean Weekly Alcohol Consumption in North West London Strategic Health Authority, London and England 1994-2002



Source: Health Survey for England

Brent's Alcohol Strategy

The Brent Drug and Alcohol Action Team's Alcohol Focus Group has developed a strategy to co-ordinate and improve on the work that is taking place by providers and operational partnerships to tackle alcohol-related harm. The strategic objectives of the Brent Alcohol Strategy are to:

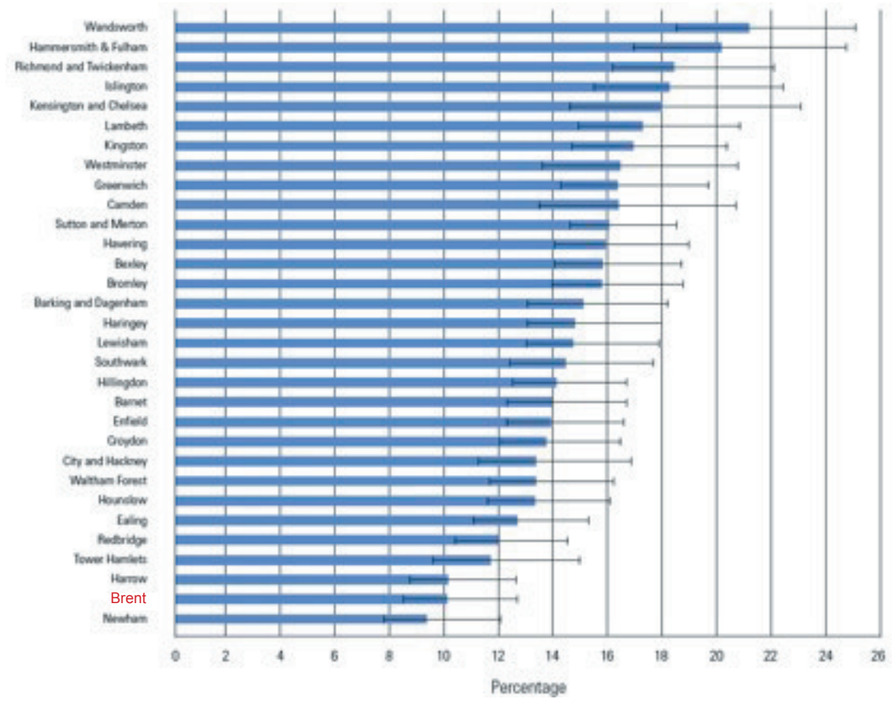
- Reduce the level of alcohol-related ill health, accidents and injuries
- Reduce the anti social and criminal behaviour associated with alcohol
- Address the alcohol-related needs of young people, their families and the communities they live in.
- Develop better information systems on alcohol misuse

Binge drinking is defined by the Office of National Statistics (ONS) as consuming 8 or more units of alcohol in men and 6 or more units of alcohol in women on their heaviest drinking day in the last week. The expected prevalence of binge drinking in Brent based on the characteristics of the local population is 10% (CI 8.5-12.6) which is significantly lower than the percentage for England of 18.2% (CI 17.6-18.6).[43]

Figure 35 shows the estimates of the percentage of adults reporting binge drinking by Primary Care Trust.

In the General Household Survey 2004 18% of men and 6% of women in London reported binge drinking compared to 22% of men and 10% of women in England as a whole. The Health Survey for England 2004 showed that binge drinking is most common in the younger (16 to 24 years) age group and decreases steadily with age. This reflects the pattern of previous years. The prevalence of binge drinking in women has increased over the last decade.

Figure 35: Estimated percentage reporting binge drinking by PCT in London 2000-2002



Source: National Centre for Social Research. Extended lines indicate 95% confidence intervals

43 National Centre for Social Research, Synthetic Estimates of Healthy Lifestyle Behaviours at PCO Level, 2000-2002

Smoking, Drugs and Alcohol

Alcohol Related Harm

Alcohol misuse is associated with a wide range of adverse affects on health. Medical problems caused by alcohol misuse include alcoholic liver disease, gastritis (inflammation of the stomach) and associated bleeding, cancers of the liver and the oesophagus, hypertension (high blood pressure) and psychiatric problems such as depression. Up to 35% of all accident and emergency attendances and ambulance calls are estimated to be alcohol related.

The North West Public Health Observatory (NWPHO) has recently published a range of indicators measuring the impact of alcohol on health. The NWPHO has assessed the number of deaths and admissions from a broad range of alcohol related conditions including conditions directly caused by alcohol as well as estimating the proportion of other conditions where alcohol is likely to be a contributing cause. According to the NWPHO alcohol consumption contributes to 12 months of life lost in men in Brent and four and a half months of life lost in females. There were 320 alcohol related deaths in Brent between 2002 and 2004, 203 in men and 117 in women. There were also 1438 alcohol related admissions in Brent at a rate of 734 and 354 per 100,000 in men and women respectively.

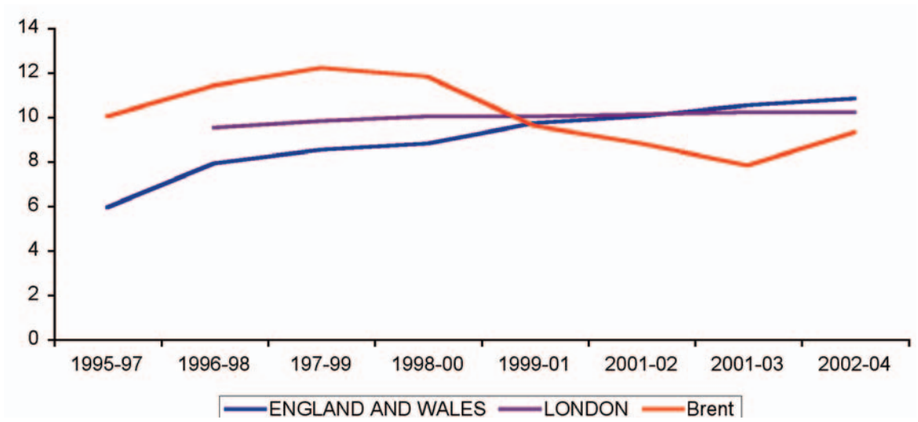
Table 17: Indicators of Alcohol Related Harm

	Brent			London			England		
	M	F	P	M	F	P	M	F	P
Months of Life Lost	12	4.45		9.7	4.7		9.55	5.14	
Chronic Liver disease SMR 02-04	114	84		118	89		100	100	
Alcohol related Hospital Admissions 04-05 per 100,000	734	351		795	406		826	461	
Alcohol specific Hospital Admissions 04-05 per 100,000	286.7	75		304	110		305.8	144	
Alcohol attributable crime per 100,000			16.58			8.77			10.45

Source: North West Public Health Observatory (August 2006)

Mortality from chronic liver disease and cirrhosis in Brent has fluctuated with no clear trend as shown in figure 36 below. Mortality rates were higher than both London and England and Wales up until 1999-01 but are now lower. Mortality has doubled in England and Wales in recent years increasing from 5.9 to 10.8 per 100,000 between 1995-97 and 2002-04 as shown in figure 36 below. Mortality rates in London have increased more gradually.

Figure 36: Mortality from Liver Disease and Cirrhosis, 1995-7 to 2002-04



Source: National Centre for Health Outcomes Development (NCHOD)

Alcohol consumption is not the only cause of liver cirrhosis. Cirrhosis can be present at birth as an inherited disease, it can be a rare side effect of certain medications and it can be caused by parasitic infections. However, sustained alcohol misuse is the most common causes along with the late effects of infection with hepatitis B or C. The Chief Medical Officer in his 2001 Annual Public Health Report stated that the most convincing explanation for the increase in death rates from chronic liver disease and liver cirrhosis reported here is the rise in alcohol consumption that took place in the 1970s and which has subsequently been sustained.[44]

44 Chief Medical Officer: Annual Report of the Chief Medical Officer 2001, Department of Health, 2001

Smoking, Drugs and Alcohol

National data on alcohol dependence is available from an ONS survey of psychiatric morbidity among 10,000 adults aged 16 to 74 living in private households in Great Britain in 2000 [45]. Alcohol dependence was assessed using a self completion questionnaire and included items on loss of control, binge drinking and other behaviour likely to be symptomatic of dependence.

Seven per cent of adults were assessed as being dependent on alcohol. In nearly all cases, the level of dependence was assessed as mild: prevalence rates were 4 per 1,000 for moderate dependence, and 1 per 1,000 for severe dependence. Men were more likely to show signs of dependence than women and younger people were more likely to have signs of dependence than older groups.

Alcohol misuse is estimated to cost £7.3 billion in crime and anti-social behaviour each year. [46] Three fifths (61%) of the population now perceive alcohol-related crime as worsening. Each year around half (1.2 million) of all violent crimes and around one third (360,000) of all domestic violence incidents are linked to alcohol misuse.[47] The NWPHO estimate that there were 4439 crimes attributable to alcohol in Brent in 2005/06 at a rate of 16.58 per 100,000, nearly double the rate for London and 60% higher than for England. Two thirds of these crimes (3059) were violent crimes against people.

45 Office for National Statistics. Tobacco, alcohol and drug use and mental health. analysis of the ONS Survey of Psychiatric Morbidity among adults in Great Britain carried out in 2000 for the Department of Health, the Scottish Executive Health Department and the National Assembly for Wales. London: The Stationery Office, 2002. Available on the internet at: http://www.statistics.gov.uk/downloads/theme_health/Tobacco_etc_v2.pdf
46 Cabinet Office. Prime Minister's Strategy Unit. The Alcohol Harm Reduction Strategy for England. London: Cabinet Office, 2004. is available on the internet at: http://www.strategy.gov.uk/output/page3669.asp
47 Cabinet Office. Prime Minister's Strategy Unit. The Alcohol Harm Reduction Strategy for England. London: Cabinet Office, 2004. is available on the internet at: http://www.strategy.gov.uk/output/page3669.asp

Big Wins Identified in the 'Choosing Health' Delivery Plan

- **Placing information for the public on alcohol containers and in alcohol retail outlets**: providing clear and accessible information about sensible drinking, including reminders about responsible drinking on advertisements
- **Raising awareness**: national communications campaign to reduce binge drinking; providing information for the public in healthcare and non health care settings (for example retail outlets)
- **Local Authority enforcement**: for example checking retailers identity and refusing to sell alcohol to under 18s, and complying with codes of practice and legislation
- **Increase access to and effectiveness of alcohol treatment**: using the national audit of alcohol services and the Models of Care guidance to develop local services; training professionals to identify and target support at harmful and dependent drinkers; establishing referral protocols between primary care and secondary care healthcare settings and specialist healthcare settings.
- **Screening and brief interventions**: piloting interventions in primary care and A+E, identifying ways to reduce alcohol intake in high-risk groups, linked to similar initiatives within criminal justice settings
- **Planning local responses**: involving local authorities, PCTs, the police, licensing trade and other local statutory partners.

Drugs

Drug misuse has a detrimental impact on both physical and mental health. Health consequences include HIV and Hepatitis B and C transmission in injecting drug users and the mortality associated with accidental and intentional overdoses. It is also associated with crime, particularly acquisitive crime such as robbery and burglary. It can have a further impact on communities through antisocial behaviour, stimulating fear of crime, intimidation by drug dealers and discarded needles.

Tackling illicit drug use is a key priority for the Mayor of London and is a principal concern for the Department of Health and the Home Office. The government published a national strategy in 1998 which was updated in 2002 and backed by earmarked funding and public service agreement targets.

Smoking, Drugs and Alcohol

The Audit Commission reported that funding for local drug partnerships grew to £537 million in England within a wider strategy for tackling all forms of substance misuse.

Estimates of the prevalence of injecting, opiate use and problem drug and crack-cocaine in London are available from a study by Hickman et al.[48] Overall, the study estimated that the prevalence of injecting drug use in those aged 15 to 44 years was 1.2 per cent in 12 London boroughs and 1.7 per cent in the eight inner London boroughs. The prevalence of problem opiate use was 2.1 per cent in London and the prevalence of problem drug use and crack or cocaine use was 3.4 per cent and 0.8 per cent respectively. The authors state that the estimates for crack/cocaine should be treated cautiously and perhaps as minimum estimates,

Table 18: Summary of estimates for opiate, crack/cocaine and problem drug use: 2000/01

Site	Total Population	Total Number of Injectors (95% CI)	Prevalence of Injecting Drug Use (95% CI)
12 London Boroughs*	1,361,267	16,782 (13,793 - 21,621)	1.20% (1.00% - 1.60%)
4 Outer London	476,411	2,099 (1,554 - 3,743)	0.40% (0.30% - 0.80%)
8 Inner London	884,856	14,684 (10,744 - 29,203)	1.70% (1.20% - 3.30%)

Table 19: Summary of estimates for opiate, crack/cocaine and problem drug use: 2000/01

Site	Total Population	Total Number of Injectors (95% CI)	Prevalence of Injecting Drug Use (95% CI)
		London (12 Boroughs*)	
Opiate	1,361,267	28,979 (22,368 - 43,022)	2.1% (1.6% - 3.2%)
Crack/Cocaine	1,361,267	11,033 (10,176 - 12,074)	0.8% (0.7% - 0.9%)
Problem	1,361,267	146,156 (35,326 - 64,705)	3.4% (2.6% - 4.8%)

**Boroughs of Brent, Camden, City of Westminster, Ealing, Hammersmith and Fulham, Harrow, Hounslow, Islington, Kensington and Chelsea, Lambeth, Lewisham, Southwark*

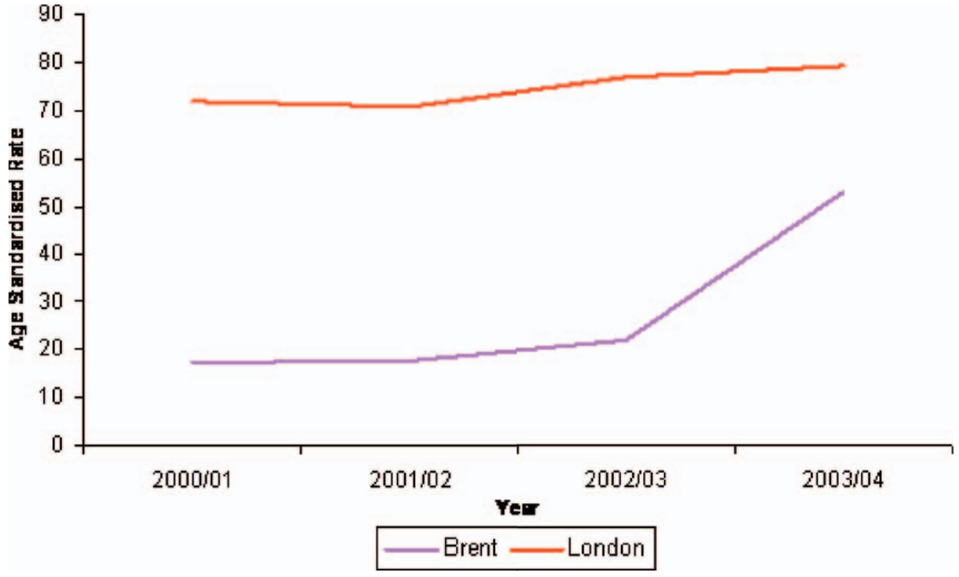
48 Hickman, M., Higgins, V., Hope, V., Bellis, M., Estimating prevalence of problem drug use: multiple methods in Brighton, Liverpool and London. Home Office

Drug related harm

The ambulance call out rate for drug overdose per 100,000 population in Brent rose slightly from 144 in 2001 to 155 in 2003. This reflects the figures for London which rose from 199 in 2001 to 209 in 2003. These figures include all overdoses with both legal and illegal drugs.

The number of hospital admissions in Brent due to drug poisoning in 2003/04 was 64 (age standardised rate 21.9, CI 16.4-27.4). Figure 37 shows the age standardised hospital admission rates for drug poisoning in Brent and London from 200/01 to 2003/04. The rate in London is on the increase. The lack of Brent data before 2001 makes it difficult to describe a definite trend though the rate for 2003/04 is considerably higher than that for 2001/2002.

Figure 37: Age Standardised Hospital Admission Rate Due to Drug Poisoning 2000/01-2003/04



Source: London Health Observatory

Smoking, Drugs and Alcohol

Hepatitis

The prevalence of Hepatitis B and Hepatitis C virus among injecting drug users is high. Amongst users recruited from specialist drug treatment agencies and community surveys in London (1998-2000) the prevalence was 27.8% and 46.7% for Hepatitis B and C respectively. Of the 884 individuals in drug treatment in Brent in 2005/06, 224 had had a hepatitis C test and 97 had had Hepatitis B vaccination. 112 individuals were offered Hepatitis B immunisation, of whom 90 accepted and 22 refused.

HIV

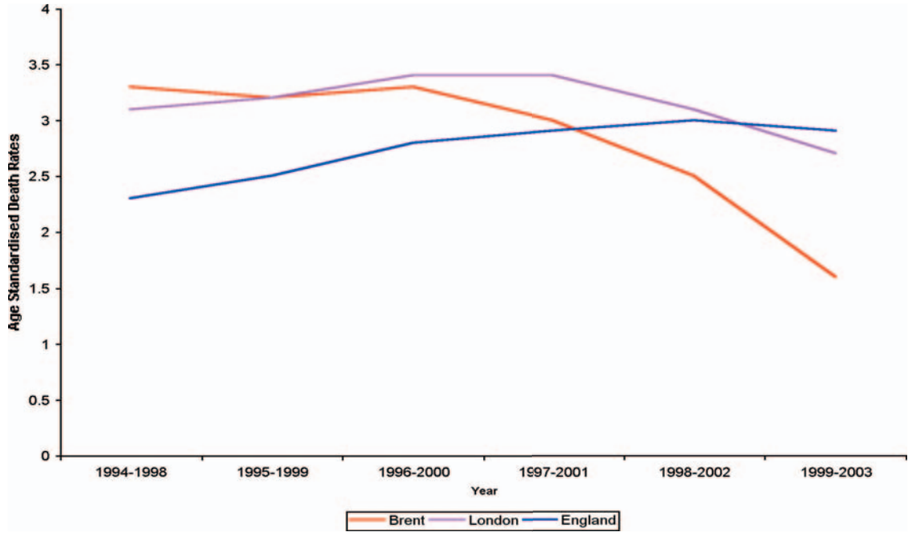
In London, the prevalence of HIV among injecting drug users recruited from specialist drug treatment agencies and community services in 1998 to 2000 was 3.2%. Of 665 people in Brent diagnosed with HIV infection, seen for HIV related care in 2004, there were 15 (2%) whose probable route of infection was injecting drug use. 3% of the 15,000 people with HIV reported to be receiving treatment in 2001 in London acquired the infection through injecting drug use.

Deaths: Overdose

Data on deaths due to drug misuse are collated by the ONS. Deaths due to drug misuse are defined as deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances are controlled under the Misuse of Drugs Act (1971). The underlying cause of death reflects the verdict of the coroner.

The number of drug misuse deaths in Brent declined by nearly 50% from 46 in 1994-1998 to 24 in 1999-2003. There was a statistically significant decline in age standardised drug misuse death rates between 6 time periods (1994-1998 through to 1999-2003) in Brent from 3.3 to 1.6. In London and England opiates are the most common substance mentioned on death certificates. Mentions of cocaine are higher in London compared to England.

Figure 38: Age Standardised Death Rates Due to Drug Misuse 1994-2003



Source: National Centre for Health Outcomes Development (NCHOD)

Drugs users in treatment

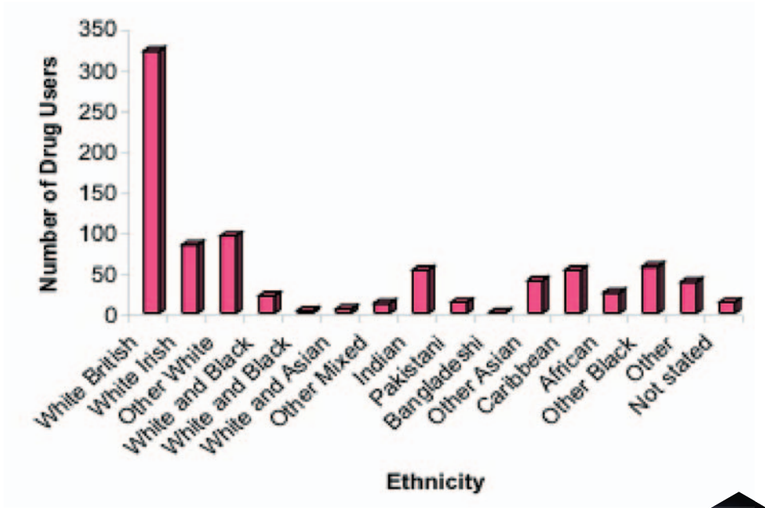
The National Drug Treatment Monitoring System (NDTMS) is the official method for measuring the number of people in contact with drug treatment services. Data from the NDTMS is published by the National Treatment Agency (NTA). There were 933 residents of Brent in treatment for drug use in 2005/06, an increase of 11% from 2004/05. There had been an increase of 16% in the number of drug users in treatment between 2003/04 (730) and 2004/05 (844). This is less than the increase in London (25%) and nationally.

The drug treatment rate is defined as the number of people in contact with drug treatment services per 100,000 of the population aged 15 to 44. The treatment rate in 2004/05 was 622.7 for Brent, 784.4 for London and 768.3 nationally. This may be because Brent residents are less likely to access treatment services than the average for London and nationally or it may be an indication that there are fewer drug users in Brent.

Smoking, Drugs and Alcohol

In 2004/05 the Brent Drug and Alcohol Action Team (based on the National Drug Treatment Demand Model) estimated that there were 1424 problematic drug users (PDU's) not in treatment in Brent. The majority of those in contact with services were male (76%) and from the white ethnic group (61%). The percentage of people that are Black and Asian is lower than expected given the percentage in the general population and may indicate that these groups are under-represented in treatment. The majority of users in contact with treatment services were in the 25 to 29 age category followed by the 30 to 34 and 35 to 39 age categories. The main presenting substance cited was heroin by the majority of Brent residents in treatment services which is the case for London in general.

Figure 39: Ethnicity of drug users in treatment in Brent



Source: Brent DAAT over 18 quarter 3 performance report 2005/06

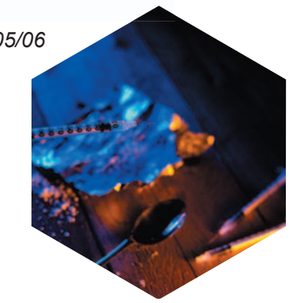
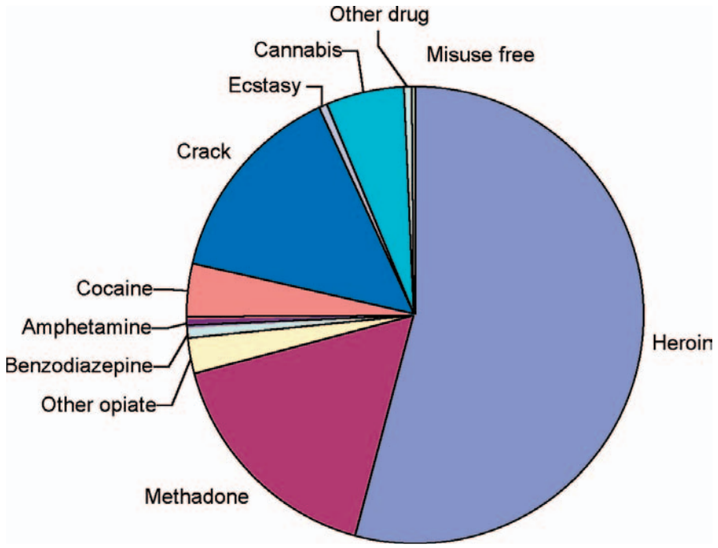


Figure 40: Age of drug users in treatment in Brent

Source: Brent DAAT over 18 quarter 3 performance report 2005/06

Figure 41: Main Presenting substance of people in treatment in Brent



Source: Brent DAAT over 18 quarter 3 performance report 2005/06

Smoking, Drugs and Alcohol

Drug treatment is more effective if a client stays in treatment for at least 12 weeks. For the NDTMS, the retention rate is calculated as the number of individuals who have been discharged from treatment who had been in treatment for more than 12 weeks, as a percentage of all individuals who had been discharged from treatment.

In 2005/06 the retention rate in Brent (60%) was higher than the rate for London (45%) and nationally (56%) and had increased since 2003/04. The Department of Health Public Service Agreement target requires services to "increase year on year the proportion of users successfully sustaining or completing treatment programs".

Drug related crime

In London there were more than 20,000 seizures of illegal drugs by Police Services in 2003. Arrest referral is a crime reduction initiative that seeks to identify drug users at the point of arrest, encourage them to address their drug problem and obtain appropriate treatment. It is offered to all arrestees by a custody officer as part of the booking in process. Dedicated drug workers contact arrestees who express interest in service. Demographic information on arrestees is collected for all contacts made.

Table 20 shows the number of assessments made in Brent and London between April 2003 and February 2004. It can be see that the majority of assessments were made for users of crack combined with heroin in Brent and London as a whole.

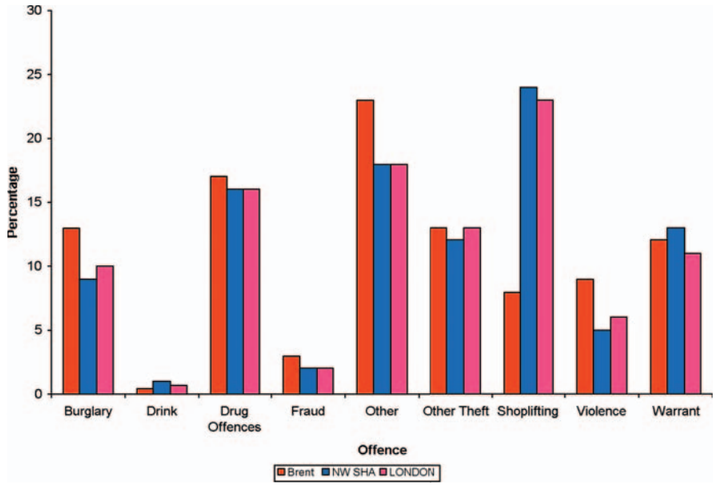
Table 20: Number of assessments between April 2003 and February 2004 by drug group in Brent and London

	Heroin only	Crack only	Heroin & Crack	Other
Brent	9	19	26	18
London	486	749	1853	943

Source: London Arrest Referral Monitoring Database (LARMD) Analysis by LHO

Figure 42 shows the number of assessments made between April 2003 and February 2004 by offence group and borough of report. The majority of arrest referral assessments for offences reported in Brent were in the "other offence" and "drug offences" group. In the North West London Strategic Health Authority shoplifting was the largest offence group followed by "other" and drug offences. This reflected the pattern for London as a whole.

Figure 42: Assessments between April 2003 and February 2004 by offence group and area of report



Source: London Arrest Referral Monitoring Database (LARMD) Analysis by LHO

Appendix 1: Glossary

Confidence Interval
The range of values within which we are 95% confident that the true population value lies.

Confidence Limits
The upper and lower values of a confidence interval.

Directly Age Standardised Rates
Standardisation adjusts rates to take into account any changes in the age structure of the population at risk and allows comparison over time and between different geographical locations. Rates have been standardised to the European Standard Population.

General Fertility Rate
Number of live births per 1,000 females of childbearing age (between the ages of 15 and 44 years).

Incidence
Rate of occurrence of new cases of disease (within a given population over a given time period)

Index of Multiple Deprivation Score
This is calculated by scoring different dimensions of deprivation – income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services. A higher score implies greater deprivation. (For more information see the website of the Office of the Deputy Prime Minister http://www.odpm.gov.uk)

Infant Mortality Rate
The number of deaths of infants under age 1 per 1,000 live births in a given year.

Life Expectancy
Life expectancy is an estimate of the number of years a new-born baby would survive if they were to experience the particular area age-specific mortality rates for that time period they were born in throughout their lives.

Locality
Area consisting of several electoral wards. There are five localities in Brent.

Low Birthweight
Any baby weighing less than 2,500 grammes at birth.

Standardised Admission Ratios (SARs)
Admission rates calculated to enable fair comparison with another area allowing for the difference in age composition of the population. Expressed as a ratio to the average value - in this case England and Wales whose SAR is set to 100. Values greater than 100 indicate higher than average mortality. Values less than 100 indicate lower than average admissions.

Standardised Mortality Ratio (SMR)
The Standardised Mortality Ratio (SMR) is the ratio of the actual number of deaths in a population to the number of deaths one would expect if the population had the same death rate as the standard population (multiplied by 100). The standard population has an SMR of 100. SMRs greater than 100 indicate that the death rate in the population of interest is higher than the death rate in the standard population. Standardisation acts to even out the differences between populations with different age structures. If death rates were not standardised a higher death rate in one population compared to another may simply be because the population with the higher rate has a greater proportion of elderly people within it. Age cannot be a reason for different death rates once standardisation has taken place.

Total Period Fertility Rate
The average number of live births that would occur per woman resident in the area, if women experienced the area's current age-specific fertility rates throughout their childbearing life span (namely at ages 15-44).

Ward
An administrative area that is laid down in statute. Brent has 21 wards.

Appendix 2: Key Facts and Figures

Data shown is for 2004 unless otherwise stated

	Factor	Brent	England	Ranking out of 303 PCTs
HEALTH AND DISABILITY	People with limiting long-term illness (2001 census)	15.6% 14099 people	17.93 %	87*
	People whose general health is 'not good' (2001 census)	8.64%	9.03%	168*
	People providing unpaid care (2001 census)	8.7% 22900 people	10%	19*
	Permanently sick or disabled ages 16-74 (2001 census)	4.72%	5.3%	168*
LIFESTYLE	Prevalence of smoking***	25.7%	25.8%	160
	Binge drinking***	10%	18.2%	5
	Obesity***	19.6%	22.1%	61
	Adult fruit & vegetable consumption***	33.8%	23.7%	4
	Child fruit & vegetable consumption***	52.3%	37.5%	11
PREVENTION SERVICES	Cervical screening (2004/05)25-64 years females	72.4%	80.6%	294
	Breast screening (2004/05) 53-94 year old females	55%	75%	288
	Whooping cough vaccine 24 month coverage (2004/5)	89.8%	92.6%	254
	Diphtheria and tetanus vaccine 24 month coverage (2004/05)	86%	94%	
	Mumps, measles and rubella vaccine, in under fives, (2004/05)	84.7%	88.6%	256
	Flu Vaccinations, over 65 year olds (2005/2006)	74.6%	75.3%	
	Number quitting smoking 4 weeks after smoking cessation programme, as a proportion of target (March 2005-March 2006)	90.4%		
	Number successfully quit (self report) per100,000 of population aged 16 and over	977	818	61
BIRTHS	Number of live births	4503	613028	
	General fertility rate 2004 (Live births per 1000 female population aged 15-44)	66.5	58.4	333**
	Total period fertility rate	1.95	1.79	268**
	% of live births under 2500 grams (2005)	8.8	7.9	241
	% of births under 1500 grams (2005)	1.8	1.5	254
	Infant mortality per 1000 (2005)	4.9	5.6	155
	Teenage pregnancy rate(2004)	53.4	41.5	
	Termination of pregnancies (2004)	2463	177691	
	Total Period Abortion Rates Maternal ages: 11-49 years 2004	1.16	0.54	297

	Factor	Brent	England	Ranking out of 303 PCTs
HIV/TB + DRUGS	People with HIV (2004)	665	58300	
	Tuberculosis notification rate (2005)	105.52 / 100,000	14.7 / 100,000	303
	Drug users in treatment (total numbers for 2005/2006, rates per 1000 for 2004/2005)	995 (622.7/1000 15-44 yrs)	181390 68.3/1000 15-44 yrs)	
LIFE EXPECTANCY	Male life expectancy (2002-2004)	76.6	76.45	205**
	Female life expectancy (2002-2004)	82.3	80.8	68**
	Male female differential	5.7	4.35	348**
MORTALITY	Deaths 2004	1636	480717	
	Mortality from all causes, age and sex standardised rate per 100,000, 2004	605.25	650.27	106
	SMR for all causes of death aged 15-64, (2002-2004)	101	100	170
	Years of life lost per 10,000, under 75 year olds (2002-2004)	442.5	494.8	92
	Cancer death rate for under 75s (2002-4)	109.28	121.60	60
	Circulatory death rate for under 75s (2002-4)	99.34	96.70	184
	Accidents mortality rate for ages 15-64 (2002-2004)	12.09	13.37	100
	SMR for Infectious diseases, all ages 2002-2004	93	100	144
	SMR for Liver Disease and Cirrhosis –all ages, 2002-2004	103	100	192

** Ranking is shown out of 376 local authorities in England and Wales*
*** Ranking is shown out of 354 local authorities in England and Wales*

In each case, rankings are given from good to bad. A high ranking for an indicator means that Brent is doing well compared to the rest of England, and a low rank means that Brent is worse than the rest of England. ie 1= best in England, 303= worst in England. A ranking against other PCT or local authorities is not available for all indicators.

**** The National Centre for Social Research (NCSR) has produced estimates of these important lifestyle choices based on the Household Survey of England, 2001.*

Brent NHS
Teaching Primary Care Trust

Contact us:

Brent tPCT

Postal address:

Trust Headquarters
116 Chaplin Road
Wembley
HA0 4UZ
Tel: 020 8795 6000

www.brentpct.nhs.uk