The Islington
Joint Strategic Needs Assessment

ISLINGTON

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Foreword

Welcome to the first Joint Strategic Needs Assessment (JSNA) for Islington. This report aims to inform the reader of the main health and wellbeing issues facing people in Islington. In doing so, it examines the underlying determinants of health and risk factors that shape and influence people's lives.

This report is the result of months of close working between Islington Borough Council and Islington PCT. The process of producing the JSNA has been as important as the product itself, forging partnerships and enabling sharing of information, building a solid foundation for future collaborative work. As a result, the JSNA is a powerful tool. It has the potential to inform the planning and commissioning of world class services that will improve the health and wellbeing outcomes of our community, and reduce unacceptable inequalities. The information contained within the JSNA will inform Islington's Sustainable Communities Strategy, in line with the key priorities of **reducing poverty, improving access and realising everyone's potential**, and will drive the vision for the PCT. The wealth of data and information available on the JSNA website will be invaluable in informing other strategies and plans across the borough.

JSNA is not a static event but an ongoing process that will improve over time as more data and information become available. JSNA provides an opportunity to engage with local people to help create an environment in which they feel empowered and active. Islington residents will be able to use the JSNA to influence and shape local services to meet their needs and expectations.

As our tools and methods become more sophisticated, we will become better at predicting future need so that we can achieve the following vision:

"In 2012 local people are healthier and live longer, living independently and participating in society. Local people know their voice is heard in how health services are provided. There are more services delivered closer to people's homes; the quality is higher and the standards more consistent; fewer practices provide a wider range of services; targeted and tailored services are provided to particular groups in the population and those with specific needs; and hospitals only do what they do best. All local people have easy access to services and make choices about their care."

This report summarises a vast amount of information. Each chapter is underpinned by more detailed information and recommendations which can be found at www.xxxxxxxx.

Our thanks to all those who have been involved in producing the JSNA from Islington Borough Council and Islington PCT, in particular the authors of the sections: Edwina Affie, Martin Baillie, Julie Billett, Renu Bindra, Marta Calonge Contreras, Marnie Caton, Ron Finch, Sinead Hayden, Clare Henderson, Sue Hogarth, Nourieh Hoveyda, Kanwal Kalim, Thanos Morphitis, Ruth Newton, Jonathan O'Sullivan, Ian Sandford, Rachel Scantlebury, Alistair Smith and Hitesh Tailor.

Priorities of the Islington Sustainable Communities Strategy and Local Area Agreement

- To reduce poverty through improving and maximising employment opportunities
- To raise educational standards
- To improve the environment and climate change
- To improve housing options
- To create safer communities
- To promote better mental and physical health

Signed:

LBI

Signed:

IPCT

Introduction to Islington

Islington is a small, densely populated, inner London borough with a growing, diverse population that is relatively young. Islington is home to a range of ethnic groups including Irish, Somali, Bengali, Turkish, Arabic, Albanian, Portuguese, Spanish, Nigerian and Ghanaian communities. Many residents were born outside the United Kingdom. The population is highly mobile and there is considerable annual churn.

Islington at a glance

- The borough covers 14.86 km^2
- There are 12, 291 persons per km
- The total population is 191,302, set to rise to 206,294 by 2020
- 56% of the population is aged 16 to 44
- The over 65s are projected to rise from 16,800 in 2008, to 19,200 by 2028
- The over 85s are projected to rise from 2,000 to 2,600 by 2028
- 74.5% of the population is white, 4.4% is black Caribbean, and 5.4% black African
- 32 % of residents were born outside the United Kingdom
- In 2005 there were 2,731 live births
- In 2005, there were 1,146 deaths

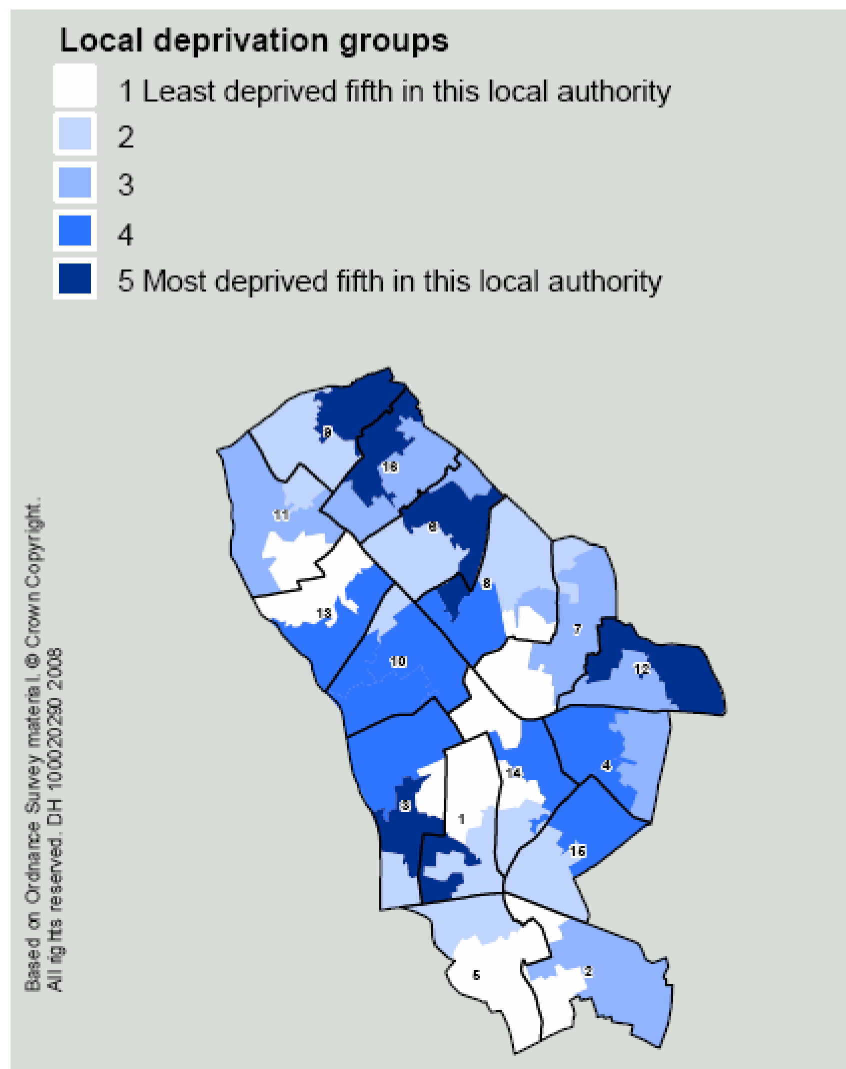
Socioeconomic profile

Islington is a borough of stark contrasts. There are high levels of deprivation, with associated long-term benefit dependency, worklessness, high levels of chronic ill health and premature mortality. The borough also contains areas of great wealth, leading to the common perception that the area is home to media celebrities and the resort of well-heeled shoppers and diners. In fact, Islington is:

- The eight most deprived local authority in England.
- The fourth most deprived local authority in London
- The borough with the second highest level of child poverty (52% of children live in poverty) in London.

The distribution of deprivation in Islington is complex and there is no clear geographical demarcation between deprived and more affluent areas. Figure A shows differences in deprivation between small areas within Islington, compared to the borough as a whole.

Figure A: Deprivation in Islington



Health and wellbeing in Islington

Life expectancy in Islington is increasing, but remains lower than for England as a whole. During the period 2004-06, life expectancy in Islington for men was 74.9 2004-06, compared to 77.3 for England as a whole. The life expectancy gap for

women is smaller: during the same period, life expectancy for women was 80 years compared to 81.55 years for England as a whole.

The main causes of death in Islington are cardiovascular disease (33%), cancer (29%) and respiratory and digestive diseases (17%). Key health, wellbeing and community indicators for Islington are shown in Figure B. Many of the indicators listed, in particular those relating to poverty and deprivation, educational attainment and crime are demonstrably worse than the English average. Likewise, many health and wellbeing outcomes are poor, in particular those related to cigarette smoking.

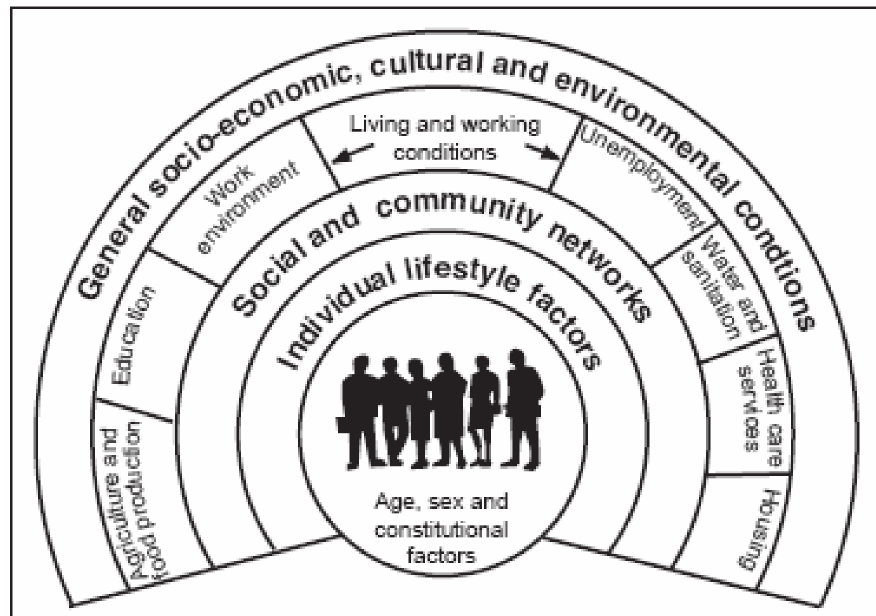
Figure B: Summary of the health and well being indicators for Islington

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	**1** Deprivation	120425	65.4	19.9	89.2		0.0
	2 Children in poverty *	15919	52.1	22.4	66.5		6.0
	3 Statutory homelessness			4.4	14.4		0.0
	4 GCSE achievement (5 A*-C) *	728	49.3	60.1	35.8		82.7
	5 Violent crime	6289	34.4	19.3	38.9		4.5
	6 Carbon emissions *	1226	7.0	7.6	20.6		4.6
Children's and young people's health	**7** Smoking in pregnancy	292	12.0	16.1	38.8		4.4
	8 Breast feeding initiation *	2104	87.8	69.2	33.2		90.9
	9 Physically active children *	16437	87.8	85.7	63.3		99.2
	10 Obese children *	160	10.1	9.9	16.1		4.9
	11 Children's tooth decay (at age 5)	n/a	1.4	1.5	3.2		0.4
	12 Teenage pregnancy (under 18) *	152	56.0	41.1	83.1		12.5
Adults' health and lifestyle	**13** Adults who smoke *	n/a	27.5	24.1	40.9		13.7
	14 Binge drinking adults	n/a	15.3	18.0	28.9		9.7
	15 Healthy eating adults	n/a	26.9	26.3	14.2		45.8
	16 Physically active adults	n/a	10.2	11.6	7.5		17.2
	17 Obese adults	n/a	16.0	23.6	31.2		11.9
Disease and poor health	**18** Under-15s 'not in good health'	543	17.8	11.6	20.8		6.4
	19 Incapacity benefits for mental illness *	6260	46.4	27.5	68.6		8.4
	20 Hospital stays related to alcohol *	696	423.1	260.3	741.1		87.6
	21 Drug misuse	4667	34.9	9.9	34.9		1.3
	22 People diagnosed with diabetes	6436	3.5	3.7	5.9		2.1
	23 Sexually transmitted infections						
	24 New cases of tuberculosis	90	48.0	15.0	102.0		0.0
	25 Hip fracture in over-65s	109	539.9	479.8	699.8		219.0
Life expectancy and causes of death	**26** Life expectancy - male *	n/a	74.9	77.3	73.0		83.1
	27 Life expectancy - female *	n/a	80.0	81.6	78.3		87.2
	28 Infant deaths	16	5.8	5.0	10.3		0.0
	29 Deaths from smoking	235	299.9	225.4	355.0		139.4
	30 Early deaths: heart disease & stroke *	160	123.3	84.2	142.4		39.7
	31 Early deaths: cancer *	185	141.1	117.1	167.8		76.7
	32 Road injuries and deaths *	91	49.2	56.3	194.6		20.8

Source: APHO 2008 Health Profiles

Many factors, such as employment, housing, education and the environment we live in directly influence health and wellbeing (Figure C). The JSNA provides a unique opportunity to bring together these many determinants of health.

Figure C: Determinants of health and wellbeing



Source: Dahlgren G and Whitehead M. Health Inequalities, London HMSO 1998

JSNA: part one

Health and Wellbeing **in Islington**

1. CARDIOVASCULAR DISEASE

1.1. INTRODUCTION

Cardiovascular disease (CVD) includes diseases such as coronary heart disease (CHD), stroke, heart failure and some other less common diseases. CVD is the biggest killer in Islington – in 2006, 118 men (67 aged less than 75) and 69 women (20 aged less than 75) died from coronary heart disease, and 48 men (20 aged less than 75) and 42 women (6 aged less than 75) died from stroke. Most deaths from CVD under the age of 75 are preventable.

Lifestyle factors such as smoking, unhealthy diet and lack of physical activity are major risk factors for CVD. Smoking, high blood pressure and raised cholesterol account for 80% of all cases of premature CHD.

There is a national target to reduce the death rate from heart disease and stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between Spearhead areas and the population as a whole by 2010.

1.2. CARDIOVASCULAR DISEASE IN ISLINGTON

The biggest contributor to premature CVD deaths in Islington is CHD (58%), followed by stroke (14%).

1.2.1. Cardiovascular disease mortality

Deaths from CVD are amongst the biggest contributors to the inequalities gap in life expectancy between Islington and England. CHD, other cardiovascular diseases (excluding stroke) and heart failure account for approximately 30% of the excess mortality for men and 20% for women.

Mortality for both CHD and stroke has been declining in Islington since 1993, and mortality rates from stroke are now similar to rates across England. CHD mortality in

men, however, remains particularly high, and although there has been a reduction in the inequalities gap for women, the gap for men has widened (Figure 2.1, 2.2).

Figure 2.1: Trends in CHD mortality, directly standardised rate, <75 years

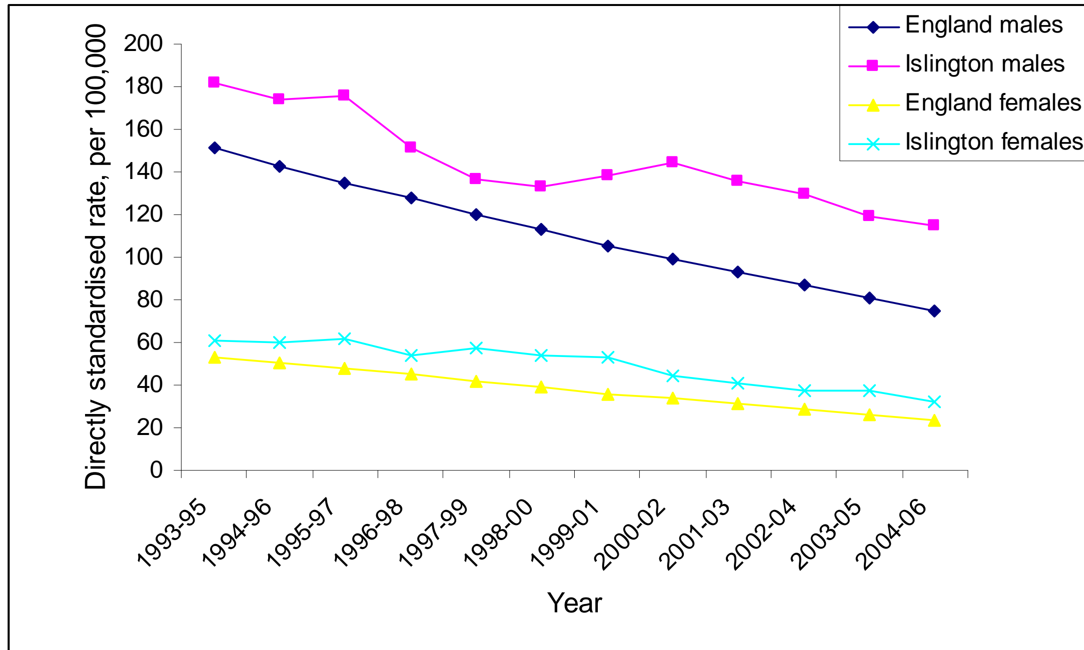


Figure 2.2: Progress towards the premature CVD mortality inequalities target in Islington

1.3. RISK FACTORS FOR CARDIOVASCULAR DISEASE

A number of demographic, genetic and lifestyle factors contribute to increased risk of CVD. Many of these risk factors are discussed in greater detail later in the JSNA.

1.3.1. Age and gender

Older people are at increased risk for CVD, with the risk higher for men than for women. Since routine CVD mortality data are adjusted for age and sex (standardisation), age and gender are unlikely to explain the high CVD mortality seen in Islington.

1.3.2. Ethnicity

Many black and minority ethnic groups are at a higher risk of CVD than the general population. People of South Asian and Irish descent are especially at risk of CHD, whilst black African and black Caribbean people have a higher risk of stroke. The largest ethnic groups in Islington are other White (mainly Turkish and Irish) and black Caribbean.

1.3.3. Deprivation

Islington is the eight most deprived borough in the country, and the fourth most deprived in London. High levels of deprivation are associated with higher mortality from all causes, including CVD.

1.3.4. Smoking

The relative risk of developing CHD in smokers is 1.58 for men (smoking 15 to 24 cigarettes per day) and 2.55 for women. It is estimated that approximately 27.5% of Islington resident adults smoke - approximately 43,533 adults aged over 16.

1.3.5. Healthy eating

Low consumption of fruit and vegetables is associated with a 1.16 relative risk of developing CHD. Only about 27% of adults in Islington consume five portions of fruit and vegetables per day.

1.3.6. Physical activity

The recommended level of physical activity for adults is 30 minutes of moderate intensity physical activity on five days per week. Low physical activity levels are associated with a 1.16 relative risk of CHD. Overall, physical activity levels in

Islington are higher than England overall, but are markedly lower for manual and non-white groups.

1.3.7. Obesity, high cholesterol and high blood pressure

These are all risk factors for CHD, increasing the relative risk by 1.3, 2.82 and 1.91 respectively.

1.4. PREVENTING AND MANAGING CVD IN ISLINGTON

Services and initiatives to address CVD in Islington are arranged as follows:

1.4.1. Health promotion

There are a number of health promotion activities around smoking prevention and cessation activities, healthy eating and physical activity, safe and sensible drinking, and promoting good mental health.

1.4.2. Primary prevention

NICE offers best practice advice on the care of adults at high risk of developing CVD or with established CVD. Primary prevention strategies in Islington include promotion of a healthy lifestyle, identification of those at high risk, and appropriate use of medicines such as antihypertensives, aspirin, and statins.

1.4.3. Secondary prevention

Secondary prevention refers to interventions to prevent recurrent cardiac morbidity and mortality and to improve quality of life in people in people with CVD. Secondary prevention activities in Islington are focussed on health promotion, cardiac rehabilitation services, appropriate medical treatment and access to revascularisation.

1.4.4. Early diagnosis

In Islington, early diagnosis of CVD is encouraged through case finding in primary care. A CVD case finding pilot is also being carried out in community pharmacies. The UK National Screening Committee has recommended the introduction of the vascular risk assessment programme for those aged 40-74, as well as implementation of abdominal aortic aneurysm screening targeting 65 year old men.

1.4.5. Services

The management of those with established CVD spans the spectrum from primary care through to tertiary care, with services also provided in the community.

1.5. RECOMMENDATIONS

Reducing CVD is a priority area for Islington. Risk factor reduction should be routinely embedded across all resource allocation decisions, workforce development and training, contracts, policies, and performance management initiatives. Recommendations to achieve this include:

- Influencing partnerships: to make health promotion an explicit part of all policies across the PCT, Council and community with an emphasis on reducing deprivation, smoking cessation, healthy eating and physical activity
- Working with primary care to improve the completeness and quality of disease registers, improve risk registers, ensure optimal control of hypertension and cholesterol, and to routinely audit all premature CVD deaths at practice level
- Improving commissioning for quality with an emphasis on health-promoting hospitals and cardiac rehabilitation
- Redesigning services with the aim of better integrating primary and secondary care provision
- Improving health information to support equity audit, modelling and programme budgeting.

2. CANCER

2.1. INTRODUCTION

The incidence of cancer and premature mortality from cancer are higher in Islington compared to the rest of England. Although death rates are reducing, this reduction is not occurring quickly enough. The Government has set national health inequalities targets to reduce mortality rates by 2010 from cancer by at least 20% in people under 75 years of age, with a reduction in the inequalities gap of at least 6% between Spearhead Local Authorities and the population as a whole. Islington is unlikely to reach this target.

Participation in national screening programmes reduces mortality from certain cancers. Islington residents are currently not taking full advantage of the opportunity afforded by cancer screening; uptake and coverage are low compared to other local authorities and there are social inequalities in uptake.

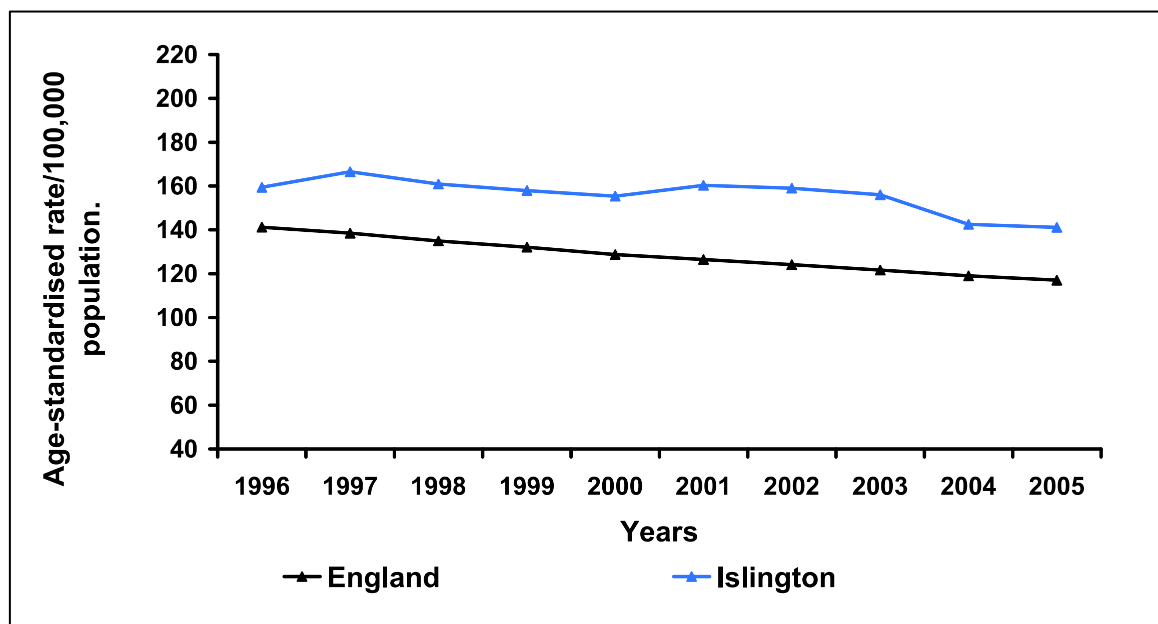
2.2. CANCER IN ISLINGTON

2.2.1. Premature mortality

Premature mortality from cancer is 20% higher in Islington than the England average (27% higher in men and 13% higher in women). In 2005, 185 people died prematurely from cancer in Islington compared to 165 premature deaths from heart disease and stroke. Many of these premature deaths were potentially preventable.

Within the London Spearhead Group of local authorities, inequalities in cancer mortality in Greenwich, Haringey and Islington are projected to increase by 2010 if current trends continue. In Islington, the gap will have more than doubled (Figure 2.1).

Figure 2.1 Trend in premature mortality from cancer (1996 – 2005)



Source: APHO and Department of Health

Premature mortality from cancer can be reduced through population based screening programmes. Currently, three national cancer screening programmes are offered to eligible populations in Islington: the breast (NHSBSP), cervical (NHSCSP) and colorectal (NHSCRSP) cancer screening programmes, that all aim to detect early stage cancer or pre-malignant disease. Effective treatment at an earlier stage greatly improves prognosis and reduces the risk of premature mortality from cancer.

2.2.2. Breast cancer

Breast cancer is the commonest cancer in the United Kingdom, the commonest cancer in women and accounts for almost one third of all cancer cases. In London, 4,235 people were diagnosed with breast cancer in 2005 and 1,185 people died from the disease. In Islington, this equated to about 72 new cases of breast cancer and 31 deaths in 2007.

Late diagnosis of breast cancer is a significant factor in why breast cancer survival in England lags behind other European countries. Late diagnosis is linked to low uptake of screening and low awareness of breast cancer symptoms. In Islington, uptake and coverage for breast screening programmes is low, at around 60%.

2.2.3. Cervical cancer

Cervical cancer is the second most common cancer in women worldwide. In London between 2000 and 2004, 1,443 women were diagnosed with cervical cancer and around 600 died from their disease. In Islington, there were eight new cases of cervical cancer and four deaths in 2006.

The main cause of cervical cancer is infection with high-risk types of human papillomavirus (HPV). This has obvious implications for primary prevention (vaccination) and secondary prevention (screening) of this disease. Precancerous changes or very early stage disease are usually asymptomatic and can be detected on a cervical smear. Improving screening coverage, especially in the 25 – 35 year old age group where participation in screening programmes has been declining in recent years, offers great opportunity to reduce mortality. For 2006/07 cervical screening coverage in Islington was 73%, considerably lower than the national target of 80%.

2.2.4. Colorectal cancer

Colorectal (bowel) cancer is the second most common cause of cancer death in the United Kingdom, accounting for 10% of all cancer deaths. In London, approximately 1,820 new cases of colorectal cancer were diagnosed in 2004, and 907 people died from the disease. In Islington, there were 80 new cases of bowel cancer and 34 deaths in 2007. Late diagnosis is significant: currently 20% of patients first present at A&E departments after experiencing mild symptoms for weeks or months. About 55% of patients are not diagnosed until the disease has spread to lymph nodes or elsewhere. Overall, 5-year survival is only around 50%, but only 7% for those presenting with lymph node disease. Diagnosing bowel cancer early through population screening is likely to greatly improve these poor health outcomes.

In 2007, the bowel screening programme was rolled out across Islington. Uptake is currently lower than the 60% national expected figure, at just under 40% of the eligible population who have been sent test kits. In 2006, the number of screen detected bowel cancers in Islington was 13 out of 76. If the 60% bowel screening coverage could be achieved and assuming incidence remained unchanged, the proportion of screen detected cancers, and hence earlier stage cancers, would almost double.

Table 2.1 summarises the comparative picture of breast, cervical, bowel cancer incidence, mortality, survival and trends compared to that for England and London as a whole.

Table 2.1 Breast, cervical, bowel cancer: comparative incidence, mortality, survival, and trends (2002 – 2004)

	Breast Cancer	Cervical Cancer	Colorectal Cancer
Incidence (ASR) per 100, 000 population (CIs 95%) for IPCT	95.77(82.93 to 108.60)	8.78 (5.17 to 12.39)	45.83 (39.49 to 52.16)
No of new cases of cancer per year	72	8	76
Is incidence significantly higher for IPCT than London average	No	No	No
Socioeconomic gradient in incidence	Higher in more affluent group – positive gradient	Higher in more deprived group – negative gradient	No gradient
Trend in incidence (1985 – 2004)	Decreasing	Decreasing	No change
No of deaths in Islington due to cancer	29 per annum	4 per annum	29 persons per annum
Mortality (ASR) per 100, 000 population (CIs 95%) for IPCT	27.81 (21.24 to 34.39)	2.69 (0.76 to 4.63)	16.55 (12.69 to 20.41)
Is mortality significantly higher for IPCT than London average	No	No	No
Socio-economic gradient in mortality	Higher in more deprived group – negative gradient	Higher in more deprived group – negative gradient	For rectal cancer, males higher in more deprived group – negative gradient
Trend in mortality (1993 – 2006)	Decreasing	No change	Decreasing
5 year survival (North London Cancer Network) (CIs 95%)	78.3% (72.9 to 83.7)	67.0% (49.6 to 84.4)	43.0% (4.5 to 51.6)
Socio-economic gradient in 5 year survival	Lower in more deprived group – negative gradient	Lower in more deprived group – negative gradient	For rectal cancer, lower in more deprived group for males and females – negative gradient

Source: Thames Cancer Registry, The Information Centre for Health and Social Care

2.3. CANCER SCREENING IN ISLINGTON

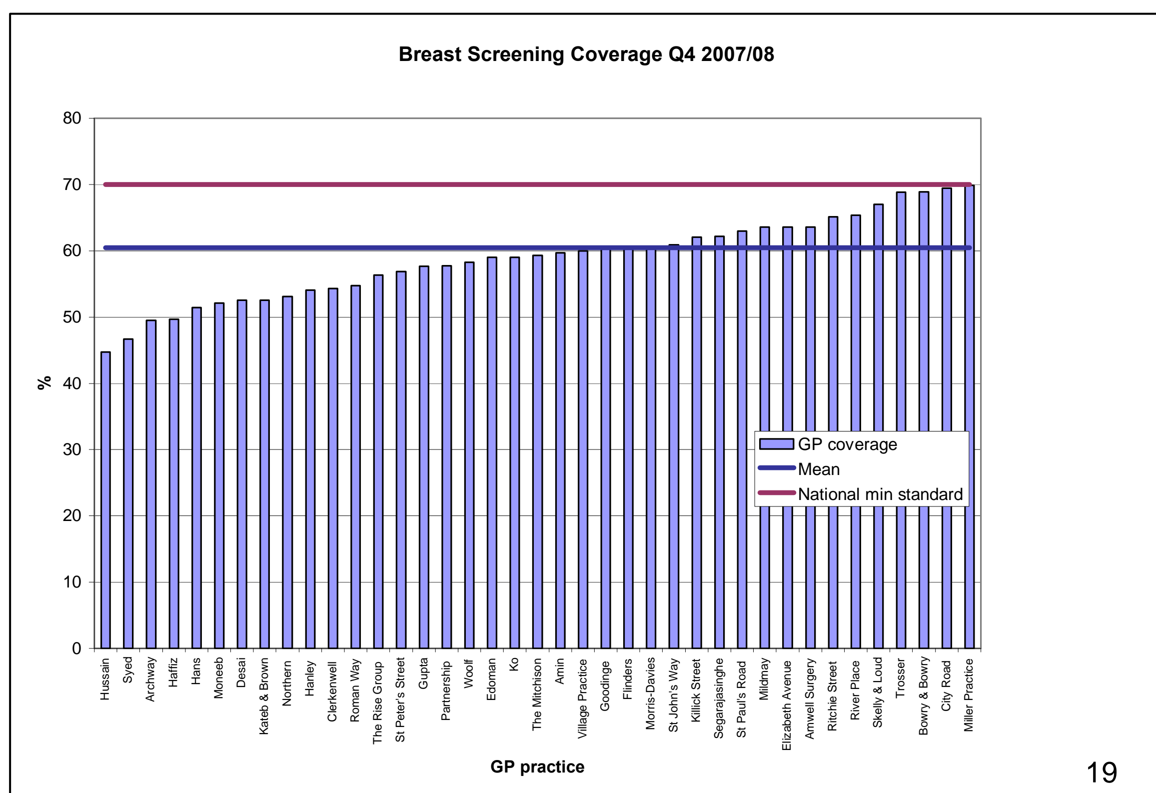
2.3.1. The NHS Breast Screening Programme

There are six breast screening programmes operating in London. London PCTs commission breast screening services from the programmes via a consortium approach (Camden, Islington, City & Hackney, Newham, Waltham Forest, Tower Hamlets PCTs) with a lead commissioning PCT (Tower Hamlets) overseeing the development of the service specification, service level agreement and procurement with Central and East London Breast Screening Service (CELBSS), the provider of breast screening services to Islington residents.

Women aged 50 to 70 are routinely invited for screening every three years. The programme will be extended to include women aged 47 to 73 from 2008. Basic screening by mammography can take place either at a static breast screening unit (St Bartholomew's Hospital) or on a mobile breast screening unit (currently at the Whittington Hospital). CELBSS currently provides services through mobile analogue vans that are located in suitable locations in each borough. Digital mammography will be introduced as the screening test by 2010.

The breast screening programme in Islington achieved 59.9% coverage in 2006/07, ranking it 22nd in London. Screening uptake varies by GP (Figure 2.2).

Figure 2.2 Breast Screening Coverage by Islington GP Practice 2007/08



2.3.2. The NHS Cervical Screening Programme

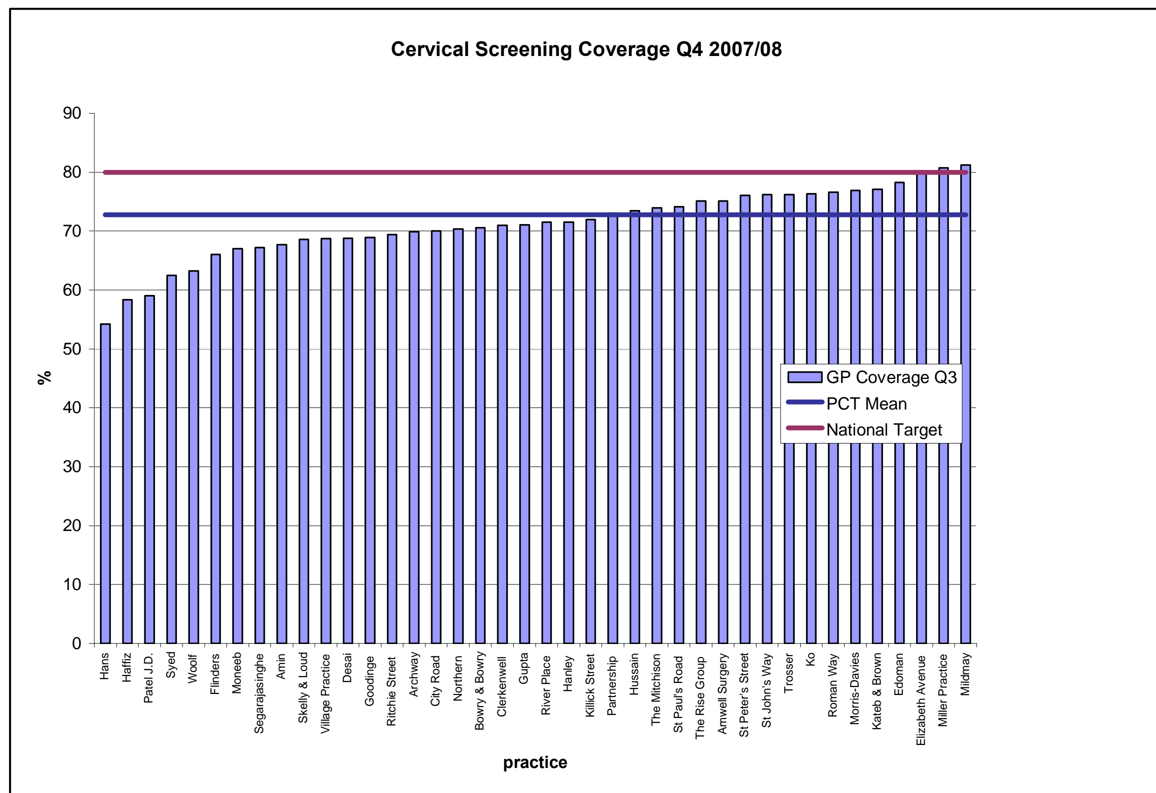
The PCT oversees the commissioning of the following services which make up the cervical screening care pathway:

- Call/recall programme, provided by Islington PCT
- The screening test: sample taking is provided by 37 GP practices in Islington, three family planning/sexual health clinics, and ten genitourinary medicine clinics. The family planning and genitourinary services are provided by Camden PCT
- Cytopathology/histopathology services report cervical smears and biopsy results
- Colposcopy services are provided by the Whittington Hospital, UCLH and the Royal Free Hospital

Women aged 25 to 49 years are screened at three yearly intervals and those aged 50 to 64 at five yearly intervals. The invitation system is delivered through the call/recall services. A GP or nurse at a primary care or community clinic usually carries out the liquid based cytology (LBC) smear. Women with negative tests are invited for re-screening at the standard three to five year interval, while those with borderline or mildly dyskaryotic smears are monitored at a reduced screening interval.

The cervical screening programme in Islington achieved 73.7% coverage in 2006/07, ranking it 16th highest in London. Screening uptake varies by GP (Figure 2.3).

Figure 2.3 Cervical Screening Coverage by Islington GP Practice 2007/08



2.3.3. The NHS Bowel Cancer Screening Programme

The NHS Bowel Cancer Screening Programme is commissioned and organised at national level. It comprises five programme hubs and 90-100 local screening centres, each serving populations of up to two million people. One week after initial invitation letters, men and women aged 60 to 69 years of age are sent a faecal occult blood test (FOBt) kit through the post. Call/recall is delivered by the programme hub, which for London is at Northwick Park Hospital.

As of June 2008, 36% of the eligible Islington population had been screened for bowel cancer, the ninth lowest recorded uptake in London.

2.4. RECOMMENDATIONS

We envisage that, by 2020, Islington residents will be aware of the risks, causes and symptoms of common cancers so that they will adopt behaviours that minimise or

eliminate risks. Eligible women and men will be aware of cancer screening opportunities and will take advantage of these programmes. Any Islington resident will be able to contact screening services to make an appointment for screening at a place and time convenient to him or her at any screening unit in London.

To achieve this, efforts will concentrate on:

- Health promotion: using social marketing to improve awareness and increase participation in screening programmes, targeting outreach at communities with low participation in cancer screening
- Improving the quality of cancer screening services: by improved commissioning; improved access, appropriateness and acceptability; and by incentivising GPs to increase screening uptake
- Recommendations for improved outcome measures, audit methods and targets: there should be a focus on equity audit, improved data collection and linkage, and an improved evidence base including the use of social marketing.

3. MENTAL HEALTH

3.1. INTRODUCTION

Mental ill health has been described as the biggest social problem and single greatest cause of human misery in Britain today. Mental health problems are common and a major cause of disability, ill health and social exclusion, and worsen outcomes in a range of long-term conditions such as cardiovascular disease. Dementia is one of the main causes of disability in later life, particularly impacting on people's capacity for independent living, and increases as a cause of death from 1% of deaths at age 65 to 23% of deaths among women aged 85-89. There are effective and cost-effective preventive interventions and treatments for these conditions. Environmental, economic and social policies are important, including action to address stigma and discrimination and to promote social inclusion.

Positive mental health is important in protecting against mental health problems and can also protect against physical health problems. Positive mental health skills such as resilience, coping, a sense of optimism for the future and good self-esteem can be developed and supported to help people to flourish and realise their potential as well as to cope with adversity and difficulties in life. The benefits of promotion, prevention and early intervention in mental health are not restricted to health gains, but extend far into economic, social and quality of life outcomes.

3.2. MENTAL HEALTH IN ISLINGTON

Estimated numbers of people in Islington experiencing mental health problems are shown in Table 3.1. The estimates for child and adolescent mental health problems, anxiety and depressive and psychotic disorders in adults and dementia in older adults are based on national prevalence studies, adjusted for local deprivation levels. In all cases, the estimates are the number of cases in any given week during 2008, and in a full year would be higher.

Table 3.1: Summary of estimated and recorded levels of mental health problems in the community, Islington 2008

	Male	Female	Persons	Crude prevalence per 1,000
Child and adolescent mental health disorders - estimate	1902	1282	3184	130.9
Any neurotic disorder - estimate	12080	16104	28184	182.1
Any psychotic disorder - estimate	806	678	1484	9.6
Serious mental illness, diagnosed – general practice registers*	1542	1276	2818	13.9
Dementia (65+) - estimate	394	739	1133	69.2
Dementia, diagnosed – general practice registers – all ages (65+ only)*	279 (244)	498 (475)	768 (719)	3.1 (42.9)
Suicide and undetermined injury**	15	10	25	0.14***

*2007/8
** 2006
*** Directly age-standardised rate per 1,000

The estimates show just under 3,200 children and young people aged 5 to17 would be expected to have a mental health disorder, equivalent to a crude prevalence rate of 130.9 per 1,000. This is approximately 36% more than the national average.

3.2.1. The prison population

The figures in Table 3.1 do not include Islington's prisons. There are significantly higher levels of mental health need among prisoners than among the general population. The high turnover of prisoners locally presents significant challenges to the initiation and continuity of treatment and care for mental health conditions, both within prisons and on release back into the community. Table 3.2 estimates the prevalence of prisoners with any mental health condition in Holloway and Pentonville on any given day in 2008. It is based on a national psychiatric morbidity survey of prisoners carried out in 1998 and it should be noted that the prison population in terms both of size and composition has changed considerably over the last decade.

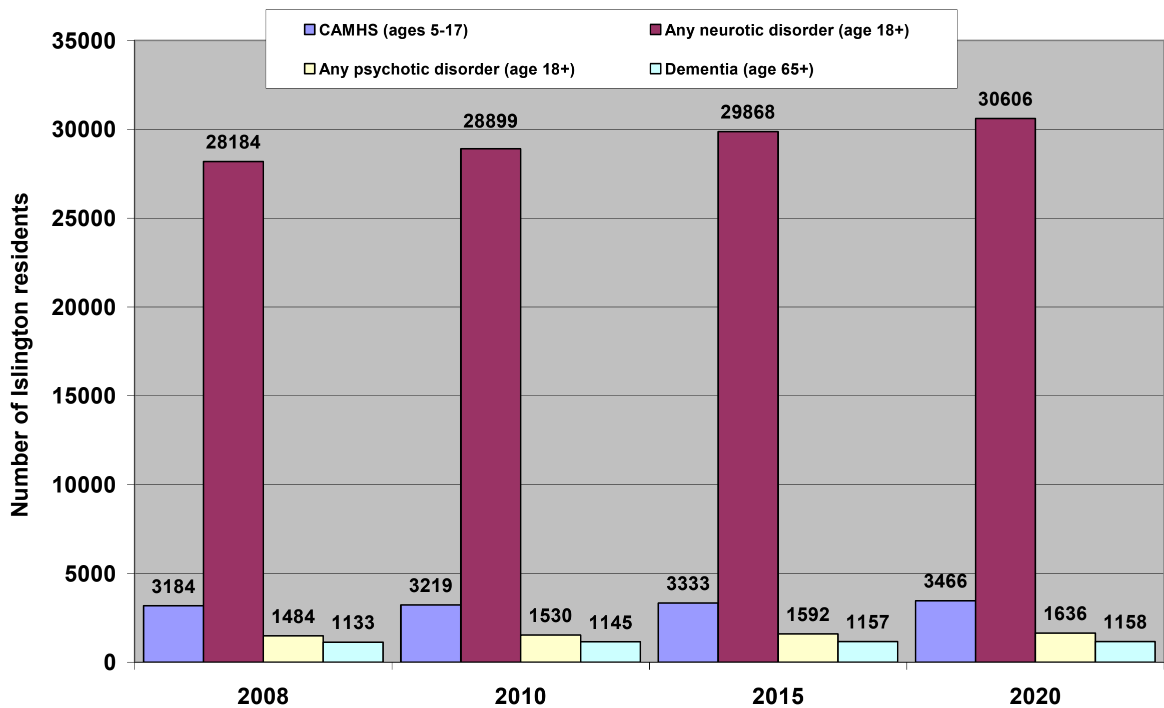
Table 3.2. Prevalence and number of prisoners with any mental health condition, Holloway and Pentonville

	Pentonville		Holloway	
	Estimated number	**Crude prevalence per 1,000**	**Estimated number**	**Crude prevalence per 1,000**
Personality disorder	781	713.2	232	500.0
Any neurotic disorder	547	499.5	311	670.3
Functional psychosis	94	85.8	65	140.1

3.2.2. Projected need

Overall, the number of children and young people with mental health disorders is expected to increase from 3,184 in 2008 to 3,466 in 2020. Depressive and anxiety disorders in adults are also expected to increase over the same period, by 8.6% from 28,184 to 30,606, and psychotic disorders by 10.2% from 1,484 to 1,636. The local demographic profile of older people means that Islington is unlikely to experience the same significant increase in dementia as expected nationally over the next decade. Estimates suggest that there will be a small net increase in dementia of 2.2%, from 1,133 cases to 1,158 in 2020. Within this overall estimate, the borough will, however, see a significant increase in dementia among residents aged 85 and over (Figure 3.1).

Figure 3.1. Projections of mental health need in Islington, to 2020

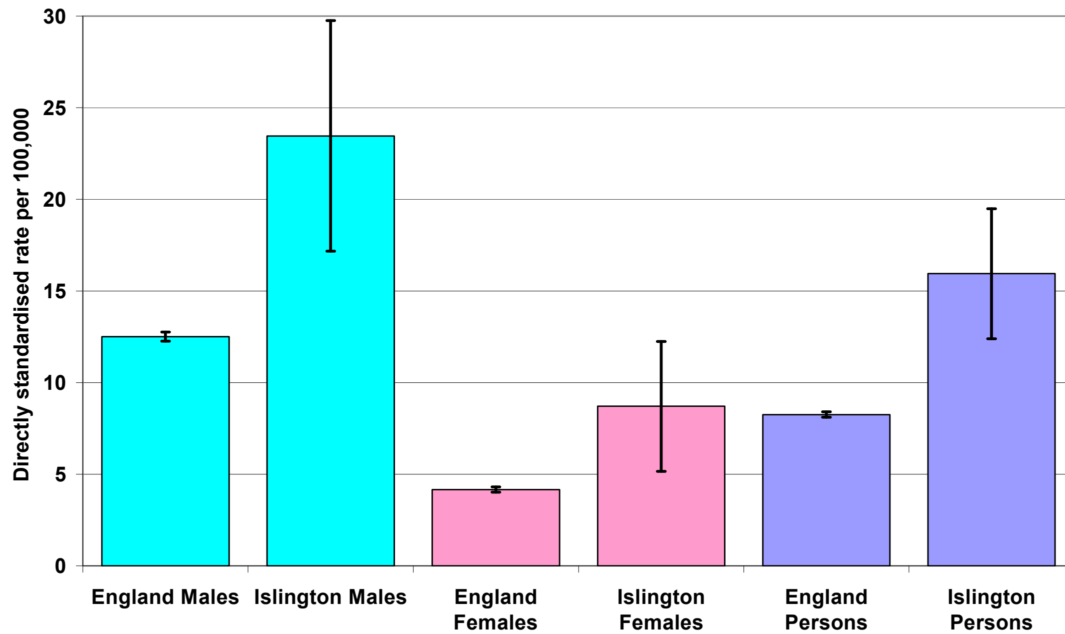


3.2.3. Suicide

The suicide rate in Islington increased through the 1990s but has remained broadly steady since then. In 2006, the local rate was 14.01 per 100,000. Figure 3.2 compares suicides and deaths due to undetermined injury between Islington and England for the three years 2004-6. Over the period, suicides and deaths due to undetermined injury in Islington were significantly higher than for the whole of England, with approximately twice the rate of suicides among both men and women compared with national rates.

Suicides In Islington are distributed across all adult age groups, and no one group or location accounts for the borough's comparatively high suicide rates. However, local audits (2000-04 and 2005-07) found that men and women from the Irish community are at increased risk of suicide compared to others in the borough.

Figure 3.2: Deaths due to suicide or undetermined injury, Directly standardised rate per 100,000, 95% confidence intervals, Islington and England, 2004-6.



3.3. MENTAL HEALTH SERVICES IN ISLINGTON

Assessment and benchmarking against key performance and quality indicators for mental health services shows that local mental health services perform strongly against national indicators. Islington's Mental Health NSF Local Implementation Team is rated among the ten strongest in the country.

For both children's and adult services, data show that local direct investment into mental health services is relatively high compared with national averages. In 2006/07, Islington PCT spent more on mental health and substance misuse than any other PCT in the country, with weighted per capita spend of £362.89, compared with a national average of £151.09. Benchmarking mental health service funding for older people shows that Islington invested £15.1 million in these services in 2006/7, with 34.5% funded through the local authority and the remainder through the PCT. This was equivalent to £446.39 per capita of the older adult population in 2006/7, compared with London and national averages of £253.5 and £251.20. Investment levels in older people's mental health services need to be treated with some caution due to difficulties or differences in disaggregating the costs of older people's mental health services within overall older people's budgets held by local authorities.

Table 3.3 shows mental health spend by selected areas of investment in Islington compared with the London and England averages in 2006/7. Clinical services, acute and crisis services, and in particular accommodation and services for mentally disordered offenders, were above average. Secure and high dependency provision, and community mental health teams and home support services were below average areas of reported spend. Although overall Islington has high spend on mental health services, investment in psychological therapies was below the London average, and investment in mental health promotion was just £0.10 per weighted capita.

Table 3.3: Above and below average investment levels, selected service areas, per capita weighted population of working age, 2006/7

Above Average

Service area	Islington	London	England
Clinical services	£33.1	£28.6	£25.9
Accommodation	£22.7	£16.3	£12.0
Acute and crisis services	£14.0	£12.5	£12.8
Day services	£6.2	£5.6	£4.8
Mentally disordered offenders	£6.1	£2.5	£1.6

Below Average

Service area	Islington	London average	England average
Secure and high dependency provision	£19.5	£24.3	£22.7
Community mental health teams	£17.1	£20.3	£18.5
Home support services	£0.3	£2.2	£3.1

3.4. RECOMMENDATIONS

The major features of an ideal mental health service model would emphasise mental health promotion, early intervention and promotion of social inclusion. Recommendations therefore include:

- Investing in early intervention and mental health promotion to create a shift to earlier diagnosis and better outcomes; universal and targeted to groups and life stages.
- A holistic approach to mental and physical health. Build positive mental health promotion and early diagnosis and treatment of mental health problems such as depression into the long-term management of long-term physical conditions. Develop a partnership-based wellbeing strategy for the physical health needs of people with mental health problems.
- Community-wide action and training to challenge stigma and discrimination and to build the skills and promote inclusion, knowledge and understanding of mental health problems into front-line services and amongst the public. Support recovery model within mental health services for people with serious mental illness.
- Building mental health promotion across local public policy, for example through health impact assessments.
- Establish a monitoring and performance matrix of metrics across the range of mental health promotion and services to improve baseline knowledge, assess progress and equity and monitor outcomes.

4. TUBERCULOSIS

4.1. INTRODUCTION

Tuberculosis (TB) is a notifiable, communicable disease caused by infection with Mycobacterium, and is endemic in many parts of the world. In the 1930s, TB was one of the leading causes of death in the United Kingdom. After falling steadily, the number of TB notifications in England and Wales has increased over the past 20 years from around 4,500 in 1988, to over 8,000 in 2007. The main underlying factor in this rise has been infection in people born outside the United Kingdom.

TB is curable with a full course of treatment. Resistance to first-line drug treatment is low in the United Kingdom and alternative drug treatment options are available. Good management of TB involves early diagnosis, rapid identification of the strain and completion of the course of treatment.

4.2. TB IN ISLINGTON

The incidence of TB is particularly high in London, with the capital accounting for 40% of notifications in England in 2007. Islington reflects the high annual incidence in the capital, with a crude rate of 51.4 per 100,000 population (95% CI 41.1 – 61.6, Table 4.1).

Table 4.1 Incidence of tuberculosis per 100,000 European Standard Population, 2006

	Rate per 100,000	95% CI Rate LL	95% CI Rate UL
England (2006)	15.7	15.3	16.0
London (2006)	45.4	43.9	47.6
Islington (2007)	53.0	42.5	63.6

4.3. TB SERVICES IN ISLINGTON

TB services in Islington include prevention, screening and treatment, and are provided in a number of ways.

4.3.1. Prevention

Neonatal BCG vaccination is routinely offered on a universal basis to all babies resident in Islington, in line with Department of Health guidance for areas with a high incidence of TB. In 2007/08, the PCT achieved coverage of 91.9% (2,528 vaccinations of 2,750 births). School Health Advisors offer BCG vaccination to all students in year 7 each year. Vaccination was given to 252 children aged 10-15 in 2007/08.

4.3.2. Screening

A mobile X-ray screening unit provides a targeted screening service to hostels, drug and alcohol service units and refugee centres within Islington. The Port Health Authority at Heathrow Airport directly notifies the PCT of new arrivals destined for Islington.

4.3.3. Treatment

TB treatment services are provided by one team at five hospital sites across the North Central London sector. Rationalisation of the service has enabled an increase in staff, and the development of a multi-disciplinary team to better support people with TB. All new patients are risk assessed for likely treatment compliance, followed by clinical judgement by nursing and medical professionals. Incentives to attend Directly Observed Therapy (DOT) are offered where appropriate.

4.3.4. Prisons

HMP Pentonville has a specialist TB nurse post funded by the Department of Health to improve the TB pathway at London prisons, and to provide direct clinical care.

4.4. RECOMMENDATIONS

There is good evidence on the prevention and treatment of TB. Recommendations arising from the North Central London TB Commissioning Group Annual Report for 2007 are:

- To improve quality of data collection
- To ensure early and prompt diagnosis:
    - Particularly in health care workers through Occupational Health
    - Raise awareness of TB in communities and primary and secondary health care to destigmatise the disease
    - Engage positively with service provider partners including Local Authorities, the Mobile X-ray Unit and others to improve the whole patient’s experience during the period of treatment
- To reduce transmission rates:
    - Detailed analysis by age, sex and ethnic group in collaboration with Local Authorities is needed to better understand how demographic changes impact on TB service provision
- To finalise development of the contact tracing database.

5. TEENAGE PREGNANCY

5.1. INTRODUCTION

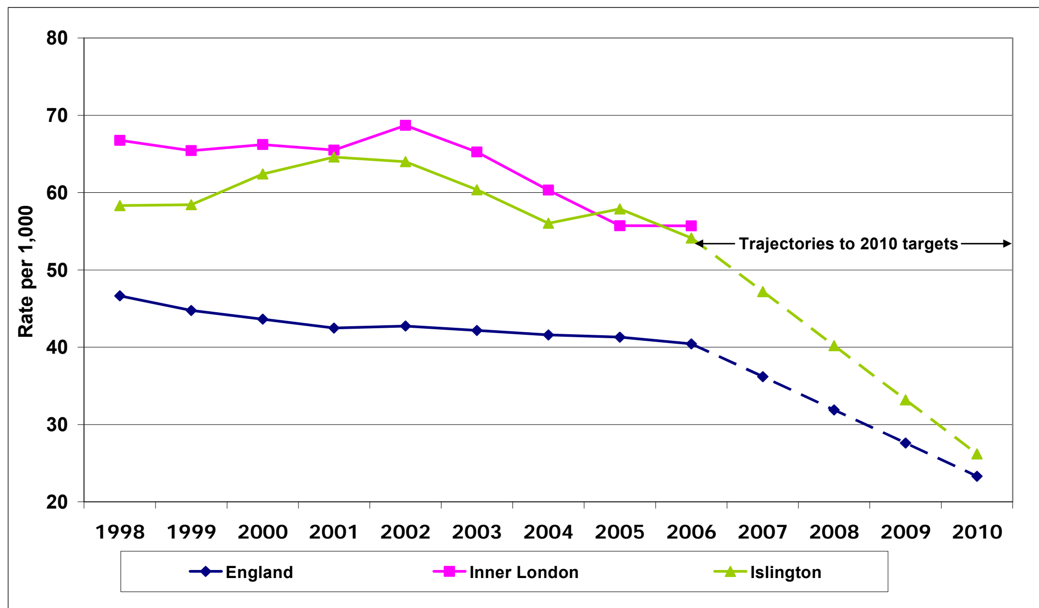
The United Kingdom has the highest rates of unintended teenage pregnancy in Western Europe. Social disadvantage and teenage pregnancy are strongly related, and are strongly associated with an inter-generational cycle of exclusion and poor outcomes. The children of teenage parents are more likely to experience a range of adverse health, social and economic outcomes and in turn to become teenage parents themselves.

The teenage pregnancy rate in Islington is higher than the national rate, but rates are decreasing.

5.2. TEENAGE PREGNANCY IN ISLINGTON

In 2006, there were 142 under 18 conceptions in Islington, equivalent to a rate of 54 per 1,000. This is higher than the national average. 59% of these conceptions ended in a termination, similar to the Inner London average, but higher than the national average of 45%. Conceptions under the age of 16 account for one third of all teenage pregnancies, and conceptions under 18 account for two thirds. Figure 5.1 shows progress in Islington on teenage pregnancy since 1998, compared with London, national and target reductions. Progress between 1998 and provisional data for 2006 showed a reduction of 7% against the baseline year, compared with a national reduction of 13%.

Figure 5.1: Under 18 conception rates in Islington compared with London and England with target trajectories, 1998-2010.



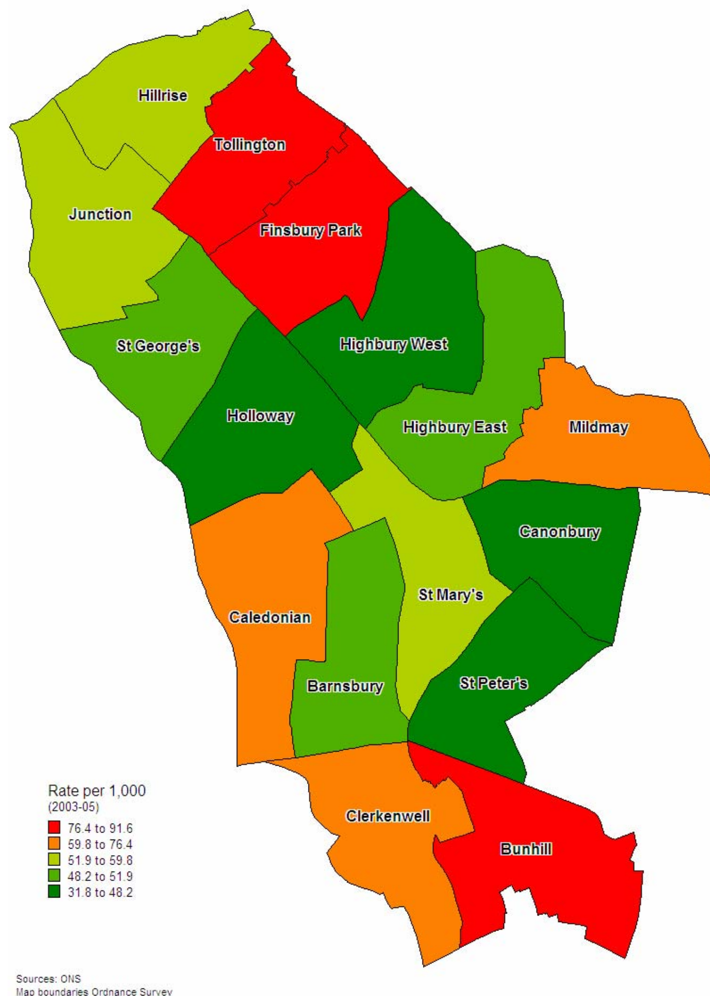
Source: ONS, 2008

5.3. RISK FACTORS FOR TEENAGE PREGNANCY

Key risk factors for teenage pregnancy include education related factors (low educational attainment, disengagement from school and leaving school aged 16 with no qualifications), risky behaviours (early onset of sexual activity, poor contraceptive use, mental health problems, alcohol and drug misuse) and family background (living in care, being the daughter of a teenage mother, ethnicity and lack of aspirations of parents).

In Islington, teenagers from white and black communities are at higher risk of becoming teenage mothers. Teenagers from Asian communities have the lowest risk when compared to other ethnic groups. Among wards with the highest teenage conception rates, teenagers living in and around Finsbury Park have the highest likelihood of teenage motherhood (Figure 5.2), whilst Bunhill has the highest rate of teenage pregnancies ending in terminations.

Figure 5.2: Under 18 conception rates in Islington wards, 2003-05



5.4. RECOMMENDATIONS

In 2005, the Teenage Pregnancy Unit and Government Office of London conducted a 'Deep Dive' analysis into areas performing well on teenage pregnancy rates and others that were not. The analysis identified important characteristics of areas that had experienced a significant reduction in teenage pregnancy compared with areas that were not performing well.

The important characteristics identified in areas with significant reductions included active engagement of all mainstream partners, a high priority given to PHSE in

schools, a strong focus on targeted interventions, youth services and young people's contraceptive and sexual health services, and the availability of sex and relationships education (SRE) training for professionals across partner organisations. A strong senior champion was also identified as being associated with success.

An assessment of progress in Islington against the national Teenage Pregnancy Strategy demonstrated good progress with the delivery of young people focused sexual health and contraceptive services, SRE in schools, and a well resourced youth service. More development and work was required on targeted work with vulnerable young people, workforce training, work with parents of teenagers, communication and data collection.

Based on this evidence, recommendations for further reducing teenage pregnancy in Islington include:

- Providing universal, targeted and specialist services: making teenage pregnancy a priority for all agencies working with children and young people , making access to education programmes and advice an entitlement for young people wherever they are accessing education, training and youth services, providing all professionals working with children and young people training on addressing sex and relationship issues
- Promoting contraception awareness and use; contraception awareness should be linked to high quality SRE and sex and relationships advice, in a variety of settings
- Monitoring and managing performance: the Children's Board should work to develop its partnership performance management arrangements to strengthen progress on teenage pregnancy. This should include incorporating teenage pregnancy strategy goals within the actions to address the needs of vulnerable groups and in improving the wider determinants of teenage pregnancy.

6. SEXUAL HEALTH

6.1. INTRODUCTION

Sexual Health is a state of physical, emotional, mental and social well-being in relation to sexuality. Sexual health is influenced by a complex web of factors ranging from sexual behaviour, attitudes and societal factors, to biological risk and genetic predisposition.

Sexual health in the United Kingdom has deteriorated significantly over the last 12 years, with large increases in many sexually transmitted infections (STIs). It is important that STIs are prevented or treated early to avoid long-term complications and ongoing transmission.

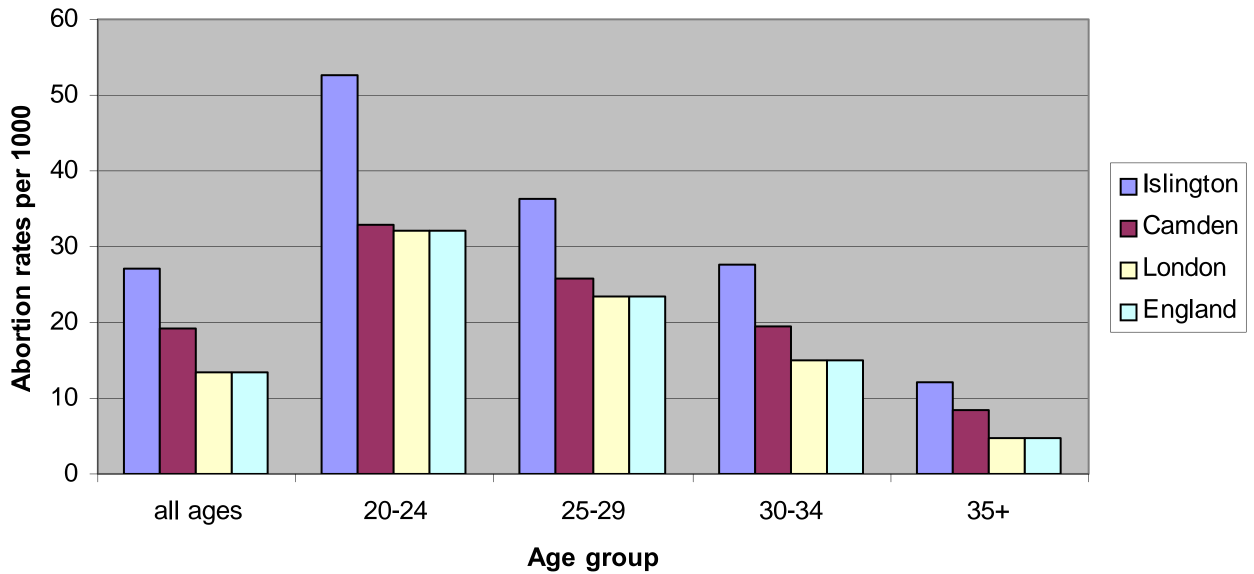
6.2. SEXUAL HEALTH IN ISLINGTON

Data on STIs are complicated by the fact that most are derived from Genitourinary Medicine (GUM) clinics, which provide services that are not restricted to place of residence. In addition, unknown numbers of people are diagnosed and treated in other settings, especially primary care. Consequently, much of the data in this section are provided on a sector-wide basis.

6.2.1. Termination of pregnancy

Termination rates in Islington are higher than those across London, with the highest abortion rate seen amongst women aged 20-24 (Figure 6.1).

Figure 6.1 Termination rates by age group



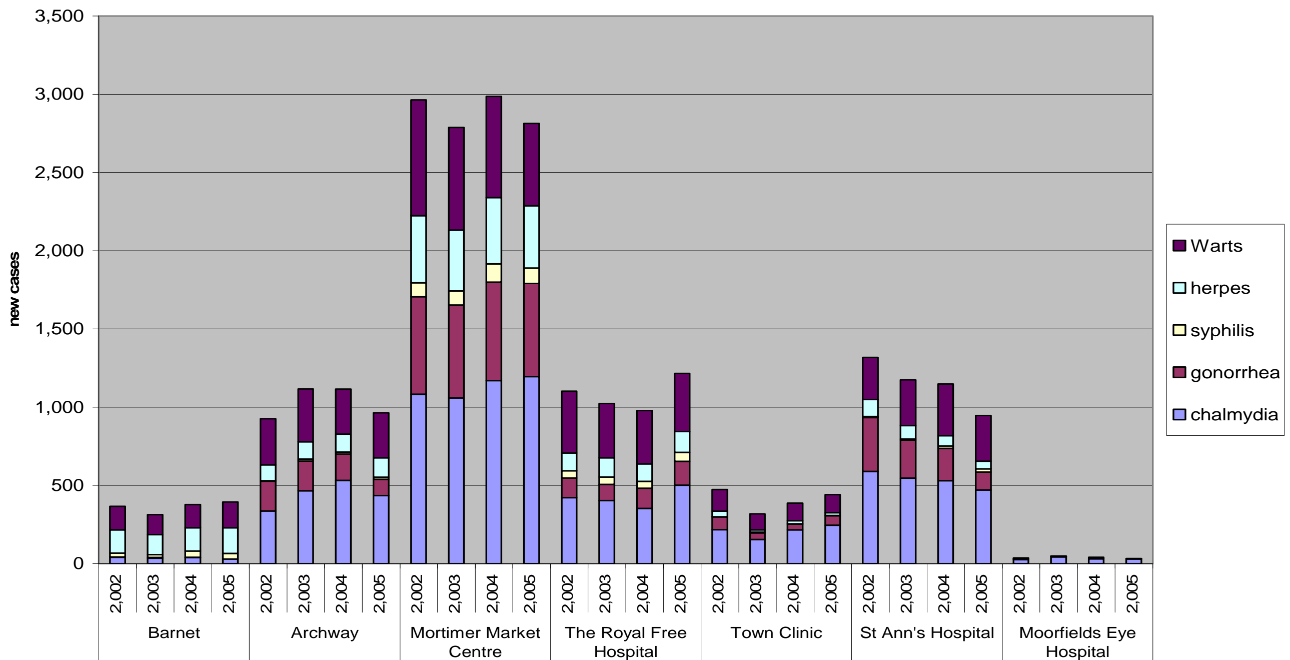
Source: ONS

Termination of pregnancy before 12 weeks is generally safer than if it is performed later in pregnancy. In Islington, 67% of terminations are carried out before 10 weeks, compared to a national target of 70%.

6.2.2. All STIs

Between 2002 and 2006, there was little change in the total number of newly diagnosed STIs seen in North Central London, with chlamydia accounting for 45%, genital warts 25%, and gonorrhoea 20% of all new diagnoses (Figure 6.2).

Figure 6.2: New cases of sexually transmitted infections seen at North Central London GUM clinics in age group 20 to 45+ years, 2002-2005



6.2.3. Gonorrhoea and Chlamydia

The total number of new diagnoses of gonorrhoea infections in North Central London fell between 2002 and 2006. The highest numbers of new diagnoses occurred amongst 25-34 year old men. Diagnoses of chlamydia, however, almost trebled during the period 1997-2006. This increase was probably partly due to increased transmission but also because of wider availability of diagnostic testing and improved sensitivity of tests.

A joint screening programme with Camden PCT was established in 2003. Camden and Islington chlamydia screening was one of the phase one programmes, established before the introduction of a target, or a nationwide screening programme. For 2007/08 the target was to have screened 15% of all 15-24 year olds. Only 6.7% (1,776) were screened during 2007-08.

6.2.4. Syphilis

In North Central London the highest incidence of syphilis is in the older 25-44 age group in males and in younger age groups (20-34) in females. The number of cases in men is considerably higher (10 times) than in women due to ongoing syphilis transmission amongst men who have sex with men.

6.2.5. Genital herpes

The incidence of genital herpes infections increased between 1997 and 2006. Genital herpes is the only STI where the number of new diagnoses in women is higher than in men. Within the London region, the highest rates of genital herpes are seen among homosexual men and black and other ethnic community groups.

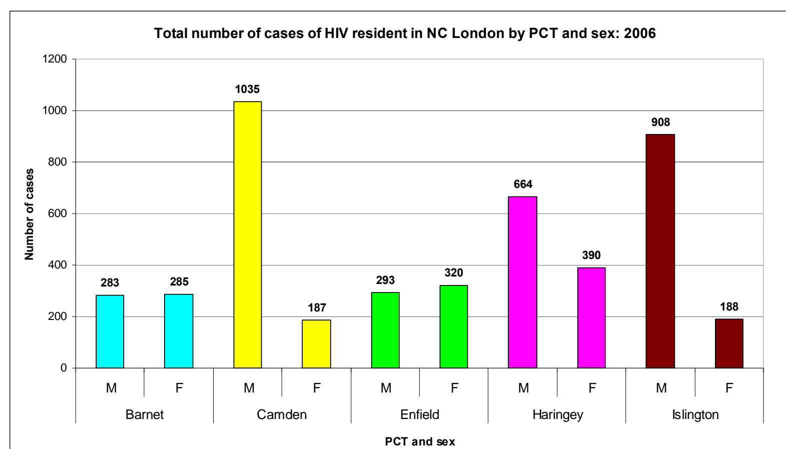
In North Central London, the incidence of genital herpes decreased slightly between 2002 and 2006. The highest numbers of new diagnoses of genital herpes were seen in the 25-44 age groups.

6.2.6. HIV

HIV is a predominantly sexually acquired infection, with a minority of infections acquired through injecting drug use or vertical transmission from mother to baby. In Islington, most of the HIV infections have been acquired by sex between men, whilst amongst women, the main mode of acquiring HIV infection is through heterosexual sex. Following the introduction of anti-retroviral treatment for HIV there have been large increases in the number of people living with HIV.

In the last five years, the number of HIV infected people who are accessing NHS services, as determined by the Survey of Prevalent HIV Infections Diagnosed (SOPHID), has risen in all boroughs in North Central London. Islington has the second highest number of HIV infected people in the sector (Figure 6.3).

Figure 6.3 HIV cases in North Central London clinics by sex



The majority of cases of HIV in Islington are seen in 35 to 44 year olds. Most of the cases are seen in white males, although amongst black Africans, there are more women who are infected than are men.

6.3. SEXUAL HEALTH SERVICES IN ISLINGTON

Sexual health services in Islington are broadly organised as follows:

- Sexual health programmes including HIV prevention and Sexual health promotion programmes
- Sexual health services delivered via primary care and GUM Services
- HIV treatment and care delivered via primary care, specialist HIV clinics, social services and the voluntary and independent sector
    - Contraceptive, pregnancy and abortion services, delivered via primary care, community contraceptive and gynaecology services
- Specialised services including prison sexual health services and sexual dysfunction clinics

6.4. RECOMMENDATIONS

Recommendations to improve and promote sexual health in Islington include:

- Enhancing information available on local needs and demand for sexual health services, through a comprehensive sexual health needs assessment
- Promoting good sexual and reproductive health through high quality SRE education and advice delivered across settings
- Ensuring timely access to screening, diagnosis and management of STIs, including through the GUM 48 hour access target, provision of services through primary care and other community settings and improvements in the uptake of chlamydia screening for under 25s
- Action to reduce late stage presentation of HIV/AIDS, to help improve long term outcomes and address inequalities
- Identifying and developing the training needs of local health care professionals, and others, to promote better sexual health and provide sexual health and contraceptive care

7. INFANT MORTALITY

7.1. INTRODUCTION

Islington has one of the lowest fertility rates in the country. The average number of children a woman would be expected to have over her lifetime given the current pattern of births locally (the Total Period Fertility Rate) was 1.48 in 2006, significantly lower than the national average of 1.85.

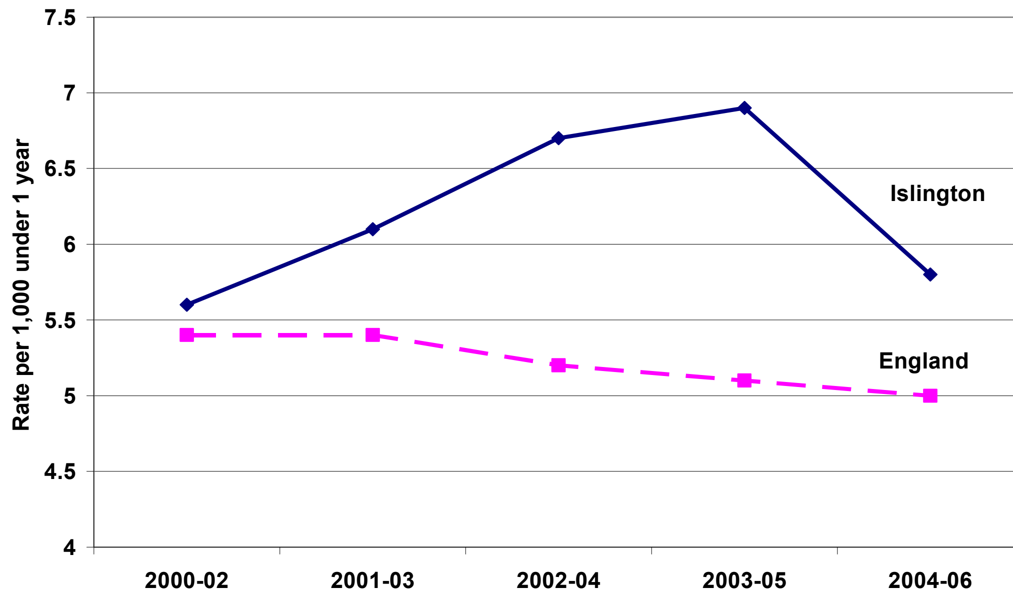
There are currently just over 2,800 births a year in Islington. Although the number of births locally has increased in recent years, births are projected to increase more slowly over the period to 2020.

Despite the low birth rate, the infant mortality rate in Islington is high. Infant mortality rates have fallen nationally in all social class groups since 1997-99, but have been falling faster in the general population than in routine and manual groups, so that the relative inequalities gap has widened. Reducing the gap in infant mortality by at least 10% between routine and manual groups and the population as a whole by 2010 (compared with 1997-99) is one of the key national health inequalities targets.

7.2. INFANT MORTALITY IN ISLINGTON

Infant mortality refers to the death of a baby before its first birthday. The infant mortality rate in Islington is higher than for the whole of England. The rate increased to 6.9 per 1,000 births in 2003/05, before falling to 5.8 per 1,000 births in 2004/06. The actual number of infant deaths changed little in that time (52 in 1999/01; 48 in 2004/06). Over the same period, the England infant mortality rate has continued to slowly decline (Figure 7.1).

Figure 7.1: Infant mortality in Islington compared to England, three year moving average



Risk factors associated with higher rates of infant mortality include the proportions of low birth weight babies, sole parent registrations, mothers living in superoutput areas (SOAs) of greatest deprivation, mothers born in countries with high infant mortality, teenage pregnancy, and routine and manual occupational groups. In 2003, Islington had the seventh highest proportion of single registrations in the capital, 62.1% of births in Islington occur in SOAs with an IMD score of 40 or more, and Islington is in the top quartile for low birth weight and very low birth weight babies.

7.3. MATERNITY SERVICES IN ISLINGTON

Maternity services make an important contribution to reductions in infant mortality, whilst networks of neonatal care provide specialist care for sick and pre-term babies. The two major maternity units that serve Islington are The Whittington and University College London Hospital (UCLH), which together see over 90% of Islington women for their maternity care. The two units are also responsible for providing community-based maternity care across the borough.

In 2007, the Health Care Commission carried out a national survey of all maternity units. The survey found that maternity services in London did markedly less well than other areas of the country. Women at the Whittington and UCLH were significantly more likely to be booked after 12 weeks (Table 7.1). Both the

Whittington (4.3 weeks) and UCLH (3.9 weeks) also reported among the longest average times between making first contact and the booking appointment, with the best performing trusts averaging about 1.5 weeks.

Table 7.1: Roughly how many weeks pregnant were women when they had their booking appointment?

	Less than 8 weeks	8-9 weeks	10-11 weeks	12-18 weeks	19 weeks or more
	%	%	%	%	%
England	12	25	22	37	4
The Whittington	7	6	15	63	8
UCLH	6	13	13	55	13

Source: Survey of maternity services in NHS trusts, Health Care Commission 2007

The Health Care Commission also estimated that a higher proportion of women at local units had fewer antenatal checks than recommended in NICE guidelines: 27.2% at the Whittington and 32.3% at UCLH, both of which were in the bottom quartile of trusts nationally. The percentage of women who said that they had attended NHS antenatal classes was 52% at the Whittington and 55% at UCLH, compared to a national average of 61%. Since the survey, both trusts have developed and are implementing improvement plans to address these and other areas.

7.4. RECOMMENDATIONS

Recommendations to reduce infant mortality in Islington include:

- Ensure the standards set out in Maternity Matters are delivered, including promoting earlier booking (including self-referral) to women in maternity services, access to and uptake of antenatal education and support and advice for breastfeeding
- Support healthy lifestyles, pre-conceptually and in pregnancy, including advice and support on smoking, healthy balanced diets, alcohol and drug use
- Ensure access to high quality sex and relationships education and contraceptive advice and services to support informed decisions about

fertility, particularly for communities who are most vulnerable to poorer outcomes

- Promotion of smokefree homes to reduce the proportion of infants being brought up in homes where there is environmental tobacco exposure and reduce the risk of death through domestic fire.

8. OLDER PEOPLE

8.1. INTRODUCTION

Islington's population is changing. Although Islington is a relatively young borough that is unlikely to follow the national pattern of large increases in the older population, it will nevertheless experience a rise in the "older old" who are likely to be more frail and living with long-term conditions. There is also likely to be an increase in the diversity of needs as the number of older people from minority ethnic groups will increase. Coupled with high levels of deprivation, this is likely to trigger increased demand for health and social care services.

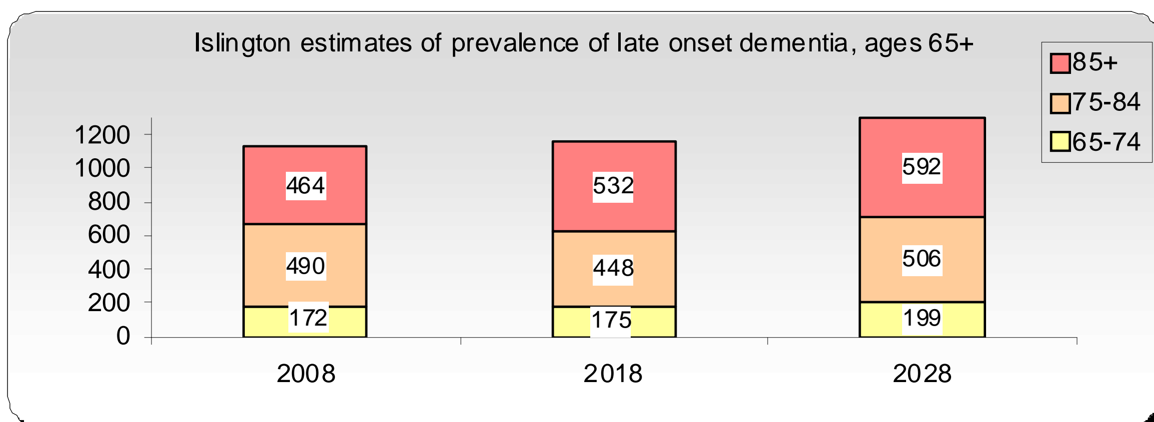
Older people in Islington are particularly vulnerable, with pensioner households having average incomes that are considerably lower than the borough average. Older people make up 25% of social housing households despite representing only 9% of the overall population. On the other hand, there are also high numbers of affluent older adults in the borough. Many of them choose to fund their social care needs; making sure that this affluent group has relevant information to make informed choices presents a further challenge.

8.2. OLDER PEOPLE IN ISLINGTON

8.2.1. Dementia

Data suggest that there will be only a 2% overall increase in prevalence of late onset dementia in Islington between 2008 and 2018, but that this will increase substantially between 2008 and 2028. The increase in the expected number of people with dementia in the 85+ age group is expected to be faster, increasing by roughly 15% over the next ten years and 28% over the next twenty years. Among people aged 90 and over, the increase is expected to be even greater (Figure 8.1).

Figure 8.1 Late onset dementia, modelled prevalence

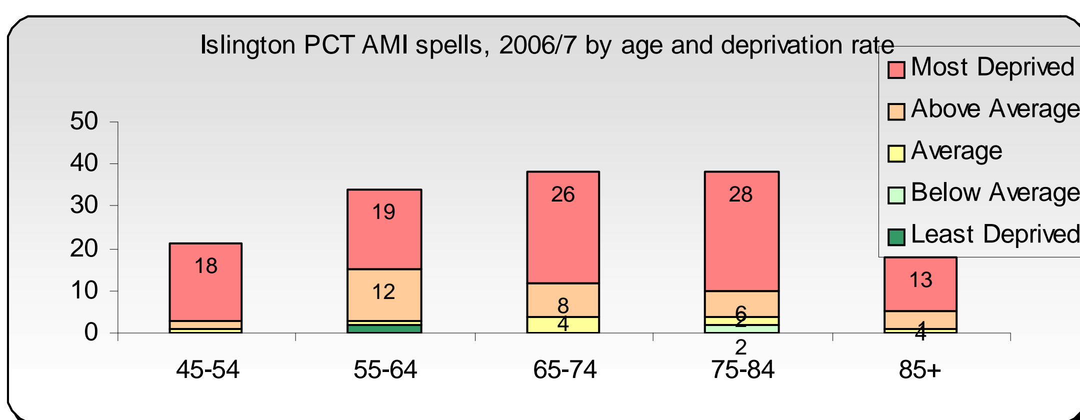


Source: Dementia UK and POPPI

8.2.2. Coronary heart disease

The death rate for the age group 65-74 from coronary heart disease (CHD) is higher in Islington compared to both London and England. Within Islington, CHD is the single biggest cause of death, with nearly 230 deaths per year. The burden of CHD is concentrated amongst the over 65 (Figure 8.2).

Figure 8.2: Breakdown of all 2006/07 inpatient spells of acute myocardial infarction in Islington PCT by age and deprivation group



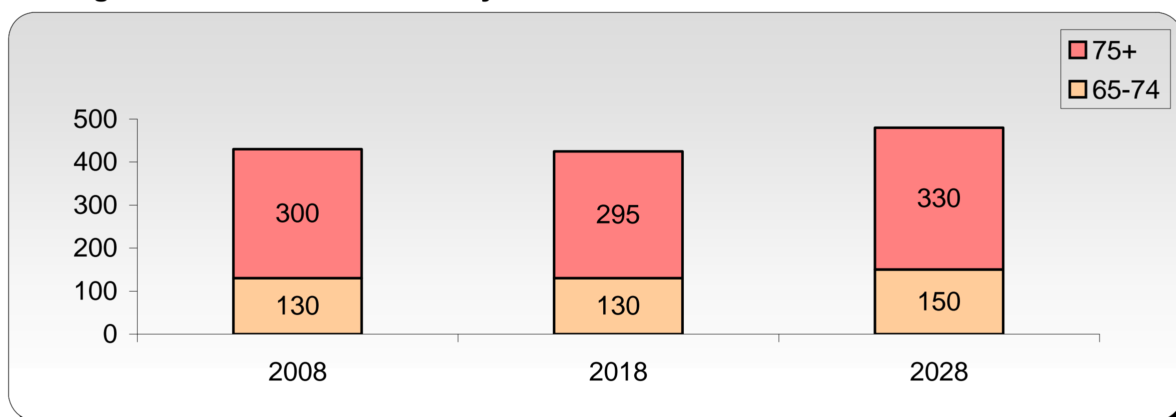
Source: Dr Foster analysis

8.2.3. Stroke

Admissions for stroke in Islington are well above the London and national average. In 2006/2007, there were a total of 334 patients admitted for stroke in Islington, of whom 220 were aged 65 and over. There are about 103 deaths from strokes each year. The mortality rate for stroke is 10% lower than for the rest of England, although

similar to the London average. Projections predict a 12% increase between 2008 and 2028 in the number of older people in Islington who will have a longstanding health condition caused by stroke (Figure 8.4).

Figure 20.4: Islington estimates of the number of people predicted to have a longstanding health condition caused by a stroke



Source: POPPI

8.2.4. Falls

The admission rate for fractured neck of femur in Islington has reduced over recent years, although it remains above the London average. Furthermore, there were considerable more admissions for fractured neck of femur in 2006/07, of which 90% were for people aged 65+.

Projections indicate there will be a 12% increase in the number of older people attending A&E departments in Islington (about 120 more people per year), and a similar increase in the number of older people being admitted to hospital as a result of falls in Islington in the next twenty years (approximately 40 more people per year).

8.3. SERVICES FOR OLDER PEOPLE IN ISLINGTON

Islington procures and develops a range of health, social care and support services for older adults. These can be classified as:

- Services to promote a healthy and active old age, such as active and healthy aging projects, provision of advice and advocacy, and falls prevention programmes such as the Falls and Bone Health Strategy

- Services to promote independence, such as specialist mental health services for older people, a memory assessment service and a day hospital focused on assessment and treatment/rehabilitation of older people with mental health needs; Homecare; Reablement Service to reduce long-term domiciliary care; Assistive technology such as Telecare; Expert Patient's Programme
- Services to provide care closer to home
- Services to improve choice and access, such as support of those people who choose to self-fund their social care)
- Services to promote stakeholder engagement and feedback (i.e. increased promotion of POVA and Dignity in Care across service providers has raised awareness amongst users, families and staff)

8.4. RECOMMENDATIONS

There is a large amount of evidence on the primary and secondary prevention of dementia, CHD, stroke and falls. Recommendations to prevent ill-health and improve outcomes in older people include:

- Work to better understand areas of unmet need and to enable resources to be focused accordingly
- A shift to prevention to enable people to live healthier lives for longer, and improve their emotional health and wellbeing
- Improved economic well-being, including for the population aged 60 and over, programmes focused on improving levels of benefit take up and promoting the benefits of deferring retirement for those approaching 60/65
- Promotion of increased choice and control, and maintenance of personal dignity and respect.

JSNA: part two

Risk factors and wider **determinants**

9. POVERTY AND WORKLESSNESS

9.1. INTRODUCTION

Poverty and employment are inextricably linked. Poverty can affect working and workless people at all stages of the life-cycle, whilst exclusion from sustained employment is a strong predictive indicator of both poverty and ill health. The London Health Observatory describes poverty as “the most important determinant of health, and also one of the most difficult areas in which to achieve change. Levels of disposable income affect the way we live, the quality of the home and work environment, and the ability of mothers to provide the kind of care for their children they want to. The relationship between health and low income exists across almost all health indicators.”

Islington is the eight most deprived borough in the country, with a large number of people who are out of work and dependent on benefits. The Islington Strategic Partnership has set the reduction of poverty as the primary objective of the Sustainable Communities Strategy. Its commitment is to make a long-term difference to people’s life chances by targeting the most deprived groups such as disabled and mentally ill people, older people and children living in low income households.

9.2. DEPRIVATION AND WORKLESSNESS IN ISLINGTON

9.2.1. Overall deprivation

Islington is a highly deprived borough. The Index of Multiple Deprivation (IMD) 2007 ranks Islington as the eighth most overall deprived of 354 English authorities, and the fourth most deprived in London. A substantial proportion of Islington’s Lower Super Output Areas (LSOAs) are in the most deprived quintiles (Table 9.1).

Table 9.1: Number of Islington’s Lower Super Output Areas in each quintile of all England Lower Super Output Areas for multiple deprivation and each domain

Domain	1st quintile	2nd quintile	3rd quintile	4th quintile	5th quintile

Multiple deprivation	77	38	3	0	0
Income deprivation	70	39	9	0	0
Employment deprivation	53	49	12	4	0
Health deprivation and disability	83	31	4	0	0
Education skills and training deprivation	1	48	26	38	6
Barriers to housing and services	117	1	0	0	0
Crime	72	30	10	4	2
Living environment	100	18	0	0	0

Source: Indices of Multiple Deprivation 2007

The overall ranking of the IMD takes account of two supplementary indices: the Income Deprivation Affecting Children Index (IDACI) and the Income Deprivation Affecting Older People Index (IDAOPI). The ranking of LSOAs for IDACI is based on the numbers of children (aged 0 to 15) living in households dependent on out of work means tested benefits or receiving working tax credit/child tax credit and having an income below 60% of the national median before housing costs. Similarly, the ranking for the older people's index is based on adults, 60 years and older, living in households dependent on pension credit. Table 9.2 shows the number of Islington's LSOAs in each quintile of all England LSOAs by the IDACI and IDAOPI:

Table 9.2: Number of Islington's LSOAs in each quintile of all England's LSOAs by two deprivation indices

Index	1st quintile	2nd quintile	3rd quintile	4th quintile	5th quintile
Income Deprivation Affecting Children Index	93	21	4	0	0
Income Deprivation Affecting Older People Index	95	20	3	0	0

Source: Index of Multiple Deprivation 2007

9.2.2. Overall worklessness

The general employment rate and the proportion of Islington residents on out of work benefits is significantly worse than the national average (Table 9.3).

Table 9.3: Rates of employment and of those receiving worklessness benefits for Islington and Britain

Worklessness Indicator	Islington	Average for England, Scotland and Wales
Employment rate	66.1%	74.3% †
Proportion on worklessness benefits	19.6%	14.3% §

† Source: NOMIS, working age population 2006

§ Source: WPLS - Working Age percentage of population May 2007

9.2.3. The working age population

73% of the Islington population is of working age (Table 9.4), higher than the national level but close to levels seen in inner London.

Table 9.4: Working age populations for Islington, Inner and Outer London and England

Area	Working age population	Working age population as a proportion of total population
Islington	134,900	73%
Inner London	2,105,700	71%
Outer London	2,926,900	65%
England	31,626,700	62%

Excluding those claiming bereavement benefits or carer's allowance, 18.7% of the working age population is dependent on out of work benefits, including jobseeker's allowance, incapacity benefits and income support. This compares with an average of 13.5% for London and 12.9% for the whole country. Over 75% of these residents have been claiming benefits for over one year. Those claiming as sick or as lone parents represent 68.3% of all claimants, whereas those actively seeking work represent only 19.5% of the claimant population.

9.2.4. Children

Islington is the second highest ranking authority in the country for the proportion of its children in households dependent on out of work benefits (Table 9.5).

Table 9.5: Number and percentage of children dependent on workless benefits

Local Authority	Number of children 0 – 18 years	Percentage of children	Rank out of 408 local authorities (England, Scotland and Wales
Camden	14,300	33.4%	18
Kensington & Chelsea	5,900	17.3	174
Westminster	10,500	27.4%	42%
Islington	**16,600**	**45.2%**	**2**
Wandsworth	12,300	24.6%	63
Hammersmith & Fulham	10,100	30.0%	31
Haringey	21,000	39.9%	6
Newham	28,800	40.6%	5
Southwark	21,700	37.6%	7
Hackney	22,300	40.7%	4

Lewisham	19,200	32.5%	22
Tower Ham	26.900	50.9%	1
Lambeth	20,700	35.8%	11

Source: GLA

Since this measure excludes those households in low paid work, this assessment underestimates the scale of child poverty in Islington.

9.2.5. Older people

As a proportion of the total population, Islington's pensionable population is just under 11%. There is no direct measure of pensioner poverty available at local authority level. The single most useful measure of pensioner poverty is the proportion claiming pension credit; in Islington over 50% of older people are dependent on this benefit.

9.3. CURRENT SERVICE PROVISION

There are a number of initiatives currently in place to address poverty and worklessness in Islington, delivered by a range of partners including: Jobcentre plus, Islington Strategic Partnership, the voluntary sector, the Learning and Skills Council, ESOL providers, Connexions, the mental health trust and the PCT, housing and adult social services. Poverty and worklessness have high prominence in Islington's Local Area Agreement.

9.4. RECOMMENDATIONS

Our vision is that Islington in 2020 will offer opportunity to all of its residents that is not pre-determined by housing tenure, health status, age or ethnicity. Services will offer personally tailored and targeted support that ensure all residents are able to enjoy their rights to work and a secure income, while living in homes that are decent and safe and which form a secure foundation from which to participate in the broader community and meet their responsibilities.

To achieve this vision, it is recommended that:

- Mainstream services should be supported to develop initiatives that integrate employment support and income maximisation into the outcome targets for their service users
- Those services, and all other local employers, should be assisted to make local jobs more accessible to local people

In addition, it is recommended that:

- Resources should be made available to develop a local intelligence source in support of mapping households in receipt of out of work benefits
- This mapping should provide the data for more personalised interventions and support services, prioritising those groups already known to be in greatest need
- Policy function in this area should be improved to allow partners to take advantage of all initiatives and interventions that may benefit local residents
- For the working age population, programmes should focus on supporting access to work, retention of work, progress in work, and managing the transition in and out of work
- For the population aged 60 and over, programmes should focus on improving levels of benefit take up and promoting the benefits of deferring retirement for those approaching 60/65
- Combined efforts should be made to reduce fuel consumption by improving fuel efficiency

10. HOUSING AND HOMELESSNESS

10.1. INTRODUCTION

Decent housing is a prime requisite for health and a major determinant of health inequalities. Badly designed and poorly built houses with inadequate heating, damp, lack of space, poor lighting and shared amenities are a major contributor to poor health. Poor housing and homelessness are not just a housing problem. They have profound implications for the health and wellbeing of the people affected, and for society as a whole.

Housing within Islington is a market of extremes. At one end, the borough contains properties at the high end of London prices occupied by high income households, whilst at the other end many residents live on low incomes in social housing. Average property prices are significantly higher than the national average: in 2007 the average property price in Islington was £449,855, and in 2008 the average cost of buying an entry level one bedroom home was £228,500.

Over 6,100 households in Islington occupy homes that are too small for their accommodation needs. In 2003, it was estimated that 17.3% of the borough's residents were living in fuel poverty. The groups most vulnerable to fuel poverty tend to be single pensioners and lone parents due in large part to their low incomes.

10.2. HOUSING PROBLEMS IN ISLINGTON

10.2.1. Homelessness

Homelessness leads to poor physical and mental health. Rough sleepers tend to have the most significant health problems, including low life expectancy, chronic chest, dermatological, and mental health problems. People who are homeless and consequently living in temporary accommodation often experience health problems such as depression, relationship problems, suicide attempts and heavy drinking.

Levels of homelessness in Islington have reduced overall since 2001/02 by about 50%. In 2007/08, Islington Council accepted 401 homeless household applicants as

eligible for re-housing due to being homeless. Of these, 55% were lone parents, and 90% of these were women. At the end of March 2008, Islington had 1,005 households placed in some form of temporary accommodation, including 445 households in either hostel or annexe accommodation. Of the total households in temporary accommodation, over 75% either contained children or children were due, and half were female lone parents with children.

10.2.2. Overcrowding

Overcrowding is associated with increased physical and mental health problems and poor educational achievement by children. The risk of infection, poor diet and nutrition is higher in people living in overcrowded conditions. Overcrowding can also have an impact on family life and relationships and lead to family breakdown.

Islington has an overcrowding rate of 6.9% (defined using the Bedroom Standard), equating to 6,100 overcrowded households. Overcrowded households are concentrated in the rental sector, in particular amongst social housing. The large majority of overcrowded households live in flats with relatively small numbers in houses or bungalows. Households with children account for nearly two thirds of overcrowded households.

10.2.3. Affordable housing and households in need

Homelessness and adverse housing conditions such as overcrowding, and their associated health problems, are both largely a consequence of the lack of good quality affordable housing for people on low incomes. The Islington Housing Needs Assessment estimates that 18% of Islington households (approx 15,500 households) are currently living in unsuitable accommodation. Of these, approximately 10,000 households require a move to alternative accommodation but cannot afford a suitable solution without some form of subsidy. Households in the rented sectors (particularly the social rented sectors) account for more than 90% of this current need. The estimated affordable housing need, taking into account the backlog and future housing needs, is 4,344 units per annum for the next five years.

10.2.4. Poor quality of existing housing stock

Poor quality housing has a significant impact on health and wellbeing. Cold and damp homes make residents vulnerable to a number of physical problems such as respiratory infections, cardiovascular problems, strokes, hypothermia, bronchial and breathing problems and skin conditions. Cold homes may also impact on conditions

such as arthritis or rheumatism and, as they impact on mobility and dexterity, increase the risk of falls and other household accidents.
Damp housing is usually associated with cold indoor temperatures and the two probably combine to increase the risk of ill health. Damp is caused by substandard construction and materials, inadequate heating systems and lack of ventilation, and provides ideal conditions for mould.

At the end of March 2008, 63% of all council homes in Islington had met the decent standard (Table 10.1).

Table 10.1 Proportion of council homes in Islington at a decent standard

Year	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
% homes decent	45	51	55	63	75	95	100

However the increase in the size of the private rented sector over the past five years has seen more vulnerable and low income households placed into private tenancies. The 2003 Private Sector Stock Condition survey estimated 6.6% of the private sector stock in Islington to be unfit. It was estimated that 31.7% of private sector dwellings failed the Decent Homes Standard under one or more of the key criteria used to assess the Standard.

The 2003 Stock Condition Survey also estimated that 17.3% of the borough's residents were in fuel poverty. Those in the private rented sector are the most vulnerable, with 31.6% of tenants in fuel poverty. Fuel poverty has serious health consequences.

10.3. RISK GROUPS

Certain groups are at particular risk of suffering from lack of housing or from inadequate or poor quality housing. Groups such as the elderly, the disabled and those suffering from long-term ill physical and mental health are disproportionately more likely to occupy poor housing stock.

10.3.1. Children

Children are particularly affected by poor housing conditions such as damp and cold, overcrowding and lack of safe and green open spaces. There are evidential links between poor housing and overcrowding and children's health and educational attainment.

The Islington Housing Needs Survey 2008 showed that over a third of households currently living in unsuitable housing contain children. The biggest reason given for unsuitability of the home was overcrowding.

10.3.2. Older people

The Islington Housing Needs Survey 2008 showed that over 2,000 pensioner households currently live in unsuitable housing, including over 1,500 single pensioner households. 15.7% of all older people households suggested they have problems with maintaining their home, compared to 9% of all general households.

10.3.3. People with special needs

Over 17,000 households (almost 20% of all households) in Islington contain a person with special needs. The biggest cause of need is physical disability, followed by the frail elderly. Of the 17,000 households, over 6,000 live in pensioner only households. This is reflected in the requests for housing improvements and services, with the most common being lower level shower units and extra handrails.

10.4. HOUSING AND HOMELESSNESS SERVICES

There are a number of services and schemes in Islington aimed at addressing housing needs. These include:

- Services for the homeless and those with unstable access to accommodation including: home visits for 16/17 year olds facing homelessness, a private sector opportunities scheme and qualifying offers for landlords, a home shelter scheme for victims of domestic violence, and Pulse N7, a one stop shop for 13-20 year olds that includes the provision of an advice service to provide guidance on housing options.
- Services to address overcrowding including: the Minor Works Pilot, Smart Move scheme, de-conversions, and Under-Occupation Initiative.

- Council New Build schemes, Homebuy and Disabled Facilities Grants to address households in need and the lack of affordable housing.
- Schemes to improve the standards of poor quality housing, including capital investment in council housing stock, private sector grants and action to address fuel poverty
- Schemes to improve the neighbourhood and the environment. These include Income Maximisation, a new service being run by Homes for Islington (HFI), HFI support officers, housing related employment schemes, youth diversion schemes and the Anti-Social Behaviour Out of Hours Team.

10.5. RECOMMENDATIONS

Our vision is to improve the health and well being of Islington's residents by increasing the quantity and improving the quality and accessibility of its housing. Recommendations to achieve this vision include:

- Reduce homelessness and improve access to accommodation by:
    - Continuing to move people away from the street and rough sleeping, maintaining effective outreach, assessment and placement services
    - Preventing homelessness through extending our pre-crisis and early intervention work, offering advice on alternative options and support for tenancy sustainment.
    - Maximising the supply of affordable homes through new build and reducing the number of empty properties.
- Tackle overcrowding by:
    - Building more, larger size homes and identifying further opportunities to de-convert existing flats into larger homes.
    - Alleviating its effects on families, by making efficient use of existing homes through under occupation schemes and family support strategies for the severely overcrowded.
- Increase affordable housing and address the needs of vulnerable groups by:
    - Increasing the number of affordable homes built in the borough and encouraging developers to build to the "lifetime homes" standards.
    - Increase floating support options for residents with special needs such as the elderly

- Improve the quality of existing stock by:
    - Ensuring all social housing meets the Decent Homes Standard by 2011
    - Improving poor quality private sector homes and promoting of energy efficiency schemes for vulnerable households.
- Neighbourhood renewal
    - Establishing a co-ordinated approach to tackling worklessness in the borough involving all departments and agencies working in this area.
- Regeneration and planning
    - Encouraging developers to undertake health and social impact assessments on new developments and engage with residents prior to regeneration schemes commencing to ensure their needs and views are taken into account
- Provide a better quality of life for vulnerable people via Supporting People.

11. EDUCATION

11.1. INTRODUCTION

Educational attainment is a powerful determinant of health and wellbeing. The longer an individual spends in education and the higher their educational attainment, the better their overall health and lifestyle. Education builds skills, confidence and learning which are transferable to decisions about health, health-related behaviours and use of preventive services. Education helps to promote and sustain healthy lifestyles and choices, supports and nurtures human development and human relationships, and supports the development of personal, family and community wellbeing. Educational attainment is closely linked to social class and income, with some analyses suggesting that the contribution of educational attainment to health outcomes is at least as great as income, and possibly greater.

Schools and other educational settings have an important role in delivering health promotion and health services. Schools present an important opportunity to provide services to groups that might be otherwise hard to engage, promote healthy lifestyles and behaviours and create environments that positively promote health and wellbeing.

11.2. EDUCATION IN ISLINGTON

11.2.1. The school population

In total, there are approximately 40,500 children and young people aged 0-19 living in Islington, accounting for just under one fifth of the local population . Children and young people are the most diverse of all population groups in the borough, with 67% from black and minority ethnic groups. It has been estimated that up to 20% of children in Islington schools belong to communities that originally arrived as refugees. 40% of resident children who attend Islington schools are eligible for free school meals. There are approximately 120 languages spoken at home by local children, and 43% of resident children do not have English as their first language.

29% of Islington school children have an identified special educational need (SEN), and 3.1% have a statement of SEN, slightly above the London average of 2.8%. It is estimated that 11,000 children and young people in Islington need, or will need, extra support or help at some stage as they grow up.

11.2.2. Schools in Islington

Islington has 68 early education settings (not including school nursery classes) across the maintained, private and voluntary sectors. There are 45 primary schools, most of which offer early years education, one all-through academy and nine secondary schools. There are three special schools, all co-located with a mainstream school, and four pupil referral units, including one at the Whittington Hospital. A large proportion of schools offer extended activities beyond the school day and work with a range of partners to offer enrichment across arts, sport and learning.

There are currently 23,080 children (May 2008) accessing education up to age 16 in Islington: 3,130 in free early years education settings, and 19,950 in schools. Although there is sufficient provision for all three and four year olds to access an early years education place (equivalent to 12.5 hours per week), not all parents take this up, either because they are at home or are attending centres outside the borough. 95% of resident children attend primary school in Islington, falling to approximately 75% for secondary school. Most post-16 places are provided at City and Islington College.

11.2.3. Educational attainment

No school in Islington is regarded as requiring special measures, and 75% of Islington primary schools have been rated by OFSTED as good or better. Overall attainment at Islington primary schools is improving, with the average point score at Key Stage 2 now standing just 0.6 points below the 2007 national average. The Contextual Value Added measure for Islington, which takes into account a range of factors that impact on the effectiveness of a school, is the second highest in both London and England.

A significant number and proportion of pupils at a substantial number of schools, however, are not achieving the nationally expected standard. Bangladeshi and Turkish pupils are the lowest attaining pupils, although the gap is closing. Black boys

across all socio-economic backgrounds are generally achieving well but differences in levels of attainment still need to be addressed. Outcomes for children at the end of the Foundation Stage (age three to five) are lower compared to national figures.

The attainment of children attending Islington schools by Key Stage 1 to 3 is shown in Table 11.1.

Table 11.1: Key Stage 1 to 3 results, 2007

	Percentage of pupils attaining level 2+ at Key Stage 1			Percentage of pupils attaining level 4+ at Key Stage 2			Percentage of pupils attaining level 5+ at Key Stage 3		
	Reading	Writing	Maths	English	Maths	Science	English	Maths	Science
Islington	77%	73%	83%	77%	74%	85%	64%	64%	60%
National	84%	80%	90%	80%	77%	88%	74%	76%	73%

The attainment of Islington children at GCSE level is shown in Table 11.2.

Table 11.2: Percentage of pupils attaining 5 or more A*-G grades, and 5 or more A*-C grades, at Key Stage 4 (GCSE & equivalent)

Key Stage 4	5 or more A* to G GCSEs or equivalent examinations		5 or more A* to C GCSEs or equivalent examinations	
	2005	2007	2005	2007
Islington	85.7%	86.2%	44.2%	48.8%
National	90.3%	90.0%	55.0%	60.8%

11.2.4. Pupil absence and exclusions

Regular attendance at school is important, especially at primary age, when children are forming their habits. In 2006/07, the absence rate in primary schools was 6.3%, down from the 2005/6 figure of 7.3%. In secondary schools, the absence rate was 9.5%, a small increase on the previous year. These average figures mask low attendance in specific schools, which is being addressed through targeted work with schools and families.

Permanent exclusions are higher in Islington schools (0.43%) compared with averages for London (0.28%) and the rest of the country (0.22%). Fixed term exclusions in secondary schools are lower than average for London (9.79%) and nationally (10.83%), at 9.61%.

11.2.5. Looked after children

Islington has successfully reduced the number of looked after children in the borough (both local children and unaccompanied asylum seeking children). As of 31st March 2008, there were 332 looked after children in Islington, 42 of whom were seeking asylum. However in 2006/07, 9% of looked after children had missed at least 25 days of schooling over the year.

The educational achievement and school attendance of looked after children in Islington is poor. Results for Key Stage 1 to 4 in this group are shown in Table 11.3.

Table 11.3: 2006/07 attainment for looked after children

	Percentage of pupils attaining level 2+ at Key Stage 1			Percentage of pupils attaining level 4+ at Key Stage 2			Percentage of pupils attaining level 5+ at Key Stage 3		
	Reading	**Writing**	**Maths**	**English**	**Maths**	**Science**	**English**	**Maths**	**Science**
Looked after children in Islington	43%	43%	43%	53%	42%	74%	17%	24%	24%
Islington (all pupils)	77%	73%	83%	77%	74%	85%	64%	64%	60%

11.2.6. Not in Education, Employment or Training

A useful indicator of economic wellbeing for young people is the proportion not in education, employment or training (NEET). Islington's NEET rate is high compared to the central London average, but has fallen substantially since 2005, when it stood at nearly 16%. Vulnerable young people are disproportionately represented in the NEET statistics, with a high proportion of young people with learning difficulties. Young white men are also disproportionately represented in the NEET group.

11.3. SERVICE PROVISION IN ISLINGTON

11.3.1. Early years

A borough-wide network of Children's Centres is currently being established in Islington. These will offer integrated care and education, family support, outreach and parenting courses, and health and associated services.

The Early Years Foundation Stage team works across all sectors co-ordinating advice, support and training for all aspects of early years care and education for children from birth to five. Structures are in place to evaluate the quality of provision in all sectors and work in partnership with schools and settings to improve outcomes for all children.

11.3.2. Children aged 5 to 13

School improvement services provide support and challenge to all schools. Work is currently underway to:

- Reinvigorate work on Assessment for Learning to embed in schools practice
- Talk to children and young people to better understand what outstanding learning means for them
- Support schools in ensuring that behaviour is good and children and young people attend school every day

11.3.3. Young people aged 14 to 19

Action has been taken to engage secondary headteachers and other leaders in accelerating the rate of pupil progress and to raise standards further at Key Stage 4. There will continue to be a focus on raising the attainment of Somali students and on White and Black working class under-achievers across secondary schools and in both key stages. The breadth of offer at 14 and at 16 has been improved by the introduction of the Diploma.

11.4. HEALTHY SCHOOLS

The Healthy Schools Programme is an education and health partnership that supports schools to become healthier places for staff and pupils to work, learn and enjoy. In order to achieve Healthy Schools status, schools need to demonstrate that they meet national expectations for each of the four major themes:

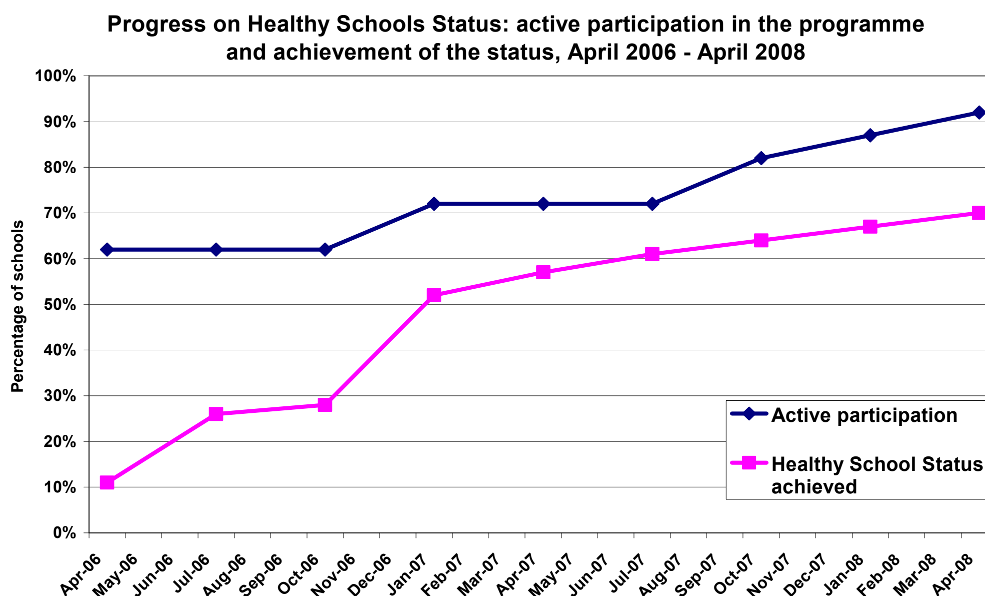
- Personal, Social and Health Education (PHSE)
- Emotional health and well being

- Healthy eating
- Physical activity

The Healthy Schools team in Islington is a partnership between Cambridge Education, Islington PCT and LB Islington Children's Services that works closely with primary and secondary schools and Pupil Referral Units across the borough. The team has achieved national recognition for its work and development of local programmes and resources. The Healthy Schools Programme has been identified as a stretch target in the Local Area Agreement, aiming for 95% of Islington schools (58 schools) to have achieved the Healthy School Programme standard on each of the four themes by March 2009.

By April 2008, 70% of schools had achieved National Healthy School Status. An increasing number of schools continue to be recruited, with 92% actively engaged at April 2008 (Figure 11.2).

Figure 11.2: Local progress on Healthy Schools status



Source: Islington Healthy Schools Team

11.5. RECOMMENDATIONS

We have high aspirations for the children and young people of Islington. We want to ensure that every child gets an equally rich start in life and becomes equipped with the skills and knowledge to make the very best of her or him self, regardless of background or home situation.

We are determined to increase the number of young people who leave school with the core skills and knowledge that they need to achieve success in life, either in work or further and higher education. This is tied in with curriculum developments in both our primary and secondary schools, with a special emphasis on ensuring vulnerable children and young people in public care benefit from our plans.

Building Schools for the Future (BSF) is providing a huge opportunity to innovate in the curriculum and we aim to ensure that this underpins young people's work in the core subjects, as it is only through systematic and carefully targeted opportunities and experiences that high achievement can be embedded.

In particular we wish to focus on higher achievers, their visibility as role models for others in the borough is critical, as is their individual achievement and on reducing the number of children who leave school with no qualifications at all. The main recommendations to improve educational attainment in Islington are:

- To provide the best start in life for young children and support their learning, development and achievement through an outstanding range of early years settings with associated excellent children's services building on the Children's Centre model and best practice nationally and internationally
- To raise standards of achievement and attainment; to narrow the gap in attainment between different groups in the borough and meet or exceed the best performance nationally. To achieve this through effective partnership between schools, children's services, pupils, parents and the wider community
- To positively change the life chances of the most disadvantaged members of the community with a specific emphasis on improving the pathways into education, employment and training for young people

- To build on the strength of our schools and educational settings and support and challenge them to move from good to great so that we have outstanding provision across all phases of education
- To support community capacity, social cohesion and well being through schools and children's centres that are 'fit for purpose' and provide centres of learning for their communities.

The main recommendation for Healthy Schools is:

- To develop and pilot an approach to Healthy Children's Centres based on the Healthy Schools programme, reflecting the particular needs of pre-school children and their families and early years settings.

12. SMOKING

12.1. INTRODUCTION

Smoking is the single most important preventable cause of death and ill health, and a major contributor to health inequalities. The prevalence of smoking in Islington is higher than the national average, and the number of quitters has recently declined.

Smoking imposes a significant economic burden on the NHS and more widely across society. The economic cost of smoking in Islington in 2007/08 is estimated at over £117 million, whilst the total societal cost is estimated to be almost £250 million.

Reducing smoking prevalence in Islington is a strategic priority for Islington Council, the PCT, Islington Health and Well Being Partnership Board and the Local Strategic Partnership. The Department of Health sets targets for PCTs to achieve a certain number of people setting a quit date and successful quitters at four-week follow-up. Islington is committed to achieving targets beyond those set by the Department of Health and has been working towards them since 2005. Based on the quitter rate per 100,000 population of 1,220 (estimated) in Islington in 2007-08, the vision for 2020 is to at least maintain this rate.

12.2. HEALTH EFFECTS OF SMOKING

Smoking is highly addictive and harms nearly every organ of the body. Smoking related diseases include cardiovascular disease, chronic obstructive airway disease and a number of cancers such as lung, mouth, larynx, oesophagus, bladder, kidney, stomach and pancreas. Smoking is associated with osteoporosis, poor oral health and age-related macular degeneration, which results in severe irreversible loss of central vision.

Passive smoking is also harmful. The health effects of passive smoking include lung cancer and ischaemic heart disease, and probably chronic obstructive pulmonary disease, asthma and stroke in adults. Passive smoking causes sudden infant death, and respiratory and ear diseases in children. Unborn children are exposed to passive

smoking as a direct result of maternal smoking, and indirectly from maternal exposure to smoking, causing low birth weight, fetal death and preterm delivery.

12.3. SMOKING PREVALENCE IN ISLINGTON

The exact number of smokers in the borough is not known. However, given the characteristics of the local population it is estimated that approximately 27.5% of resident adults smoke - approximately 43,533 adults aged over 16. This is higher than in other parts of London, and significantly higher than the rate seen in Harrow, which has the lowest estimated smoking prevalence in London (Table 12.1).

Table 12.1 Smoking prevalence

	Smoking in adults 2003-05 (95% CI)
Islington	**27.5% (22.9 –32.6)**
Camden	23.5% (19.7 –27.7)
England	24% (23.4 –24.7)
Islington rank in London	6th highest
Highest in London	Barking and Dagenham (32%)
Lowest in London	Harrow (14.5%)
Highest in England	Kingston upon Hill (40%)
Lowest in England	East Dorset (13.7%)

Source: www.neighbourhood.statistics.gov.uk

In January 2007, data on smoking was extracted from 32 out of 39 GP practices in Islington. Preliminary analysis shows a 93% recording of smoking status, with 27.7% of registered patients recorded as smokers.

12.4. RISK GROUPS

The prevalence of smoking varies across different groups and communities.

12.4.1. Deprivation

Smoking is most common in deprived communities. Social deprivation is associated with both high rates of smoking and very low rates of quitting. Islington's routine and manual workers are therefore a key target for all prevention and cessation activities.

12.4.2. Ethnicity

The majority of smokers in Islington are White. Certain ethnic groups, particularly Bangladeshi, Irish and Pakistani men, have very high smoking prevalence. Some ethnic groups in the United Kingdom favour chewed or other oral tobacco, notably betel quid which is also associated with oral cancer.

12.4.3. Mental health

Levels of smoking are particularly high among people with severe mental illness, contributing to the high mortality rates seen in this group. The prevalence of mental health problems in Islington is high, increasing the smoking cessation challenge.

12.4.4. Prisons

Islington has two prisons; Holloway and Pentonville. It is estimated that up to 80% of prisoners smoke.

12.4.5. Children

Children who smoke become addicted to nicotine very quickly and tend to continue the habit into adulthood. Around two-thirds of people who have smoked took up the habit before the age of 18.

12.4.6. Pregnancy

In 2007/08 there were 2,452 maternities in Islington, with 2172 women (88.5%) known not to be smokers at the time of delivery, 223 women (9.5%) smoking during pregnancy and 56 women (2.3%) whose status was not known.

12.5. SERVICES IN ISLINGTON

Local services to address cigarette smoking include smoking cessation activities, smoking prevention (including Smokefree legislation), and tobacco control.

12.5.1. Smoking cessation

Smoking cessation activities include brief interventions, individual behavioural counselling, group behaviour therapy, telephone counselling and quitlines. Pharmacotherapies such as nicotine replacement therapy (NRT), varenicline or bupropion can be used as an aid to help people to quit smoking. Smoking cessation services in Islington are delivered via primary care, through a local enhanced stop

smoking service agreement, community pharmacies and at the Whittington Hospital Trust and Highgate Mental Health Centre.

12.5.2. Children's services and Healthy Schools

Work has been undertaken with Children's Services staff and the Healthy Schools Programme to ensure settings have Smokefree policies and that front line staff receive level one smoking cessation training. A number of school health advisers have been trained in level two interventions, and a drop-in clinic has been established at Pulse N7, which provides services for young people.

12.6. SMOKING QUITTERS

In 2007/08, there were 1,932 quitters in Islington. The estimated resident adult population (16+) was 158,305. The rate of quitters per 100,000 population is therefore estimated to be 1,220. Of these quitters:

- 726 of these were recorded in general practice
- 337 were recorded in pharmacies
- 47 were recorded at the Whittington Hospital
- 3,670 people sought advice from the smoking cessation advisors within Islington in 2007/08. Of these, 330 were identified as having mental health problems and of these, 137 quit smoking.

12.7. RECOMMENDATIONS

Based on the rate of 1,220 quitters per 100,000 population in 2007/08, the vision for 2020 is to maintain this rate. To achieve this vision, the following actions are recommended:

- Ensure the reduction of smoking prevalence is embedded into all relevant health and council policies.
- The LAA continues to support a co-ordinated programme across partner agencies, including special focus on all sub-groups with greater need and hard-to-reach groups

- Develop a comprehensive tobacco control strategy in partnership with all stakeholder organisations
- Use mass media campaigns including those to prevent children and young people from starting smoking.
- Increase equitable access to effective smoking cessation services in various settings
- Provide smoking cessation support to Pentonville and Holloway prisons.
- Develop a social marketing programme for smoking cessation and wider tobacco control.

13. HEALTHY EATING AND PHYSICAL ACTIVITY

13.1. INTRODUCTION

Obesity is a global epidemic and one of the top ten key global health risks in terms of burden of disease. Being overweight or obese reduces life expectancy. Obese individuals are at increased risk of spending a greater proportion of their lives in a poorer health state compared to non-obese people. It is estimated that almost 17% of adults in Islington are obese.

At the heart of the problem of excess weight and obesity is an imbalance between energy consumed through eating and energy expended by the body, including that expended during physical activity. Healthy diets and increasing levels of physical activity are therefore key to tackling overweight and obesity. Early preventative measures are fundamental to the success of a long term strategy to tackle the obesity epidemic at a population level

There is a new PSA target on child health and wellbeing: to reduce the proportion of overweight and obese children to 2000 levels by the year 2020. This new target builds on the PSA target set in 2004 to halt the year on year rise in obesity among children under 11 by 2010. The LAA has a target to reduce the percentage of children in year 6 who are obese, as measured by the National Child Measurement Programme. From September 2008, there is a target for all pupils to do five hours of PE, sport and physical activity.

13.2. THE IMPACT OF OVERWEIGHT AND OBESITY

13.2.1. Adults

Obesity is associated with a range of conditions that contribute to a reduction in life expectancy of an average of nine years. Obese individuals are at increased risk of spending a greater proportion of their lives in a poorer health state compared to non-obese people. The estimated proportion of various diseases attributed to obesity is shown in Table 13.1:

Table 13.1: Proportion of various diseases attributable to obesity

Disease	Relative Risk	Attributable proportion (%)
Hypertension	2.9	24.1
Myocardial infarction	1.9	13.9
Angina pectoris	2.5	20.5
Stroke	3.1	25.8
Venous thrombosis	1.5	7.7
NIDDM	2.9	24.1
Hyperlipidaemia	1.5	7.7
Gout	2.5	20
Osteoarthritis	1.8	11.8
Gall-bladder disease	2	14.3
Colorectal cancer	1.3	4.7
Breast cancer	1.2	3.2
Genitourinary cancer	1.6	9.1
Hip fracture	0.8	-3.5

13.2.2. Children

Reducing overweight and obesity in children is fundamental to the success of a long-term strategy to tackle the obesity epidemic at a population level. The main long-term risk of obesity in children and young people is its persistence into adulthood, where it is associated with a greatly increased risk of type 2 diabetes; a moderately increased risk of high blood pressure, coronary heart disease, stroke, osteoarthritis; and an increased risk of specific cancers. Obesity is also associated with reproductive problems in women.

Additional health problems associated with overweight or obesity, which can arise in childhood or adolescence, include hypertension, dyslipidaemia and hyperinsulinaemia, the exacerbation of existing conditions such as asthma, and psychological impacts. Psychological impacts of obesity include poor self-esteem, being perceived as unattractive, depression, disordered eating and bulimia.

13.3. OBESITY AND OVERWEIGHT IN ISLINGTON

13.3.1. Adults

The prevalence of adult obesity in Islington is estimated to be 16.8% (95% CI 15%-19.0%). This is slightly lower than for England as a whole (21.4%). The results of the

new Health Survey for England Boost may provide fresh local data on which to update these estimates for the borough.

Crude estimates of the numbers of overweight and obese adults in Islington by age and sex are given in Tables 13.2 and 13.3 below. These estimates do not take into account differences between the England and Islington populations in terms of deprivation or ethnicity. These crude estimates suggest there are approximately 28,000 obese adults in Islington, and a further 50,000 adults who are overweight.

Table 13.2: Estimated number of overweight and obese men in Islington, by age

BMI category	16-24	25-34	35-44	45-54	55-64	16-64 total
<25	7684	10279	4939	2290	1480	26671
25 to <30 (overweight)	2513	10254	8332	4532	3236	28867
30 to 40 (obese)	916	4156	4264	2546	1647	13529
>40 (morbidly obese)	45	199	231	143	71	688
Total ≥30	**960**	**4356**	**4495**	**2689**	**1718**	**14217**

Source: GLA and Health Survey for England 2005

Table 13.3: Estimated number of overweight and obese women in Islington, by age

BMI category	16-24	25-34	35-44	45-54	55-64	16-64 total
<25	8691	14227	7419	4024	2410	36771
25 to <30 (overweight)	2318	7498	5552	3235	2848	21451
30 to 40 (obese)	1406	4001	3101	2210	1862	12579
>40 (morbidly obese)	253	795	583	385	183	2199
Total ≥30	**1660**	**4795**	**3684**	**2594**	**2045**	**14778**

Source: GLA and Health Survey for England 2005

Fruit and vegetable consumption is a key marker of a healthy diet. Low levels of fruit and vegetable consumption (less than five portions per day) is a key risk factor for a range of chronic diseases. An estimated 26.9% of adults in Islington consume five portions of fruit and vegetables per day, broadly similar to the estimated 26.3% of adults in England.

The recommended level of physical activity for adults is 30 minutes of moderate intensity physical activity on five days per week. Overall, physical activity levels in Islington are higher than England overall, but markedly lower for manual and non-white groups (Table 13.4).

Table 13.4: Proportion of adults undertaking 30 minutes of moderate physical activity on at least three days per week, by gender and social class, 2006

	Gender			Social Class	
	Persons	**Male**	**Female**	**Non-manual**	**Manual**
Islington	24.0%	26.4%	21.7%	27.9%	9.8%
London	21.3%	23.8%	18.9%	21.9%	15.1%
England	21.0%	23.7%	18.5%	22.0%	15.9%

Source: Sport England: Active People Survey, 2006.

13.3.2. Children

Almost a quarter of year 6 children in Islington are obese, considerably higher than across the whole of England. Table 13.5 shows the prevalence of overweight and obesity in Islington in 2007, as recorded by the National Child Measurement Programme.

Table 13.5 Prevalence of overweight and obesity in Islington by school year, 2007

		% overweight	% obese	% measured
Reception	Islington	12.8	10.6	91
	London	12	11.3	83
	England	13.0	9.9	83
Year 6	Islington	14.2	23.6	89
	London	14.8	20.8	81
	England	14.2	17.5	78

13.4. SERVICES IN ISLINGTON

A broad range of interventions and activities are directed towards the prevention and management of overweight and obesity across Islington. These interventions span

the entire pathway from primary prevention activities focused on promoting healthy eating and physical activity in the general population, through to tertiary services for obese and morbidly obese individuals, including pharmacotherapies and bariatric surgery.

The best way to prevent overweight and obesity is to eat healthily and exercise regularly. Prevention activities in Islington include the promotion of healthy eating and regular physical exercise in both adults and children. The provision of green and open spaces, parks and play areas, and safe walking and cycling routes all contribute opportunities for physical activity.

Secondary management is primarily based on weight management, through diets, exercise and behavioural therapy, and pharmacotherapies or surgery where appropriate. These activities happens in a variety of settings ranging from self-help, community and commercial activity, primary care and acute settings. Acute-based tertiary services are provided for people with morbid obesity (a BMI of 40 or more, or 35 or more in the presence of significant co-morbidities).

13.5. BREASTFEEDING

Breastfeeding provides significant health benefits for both baby and mother. For the baby, benefits include protection against common childhood infections, including gastroenteritis, respiratory infections, otitis media and urinary tract infections, as well as diabetes mellitus. The longer-term benefits include lower blood pressure and protection against obesity. Exclusive breastfeeding for six months is associated with a 20% reduction in the relative risk of obesity in childhood. Mothers who breastfeed have lower levels of breast, ovarian and endometrial cancers.

Islington recognises the importance of breastfeeding locally, making it a partnership target in its first Local Area Agreement.

13.5.1. Breastfeeding in Islington

Initiation rates for breastfeeding in Islington are high. Nationally, there is a significant reduction in breastfeeding between initiation and breastfeeding at six weeks. Islington reflects this national pattern (Table 13.6).

Table 13.6: Exclusive breastfeeding rates: initiation (within 48 hours), 10-14 days and 6-8 weeks

	Initiation	10-14 days	6 – 8 weeks
Islington 2007/8	85%	59%	N/A
England 2005	66%	39% (2 weeks)	22% (6 weeks)

Source: Islington 2007/8: Child Health Records
England 2005: Infant Feeding Survey, 2005

In Islington, there are currently seven breastfeeding support groups, located in health centres and Children's Centres. 50 staff and volunteers have received UNICEF baby-friendly training (as at November 2007), and 23 Islington mothers finished training as peer helpers during 2007/8 (with another 12 in training as at January 2008); 8 have gone on to higher level training to become trained peer supporters.

The Local Area Agreement has invested in a breastfeeding co-ordinator post, development of volunteers and drop-in support networks and in the training and development of staff and volunteers.

13.6. RECOMMENDATIONS

Action to tackle overweight and obesity in Islington and its determinants requires concerted action across a wide range of settings, by a broad range of partners. There are examples of good practice on which to build, including the ProActive five-year strategy and action plan for promoting physical activity for all in Islington, developed and supported by the ProActive Partnership. This borough-wide physical activity and sports partnership provides a strategic lead and a joined up approach to increasing physical activity levels in Islington.

Recommendations to address obesity and overweight in Islington include:

- Use of social marketing techniques to promote behaviour change (healthier eating and increased physical activity)
- Continued support of the ProActive Partnership and ProActive strategy, and progress with implementation of the five-year ProActive action plan
- Tackling obesity in children should be a fundamental component of a long-term population strategy for overweight and obesity in Islington.
- The London 2012 Olympics present opportunities across London to promote and improve health and well-being and these should be harnessed.

- Partners should support the development and implementation of an Islington Food Strategy and three year action plan for 2008-2011.

Specific recommendations to address childhood obesity include:

- All Health Visitor team staff, relevant maternity and Children's Centre staff should receive up to date UNICEF baby-friendly training
- Fully implement the children's obesity care pathways, ensuring all relevant professionals are fully aware and utilising the pathway
- Continue to participate with the National Child Measurement Programme and aim for maximum participation rates. Use this information to identify school populations who are likely to be at greater risk of obesity and target interventions to these schools and/or geographic areas
- Use health impact assessments with partners including planning and housing departments to create local environments that promote physical activity through spaces to play, good public transport, appropriate sitting of services (e.g. schools and shops) and increasing safety and perception of safety in order to increase "walk-ability" and "cycle-ability" in the borough.

14. CHILDHOOD IMMUNISATION

14.1. INTRODUCTION

After clean water, vaccination is the most effective and cost-effective public health intervention in the world. The main aim of vaccination is to protect the individual who receives the vaccine from specific infections. Those who are vaccinated are also less likely to be a source of infection to others. This reduces the risk of unvaccinated individuals being exposed to infection and means that individuals who cannot be vaccinated will still benefit from the routine vaccination programme (population or 'herd' immunity). A decrease in vaccination uptake is likely to lead to outbreaks of disease.

Childhood immunisation rates tend to be lower in Islington than the national average, but higher than the London average for some vaccines. Improvement of immunisation uptake is an important public health priority for Islington PCT over the next few years.

14.2. CHILDHOOD IMMUNISATION SCHEDULES

14.2.1. Routine childhood immunisation

Table 14.1 illustrates the routine childhood vaccination programmes in the UK.

Table 14.1: Routine vaccination schedule in Islington, September 2008

Age	Vaccination
0	BCG
2 months	DTaP(5)/IPV/Hib & PCV
3 months	DTaP(5)/IPV/Hib & Men C
4 months	DTaP(5)/IPV/Hib & PCV & Men C
12 months	Hib/Men C
13 months	MMR & PCV
3yr 4 months	MMR, DTaP(3)/IPV (or dTaP(5)/IPV)
12-13 years	HPV *(for girls only)*
13-18 years	Td/IPV

Key: BCG = tuberculosis vaccine; D = diphtheria; T = tetanus; aP = acellular pertussis (whooping cough); IPV = inactivated polio vaccine; Hib = *haemophilus influenzae* type b; PCV = pneumococcal conjugate vaccine; Men C = meningocococcal group C vaccine; HPV = human papilloma virus vaccine.

Primary courses of the vaccines are given at specified ages and, for some vaccines, boosters are given to maintain the duration of the immunity and hence the protection against the particular infection.

14.2.2. Selective childhood immunisations

In addition to the routine childhood vaccinations, there are also selective vaccinations including:

- Neonatal Hepatitis B for babies at high risk, for example babies born to mothers who are carriers of the virus
- Neonatal BCG vaccination for TB. This is offered to all babies born to Islington residents as the prevalence of TB is high in this area. The Islington PCT universal neonatal BCG programme was implemented on 1st of May 2007.

14.3. IMMUNISATION IN ISLINGTON

The uptake of vaccination in parts of England including London has decreased over the past few years and Islington's immunisation uptake rate is below recommended levels necessary to prevent outbreaks. There has already been an outbreak of measles involving two schools in Islington this year.

14.3.1. DTaP/IPV/Hib coverage

In 2007-08, the uptake of DTaP/IPV/Hib for one year olds was 84%. This is higher than the London rate but lower than the rate for England at 90%.

14.3.2. Measles Mumps and Rubella (MMR)

Following a decade of relatively low MMR vaccination uptake, there are now a large number of children who are unvaccinated or partially vaccinated with MMR. Measles is serious, and can lead to pneumonia and encephalitis, and ultimately death. In 2007-08, the uptake of MMR vaccination in Islington among two year olds was 71%, lower than London at 72% and England at 84%. These data may not be entirely

complete or accurate, however, due to problems with the child health interim application (CHIA).

14.3.3. TB

In 2007-08, 2,468 BCG vaccinations were given to children under one. This included children under one year of age who were offered the vaccination as a catch up until August 2007.

14.3.4. Hepatitis B and rubella

Vaccination coverage rates for neonatal/infant Hepatitis B and postpartum MMR are below expected levels.

14.3.5. HPV

The new human papillomavirus (HPV) vaccine programme for 12-13 year old girls in school year 8 will start from autumn 2008. The vaccine will be available to protect against HPV types 16 and 18 that cause 70% of cervical cancer. Over the next three years, there will also be a catch-up programme for older school girls.

14.4. IMMUNISATION SERVICES IN ISLINGTON

The majority of primary childhood immunisations are provided by GP practices. 32 practices in Islington are contracted to deliver the childhood immunisation programme. Childhood immunisations are also delivered within community clinics and Children's Centres.

The neonatal BCG programme is delivered in designated health centres within universal children's services. Immunisations for children aged over 5 years, including targeted BCG, are provided within a schools based programme with the support of Islington schools and the CEA.

Neonatal Hepatitis B vaccination is mainly provided by maternity services at UCH and the Whittington Hospital with follow up vaccines given in the paediatric out patients.

The Looked after Children team (LAC) assess the immunisation status of all children within their remit. 82% of looked after children are fully immunised, and this is expected to increase following a review of data collection. The main difficulties faced are not receiving information for out of borough placements, tracing historical data for older children and identifying asylum seeking children whose immunisation status have not been picked up prior to being looked after.

In recognition of the need to improve the uptake of childhood immunisations several developments are underway in Islington:

- The establishment of an immunising team to be headed by an immunisation specialist and to include a nurse co-ordinator and administration post
- The further development of immunisation clinics within Children's Centres
- Collaborative working with neighbouring PCTs
- Improved seamless working between health visiting and school health; reconfiguration of services towards a universal 0-19 years service
- Implementation of a new database system for children's services (RiO)

14.5. RECOMMENDATIONS

Recommendations to improve the uptake of childhood immunisations in Islington include:

- To improve data flow, collection and collation
- To review patient reminder and recall systems
- To increase the reach in primary care and community setting and also consider delivery of immunisation at home (domiciliary visits) and in all children's venues including schools, health centres, children's centres and hospitals
- To promote immunisation at various settings by various stakeholders
- To work with Cambridge Education Authority to investigate possibility of including immunisation status on school entrant information
- To develop an immunisation strategy in partnership with all stakeholders including primary care.

15. COMMUNITY SAFETY

15.1. INTRODUCTION

Crime and anti-social behaviour can have a significant detrimental impact on the health and wellbeing of the people affected.

Over the last four years, Islington has seen a continual decline in crime figures, with notable reductions in violent crime, sexual offences and racist crime. Although overall levels of crime have dropped, they did so at a lesser rate than those of other boroughs across the whole Metropolitan Police Service area.

15.2. THE EFFECT OF CRIME ON HEALTH AND WELLBEING

There is a clear correlation between crime and negative quality of life. Violent crime obviously causes physical injury, but can also have a serious impact on a person's mental health. Less directly, fear of crime can be detrimental in ways affecting both health and wellbeing, and can result in an individual limiting his or her lifestyle and becoming socially withdrawn.

Violence disproportionately affects certain groups of people, including the young, vulnerable and deprived. The British Crime Survey (BCS) shows that violent crime displays unequal risks compared to other offences such as burglary and vehicle-related theft. Victims of crime often suffer beyond immediate injuries. A 1999 review by Crime Concern indicated that victims of violent crime experienced deterioration in both their actual and perceived health resulting in increased medical consultation. Victims of physical violence have increased rates of cigarette smoking, alcohol and other substance misuse, risky sexual behaviours and sleeping and eating disorders

Violent attacks are not the only offences that affect health and wellbeing. The majority of people who suffer other forms of crime, such as acquisitive offences, suffer some level of psychological distress in the immediate aftermath. There are also health issues associated with anti-social behaviour and disorder. Research suggests that a person's early contact with the police, truancy, school misconduct

and divorce are significant predictions of premature death. Damage to the environment can also have an adverse affect on the community's residents.

Sex workers also face a number of health issues. Although levels of sexually transmitted infections have declined by two thirds over the last 20 years within this group, sex workers continue to be at high risk.

15.3. CRIME AND ANTISOCIAL BEHAVIOUR IN ISLINGTON

The Home Office regards Islington as a high crime area. The borough has more offences per 1,000 residents than any other London borough, and experiences proportionally more crimes than all of its comparator areas, with 25.3 crimes per 1,000 residents compared to the London average of 19.5 (Table 15.1).

Table 15.1: Islington performance against British Crime Survey comparator crimes

	Performance (number of crimes)			
	Baseline 2003/04	**2006/07**	**2007/08**	**Change from baseline**
BCS comparator crime	25,066	20,434	16,818	Down 33%
Theft from a vehicle	5,553	3,581	3,152	Down 43%
Criminal damage (excluding 59)[1]	4865	3408	2894	Down 41%
Assault without injury (including on police officer)	2860	1493	1427	Down 50%
Domestic burglary	2611	2450	2113	Down 19%
Theft from the person	2344	2466	1687	Down 28%
Theft or unauthorised taking of a vehicle	2043	1192	838	Down 59%
Theft or unauthorised taking of a cycle	1898	1682	1301	Down 31%
Wounding (serious and other)	1594	2668	2199	Up 38%
Robbery of personal property	1274	1381	1119	Down 12%

[1] Refers to criminal damage offences which do not include threat or possession with intent to commit criminal damage.

Vehicle interference	24	113	88	Up 267%

The Safer Islington Partnership recently identified the priority crimes and disorders as:

15.3.1. Crime priorities

- Violence against the person: decreased over the last four years
- Personal robbery: following an increase in 2005/06 and 2006/07, Islington saw a 19% decline during 2007/08, which mirrors reduced levels seen across London for the same period. Although personal robbery offences are generally low, the public perception is that these offences are more common. Analysis suggests that personal robbery offences are largely concentrated around busy areas such as the prominent commercial areas of Angel and the Nags Head as well as London Underground stations including Finsbury Park, Archway and Highbury Corner
- Life threatening and gun crime: over the past couple of years the borough has seen a marked decline in life-threatening and gun crimes, with overall offences down by 35% in the 12 months ending March 2008 and a 46% decline on 2005/06 levels
- Residential burglary: burglary offences are split into two categories: - residential and commercial. In 2006/07 there was a slight increase in burglary offences in Islington, attributed to a rise in the number of residential offences (1.2%). However, 2007/08 has since seen a decline of 10.3% – the lowest levels in four years, which can largely be attributed to the fall in residential offences.

15.3.2. Disorder priorities

- Youth disorder
- Substance misuse and alcohol
- Street population
- Environmental disorder

Disorder and anti-social behaviour are complex and difficult to measure for a number of reasons. They cannot be measured in the same way as crimes since acts of antisocial behaviour are perceived differently by different people. Crime data relating

to drug use is often misleading as figures are dependent on the priorities or policing operations occurring at any given time.

15.4. RECOMMENDATIONS

Our vision for 2020 is that Islington will be a place where people feel secure, enjoy the facilities and services the borough provides, and have an increased sense of community cohesion. Recommendations to achieve this vision are:

- To reduce priority crimes (personal robbery, serious violence, life threatening and gun crime and residential burglary) through developing robust enforcement, increasing the number of offenders brought to justice and targeting crime hotspots
- To prevent young people from falling into offending behaviour through education programmes, drug and alcohol prevention schemes, and support to stay in education and training taking them into work
- To tackle substance misuse through the disruption of drug supply, preventing harm to children exposed to drug and alcohol misuse, and delivering new approaches to treatment
- To improve outcomes for victims of domestic violence and hate crimes through targeted programmes to support survivors, improved co-operation between agencies when responding to victims and increased awareness through education
- To build safer communities through reducing antisocial behaviour and the perceptions of crime by introducing a system of restorative justice and building links with new communities.

16. ALCOHOL

16.1. INTRODUCTION

Alcohol plays an important role in our society and economy. Alcohol misuse is an increasing problem, with binge drinking and chronic drinking particularly likely to cause harm. There are a number of adverse health outcomes associated with alcohol misuse. Alcohol misuse is also associated with crime and disorder, social problems and economic loss.

In Islington, alcohol misuse reduces average life expectancy by an estimated 10.5 months for men and 9.4 months for women. Hospital admissions associated with alcohol are significantly higher for men in Islington compared to England. Islington also has the highest recorded rate of crimes attributable to alcohol in London.

16.2. THE HEALTH EFFECTS OF ALCOHOL

There is some evidence that moderate amounts of alcohol may have health benefits for some groups of people. Certain drinking patterns are likely to lead to harm, including binge drinking (where large amounts of alcohol are drunk in a relatively short space of time), and chronic drinking (the regular consumption of large amounts of alcohol).

Alcohol-related diseases include acute events such as alcohol poisoning, accidents and premature death, and chronic conditions such as hypertension, liver disease, pancreatitis, fetal damage, certain cancers, and premature death. In addition to health-related problems, alcohol misuse is associated with crime and disorder, including anti-social behaviour and domestic violence, social problems such as incapacity, teenage pregnancy, and school exclusions. Alcohol misuse results in significant economic cost to both the NHS and the criminal justice system, loss of productivity and earnings, and wider societal costs such as family breakdown.

16.3. ALCOHOL MISUSE IN ISLINGTON

Table 16.1 lists the estimated rates of alcohol misuse and other patterns of drinking in Islington.

Table 16.1 Drinking patterns in Islington

Indicator	Definition	Rate in Islington	England
Safe (sensible) drinking	Drinking in a way that is unlikely to cause yourself or others significant risk of harm. The Government advises that: ▪ adult women should not regularly drink more than 2–3 units of alcohol a day ▪ adult men should not regularly drink more than 3–4 units of alcohol a day ▪ pregnant women or women trying to conceive should avoid drinking alcohol	Not calculated	Not calculated
Binge drinking	Drinking over twice the recommended units of alcohol per day in one session.	15.2% (95% CI 13.0 – 17.8)	18.0% (95% CI 17.4 – 19.6)
Hazardous drinking	Drinking above safe levels, but so far avoiding significant alcohol-related problems.	21.4% (95% CI 19.3% - 23.5%)	20.1% (95% CI 15.5% - 21.7%)
Harmful drinking	Drinking above safe levels (usually beyond those of hazardous drinking) with evidence of alcohol-related problems	6.1% (95% CI 5.4 – 6.8)	5.0% (95% CI 4.5% - 5.6%)

Drinking patterns in Islington do not differ significantly from rates seen for the whole of England. The health impacts of alcohol misuse in Islington are listed in Table 16.2.

Table 16.2: Alcohol related health outcomes in Islington

Indicator	Rate in Islington	England
Alcohol specific mortality	Male: 11.6 per 100,000 (95% CI 6.7-16.3) Female: 5.0 per 100,000 (95% CI 2.0-8.0)	Male: 12.0 per 100,000 (95% CI 11.8 – 12.3) Female 5.4 per 100,000 (95% CI 5.3 – 5.6)
Alcohol related mortality	Male: 53.6 per 100,000 (95% CI 36.0 – 71.3) Female: 18.9 per 100,000 (95% CI 9.9 – 28.0)	Male: 47.2 per 100,000 (95% CI 46.4 – 48.0) Female 23.8 per 100,000 (95% CI 23.3 – 24.3)
Mortality from chronic liver disease	Male: 19.1 per 100,000 (95% CI 8.4 – 29.8) Female: 0.0 per 100,000 (95% CI 0.0 – 0.0)	Male: 13.4 per 100,000 (95% CI 12.9 – 13.8) Female: 6.8 per 100,000 (95% CI 6.5 – 7.1)
Reduced life expectancy attributable to alcohol	Male: 10.5 months Female: 4.8 months	Male: 9.4 months Female: 4.4 months
Alcohol specific hospital admissions	Male: 604.35 per 100,000 (95% CI 546.6 – 662.1) Female: 185.2 per 100,000 (95% CI 155.2 – 215.1)	Male: 339.7 per 100,000 (95% CI 337.4 – 342.0) Female 164.0 per 100,000 (95% CI 162.5 – 165.6)
Alcohol related hospital admissions	Male: 1217.8 per 100,000 (95% CI 1137.1 – 1298.5) Female: 563.3 per 100,000 (95% CI 511.8 – 614.7)	Male: 909.0 per 100,000 (95% CI 905.3 – 912.6) Female 510.4 per 100,000 (95% CI 507.8 – 513.1)
Alcohol specific hospital conditions, under 18	48.0 per 100,000 (95% CI 35.6 – 63.2)	60.6 per 100,000 (95% CI 59.8 – 61.5)

Although many of the indices in Islington are similar to national rates, the rate of alcohol specific and alcohol related hospital admissions in Islington is significantly higher for men. Likewise, the alcohol related crime rates are higher in Islington than for the country as a whole (Table 16.3).

Table 16.3: Alcohol related crime in Islington

Indicator	Rate in Islington	England
Alcohol related crime	19.6 recorded crimes per 1,000 population (95% CI 18.9 – 20.2)	10.2 per 1,000 population (95% CI 10.1 -10.2)
Violence against the person attributable to alcohol	12.7 per 1,000 population (95% CI 12.2 – 13.2)	7.2 1,000 population (95% CI 7.1 – 7.2)
Sexual offences attributable to alcohol	0.2 per 1,000 population (95% CI 0.1 – 0.3)	0.1 per 1,000 population (95% CI 0.1 – 0.1)

In Islington, the number of claimants of Incapacity Benefit or Severe Disablement Allowance whose main medical reason is alcoholism is 250.6 per 100,000 working age population, considerably higher than the rate for England (122.7 per 100,000).

16.4. ADDRESSING ALCOHOL MISUSE IN ISLINGTON

Services to address alcohol misuse in Islington are organised as follows:

16.4.1. Better education and communication

Islington Healthy Schools includes alcohol awareness as part of the PHSE curriculum. Nationally, the Department of Health and the Home Office are running the "Know Your Limits" campaign, whilst locally sensible drinking messages are published at key times, for example at Christmas.

16.4.2. Identification and treatment

The current Alcohol Treatment system is undergoing a period of service redesign arising from the Alcohol Treatment Service Review in 2006. There are currently a number of services in place, including shared care and direct access tier 2 and 3 services, a women's alcohol service, a tenancy support programme, day centres, a crisis centre, and hospital and community services.

16.4.3. Combating alcohol-related crime and disorder

Islington's Alcohol Task Force conducts intelligence led patrols to prevent alcohol related crime and anti-social behaviour, as well as providing a rapid response to alcohol-related incidents. This is in addition to regular patrols already carried out by Safer Neighbourhood Teams. Police officers, park rangers, youth workers, town centre managers, representatives from Connexions and housing providers work together to tackle alcohol-related crime and anti-social behaviour. Alcohol exclusion zones have been established in Elthorne and Kinloch parks. An alcohol arrest referral scheme is being piloted, and the Probation Service undertakes alcohol screening for all clients.

16.4.4. Working with the alcohol industry

Regulation of licensable activities, including the sale of alcohol, is undertaken by Islington Council. The Council facilitates the "Pubwatch" and "Best Bar None" schemes, and works with the police and fire service undertaking proactive visits to licensed premises. The council also holds an annual Licensing Seminar. Trading Standards work with the police on tackling under-age sales and counterfeit alcohol.

The Islington Alcohol Treatment Services Review in 2006 identified a number of findings concerning current provision, including unclear pathways of care for service users and a level of fragmentation in current provision. In response to this it made recommendations concerning areas of service improvement including greater specificity in the services provided and pathways into the service. It also recommended the re-specification of existing specialist statutory alcohol services focused on the delivery of medical and psychological interventions for complex dependent drinkers, and a re-allocation of existing resources to enable the development of a more comprehensive primary care based alcohol service. This service was expected to be operational from April 2008, however, this has been delayed and is expected to be finalised soon. This reallocation will also lead to a reconfiguration of local services provided in A&E and hospital settings as well as increasing the services available to assess, identify and treat in a primary care setting.

16.5. RECOMMENDATIONS

Islington's local Alcohol Harm Reduction Strategy reflects the national Alcohol Strategy, aiming to provide a multi-agency response to prevent or minimise harm through information, advice and guidance, training and education, screening, communications, and co-ordination of activities. The Models of Care for Alcohol Misusers (MoCAM) provides evidence-based good practice guidance to both commissioners and providers for the delivery of interventions and treatment for adult alcohol misuse.

Current recommendations are as follows:

- Promote organisational and community awareness – through consistent information, advice and guidance in a variety of settings and formats.
- Workforce interventions – use opportunities to identify and intervene early if there are problems; develop staff training to recognise signs and symptoms and provide advice. Public sector organisations are required to have workplace substance misuse policies.
- Work with the alcohol industry - licensing policy, bar layout and staff training can support reductions in drunkenness, as well as protect staff and other customers from violence and injury. Plastic/polycarbonate glass schemes have the potential to reduce injuries. Action on underage sales remains important.
- Identification and treatment: Implementation of the Islington Alcohol Services Review (2006). The review made a number of recommendations for service improvement, including clearer pathways into the service, services more focused on the delivery of interventions for complex dependent alcohol users and a more comprehensive primary care service.
- Identification and treatment: Accident and Emergency, primary care and criminal justice settings (e.g. custody suite) are all potential areas for screening and brief interventions.

17. SUBSTANCE MISUSE

17.1. INTRODUCTION

Substance misuse is strongly associated with poverty and deprivation and results in a range of problems, including death, poor physical and mental health, crime, poor family and social functioning, and social and economic exclusion. The total economic, health and social cost of drug misuse is estimated at between £10.9 billion and £18.8 billion, with problem drug use accounting for 99% of the total cost.

Most illicit drug use is on a recreational basis. London has the highest rates of illicit drug use in the country, and has been dubbed the 'drugs capital of the United Kingdom'. The highest proportion of drug use is in the 16-24 age group. National estimates of the prevalence of opiate and/or crack cocaine use in 2004/05 and 2005/06 ranked Islington as the borough with the highest and second highest prevalence in London.

Islington exceeded its target of 1,627 people in substance misuse treatment in 2006/07, achieving 1,806 persons in treatment. Concerns over the capacity of the existing treatment system means that there is doubt around meeting the stretched target of 1,789 for 2007/08. Islington's performance for retention during 2006/07 was one of the lowest at 66%, and improving retention has been identified as a local priority. The target has increased in 2007/08 to 83%.

17.2. HEALTH EFFECTS OF SUBSTANCE MISUSE

Substance misuse has significant negative effects on health and wellbeing. Levels of mortality and morbidity among people who misuse drugs is high as a consequence of overdose and blood-borne virus infections. Nearly 75% of people using drug treatment services have experienced mental health problems including depression, anxiety, personality disorders and psychotic disorders. Drug-related mortality following release from prison is high. Drug misuse can place an enormous strain on families. It is estimated there are between 250,000 and 350,000 children of problem drug users in the UK.

17.3. SUBSTANCE MISUSE IN ISLINGTON

There are a number of methodological issues regarding measurement of the prevalence of substance misuse, particularly amongst certain population sub-groups. However, evidence suggests that rates of problem drug use in Islington are significantly higher than the rest of the country (Table 17.1).

Table 17.1: Estimated prevalence of substance misuse, persons aged 15-64, 2004/05 and 2005/06

	England			London			Islington		
Problem drug use	**Rate**	**LCL**	**UCL**	**Rate**	**LCL**	**UCL**	**Rate**	**LCL**	**UCL**
2004/05	9.93	9.88	10.41	14.35	13.86	15.68	34.93	27.23	49.96
2005/06	9.97	9.74	10.40	14.99	14.48	15.90	29.87	26.02	36.02
Opiate use	**Rate**	**LCL**	**UCL**	**Rate**	**LCL**	**UCL**	**Rate**	**LCL**	**UCL**
2004/05	8.53	8.48	8.88	10.64	10.15	11.53	22.01	18.44	27.10
2005/06	8.60	8.46	8.99	11.39	11.04	12.41	21.10	17.97	26.39
Crack use	**Rate**	**LCL**	**UCL**	**Rate**	**LCL**	**UCL**	**Rate**	**LCL**	**UCL**
2004/05	5.85	5.70	6.39	9.90	9.29	10.77	19.93	15.82	24.03
2005/06	5.93	5.73	6.25	10.77	10.27	11.43	28.33	23.32	34.82
Injecting	**Rate**	**LCL**	**UCL**	**Rate**	**LCL**	**UCL**	**Rate**	**LCL**	**UCL**
2004/05	4.16	4.04	4.52	3.45	3.12	4.63	10.45	8.18	14.04
2005/06	3.90	3.78	4.11	4.03	3.78	4.49	11.81	9.31	15.63

In 2004/05, Islington was identified as having the highest prevalence of problem drug misuse in England, and the second highest rate in 2005/06. The Islington estimate for 2005/06 is almost twice the London rate, and represents an estimated 4,080 problem drug users.

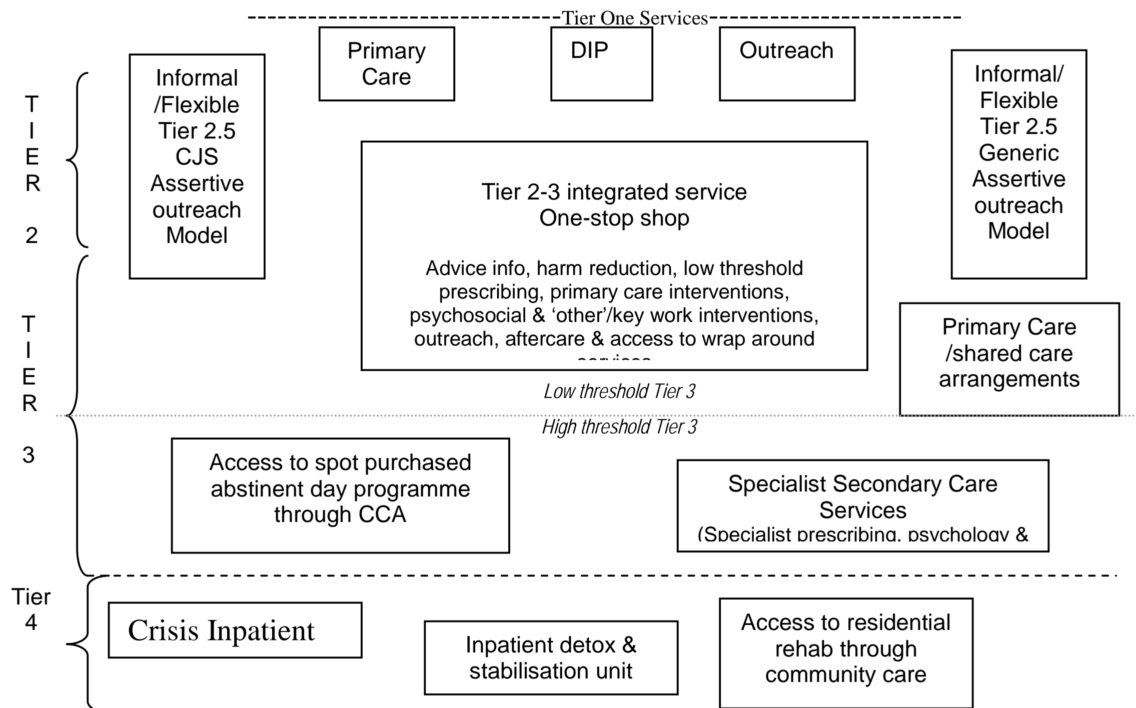
In 2007, 17% of a sample of pupils aged 11-15 said they had taken drugs in the previous year and 10% in the previous month. The prevalence of drug use is similar among boys and girls, and increases with age.

17.4. ADDRESSING SUBSTANCE MISUSE IN ISLINGTON

The focus of the Islington strategy for drug treatment is to develop an integrated treatment system that promotes easy access to and retention in structured treatment.

Whilst services are provided within a harm reduction model of service delivery, the ultimate aim of local treatment is to support individuals in decreasing and abstaining from drug use and activities associated with problematic drug use services. Current adult service provision is expected to be restructured during 2008/09. The revised model is shown in Figure 17.1.

Figure 17.1 Model of Service Delivery from 2008/09



The Islington Young People's Drug and Alcohol Service (IYPDAS) provides an integrated service across the four tiers with a multidisciplinary team across children's services and Children and Adolescent Mental Health Service (CAMHs) working with young people under 19 years. These services aim to provide a series of specialist substance misuse services within mainstream service provision which a young person and their family can access as a complete package or select the most appropriate combination for their needs.

17.5. RECOMMENDATIONS

For 2008/09 the key priorities for adult treatment are:

- To ensure the implementation of the Islington Drug Treatment System and Services Review
- To make low threshold prescribing accessible through the 'one stop shop', primary care prescribing accessible through GPs and specialist prescribing accessible through specialist secondary care services providing structured treatment for 2,000 people per year
- Re-specification of services as provided by the Camden and Islington Foundation Trust, Islington PCT and Cranston Milton Days Skills Centre so that they are provided as part of an integrated treatment system.

The key recommendations for young people's services are:

- Pilot and evaluate a group work programme
- Implement a notification system, which will enable IYPDAS to contribute to all pre-sentence reports for drug-related and other offences.
- Forge stronger links between IYPDAS, homeless services, primary care and adult drug and alcohol services around transitions for young people
- Facilitate a multi-agency conference in 2008, incorporating a family approach, to launch the proposed interagency procedures for working with substance-using families
- Develop a mentoring scheme specific for young people affected by parental substance misuse, following participation in group work.

18. THE LOCAL ENVIRONMENT

18.1. INTRODUCTION

For people to achieve optimal health, the physical environment around us must both enhance health directly and provide opportunities for people to live a healthy life. Dissatisfaction with the environment can lead to low levels of physical activity, low levels of mental wellbeing, and poor quality of life.

Islington is the smallest and most built up of all London boroughs. The dense, urban environment presents both challenges and opportunities. While access to local shops, services and public transport is generally good, Islington suffers high levels of air pollution from traffic, particularly around main roads and the quality of open spaces varies considerably.

The LAA includes the following targets relating to environmental quality:

- To increase the number of Green Flag or Green Pennant Accredited parks and open spaces in Islington to nine by 2009
- To increase residents' use of parks as judged by the following indicators:
  - To increase the proportion of residents who say they use parks and open spaces in Islington to at least 62%
  - To increase the proportion of residents who say they are satisfied with the quality of parks and open spaces in Islington to at least 65%
- To increase the number of hectares of publicly accessible parks and open spaces to 85.28 by 2009
- To achieve a 22% increase in the area of land approved for improved nature conservation status within the Local Development Framework (equivalent to 474,190m^2)
- To have brought unacceptable levels of litter and detritus down to an average of 18% in publicly accessible areas of both high and low density social housing estates
- To have brought unacceptable levels of litter and detritus down to an average of 24% borough-wide

18.2. THE ENVIRONMENT IN ISLINGTON

18.2.1. Open space

There are just 86.24 hectares of registered green space in Islington, among the smallest amount per person of all London boroughs. The area is made up of over 165 open spaces, mostly small but very well distributed across the borough. Islington contains a large amount of open space outside its public parks, including estate grounds, railway land and school sites. There are also several large parks just outside the borough boundary. There are three local nature reserves within Islington: Barnsbury Wood, Gillespie Park, and Parkland Walk. Fifty-two places within the borough have been designated as sites of importance for nature conservation due to their value for plants and animals.

It is estimated that there are 50,000 trees in Islington, 38,000 of which are on council owned land. Islington currently has more highway trees per linear kilometre than any other London borough.

One of the key measures of accessibility to sites of nature conservation importance is the Areas of Natural Deficiency Indicator (AOND). Islington currently has an AOND measure of 25% which means that 25% of the borough is in excess of 1 km walking distance from a site of nature conservation importance.

18.2.2. Local environmental quality

The Local Environmental Quality Survey (LEQS) provides information on how local authorities perform in providing external street cleaning services. In the first survey of 2007/08, the council LEQS score was 17.7, making it the ninth best in London.

The number of reported potentially abandoned vehicles in Islington has declined significantly over the past few years, from over 6,000 vehicles in 2002/03 to less than 1,500 in 2004/05. Table 18.1 below provides more detailed indicators relating to local environmental quality and also fear of crime.

Table 18.1: Local environmental quality and fear of crime indicators

Indicator	Value	Trend	Quartile/ Ranking	England, Wales and Scotland
Percentage of land and highways from which	11	No Trend	Bottom Quartile	4.31

unacceptable levels of graffiti are visible				
Percentage of land and highways from which unacceptable levels of fly-posting are visible	13	No Trend	Bottom Quartile	1.27
Percentage of residents surveyed who say that they feel fairly safe or very safe outside during the day	94	Worsened	Bottom Quartile	97.24
Percentage of residents surveyed who say that they feel fairly safe or very safe outside after dark	61.5	Worsened	Bottom Quartile	70.18

Source: Islington Area Profile. Audit Commission. April 2007

18.2.3. Density

Islington is the second most densely populated borough in London with 118.3 persons per hectare (pph), compared to an average of 47.8pph across London. The average density of new homes in Islington between 2002 and 2005 was 110 dwellings per hectare (dph), the tenth highest of all English local authorities. Islington has a housing target of over 1,000 new dwellings per year, making it likely that density will continue to increase.

18.3. THE HEALTH AND WELLBEING IMPACT OF THE ENVIRONMENT

18.3.1. Access to nature and open space

Access to open space and nature delivers a range of health and wellbeing benefits, both directly, by promoting good physical and mental health and wellbeing, and indirectly, by facilitating social interaction and supporting increased physical activity. People with access to nearby nature and green space are generally healthier than those without, and people living in urban areas with gardens and green space have been shown to have fewer mental health problems. Parks provide a variety of psychological, emotional and mental health benefits. Use of green space is dependent on a range of complex factors, including perceptions of safety and how accessible and welcoming parks are.

The existence of high quality urban green space contributes to wider Government objectives around quality of life, neighbourhood renewal and community cohesion. Parks provide a focal point for communities, a place for relaxation or recreation, and

the opportunity to experience nature in an urban environment. Evidence indicates that natural features within urban environments, especially in underprivileged neighbourhoods, can facilitate higher levels of social contact and social integration which have been shown to contribute to better health. Parks also provide opportunities for play for children; this provides a range of health benefits including increased physical activity.

18.3.2. Local environmental quality

Studies have suggested that features of the built environment such as graffiti, litter and general cleanliness affect mental health, although this relationship is less well established than for open space.

18.3.3. Facilitating physical activity

The physical environment plays a major role in encouraging and facilitating physical activity. The World Health Organisation has suggested that incorporating 30 minutes of physical activity into daily routine may best be achieved through active travel such as walking and cycling. Factors influencing physical activity include access to open space and greenery, levels of graffiti and litter, fear of crime, provision of local services, play and leisure opportunities and neighbourhood/street design.

18.3.4. Air quality and noise pollution

Air pollution has a negative impact on health. The World Health Organisation cites the following adverse health effects of transport-related air pollution: asthma, rhinitis, cardiovascular disease, cancer, adverse pregnancy and birth outcomes and lower male fertility. Their research indicates that distance between roads, housing and workplaces, weather conditions, volume of traffic and mode of transport all influence the level of exposure to air pollution. The World Health Organisation recommends immediate action to reduce air pollution, including considering the health impacts of urban planning to reduce exposure to transport-related air pollution.

Noise can also have a detrimental effect on health and wellbeing. In addition to causing annoyance and sleep disturbance, persistent environmental noise can have negative impacts on health, for example contributing to heart disease, hearing impairment and poor mental health.

18.3.5. Built environment and density

Evidence suggests that higher density housing can increase mental health problems, although this may be confounded by factors such as personal control, socially supportive relationships, restoration from stress and fatigue, and noise. High density areas are associated with lower social interaction. Even after adjustment for individual factors, low social capital has been shown to have a negative effect on self-rated poor health. Housing type has also been linked to a reduction in opportunity for social interaction and poor mental health. People living in deck access buildings have a significantly higher risk of depression than people living in other housing types.

18.4. RECOMMENDATIONS

Our vision is of a greener, cleaner Islington environment where continual improvements in quality, quantity and accessibility contribute to improving the health and wellbeing of the local community. Recommendations to achieve this vision include:

- Increasing the quantity and quality of open space by seeking additional open spaces from new developments and through other innovative mechanisms, and by working with residents to improve the quality of existing green spaces to better serve their needs.
- Promoting urban greening and biodiversity particularly in areas of nature deprivation, by increasing the amount of land that is deemed to be of nature conservation value, further developing of the 'greening the grey' programme and promoting of green roofs and other ecological measures in new developments.
- Improving access to play and leisure opportunities in a range of locations and areas, including by ensuring provision of play space, including unstructured space, in new developments and improving the quality of existing spaces.
- Improving environmental quality through ongoing work to tackle the cleanliness of Islington's public realm and by involving the community in delivery of projects to improve the local environment.
- Development of a healthy environment that promotes physical activity particularly through use of the Local Development Framework to further develop walkable, mixed-use neighbourhoods designed around a public

transport system which provide wide access to a range of services and facilities and open space.

19. CLIMATE CHANGE

19.1. INTRODUCTION

Climate change is having an impact in Islington. Summer temperatures are higher, and winters are warmer, wetter and windier. The high population density in the borough, coupled with the lack of open space and predicted growth in the local population, suggest that Islington will suffer the future impact of climate change to a greater extent than other parts of the country.

The borough itself is making a significant contribution to climate change through the emission of greenhouse gases, particularly carbon dioxide (CO_2). Islington's CO_2 emissions were estimated at 1.06 million tonnes in 2005, equivalent to 6.7 tonnes per person.

Islington has set itself a climate change mitigation target within its Local Area Agreement, covering the period 2006-09. The target requires:

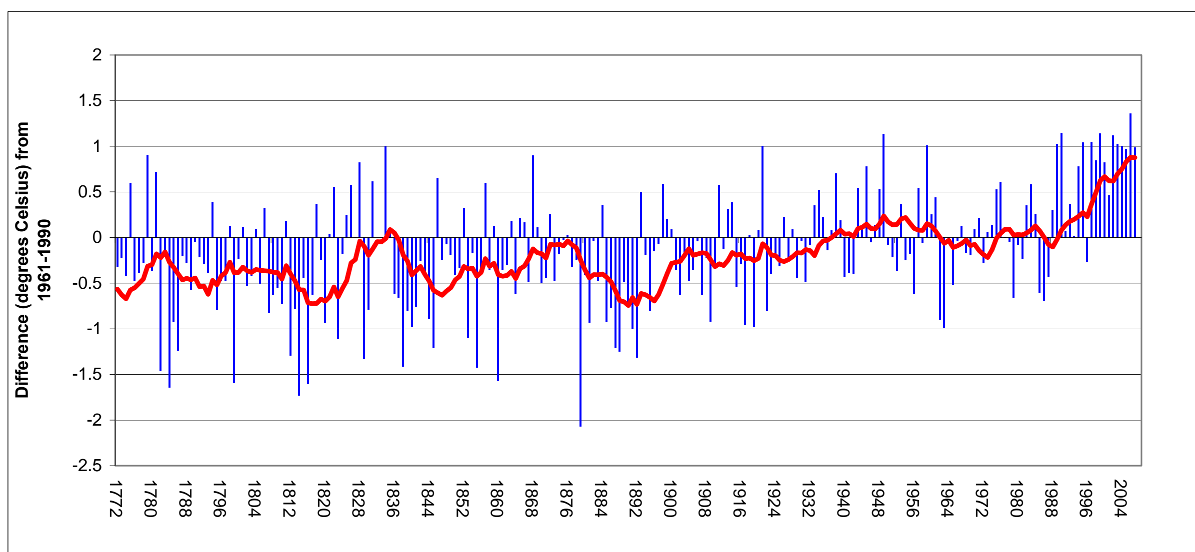
- A 15% reduction in CO_2 emissions from Islington Climate Change Partnership members using the 2006/07 baseline. This equates to a reduction of 18,750 tonnes of CO_2.
- A 5% reduction in borough wide CO_2 emissions from gas and electricity usage and transport using the 2006/07 baseline. The overall target for the borough is a combination of the reduction expected through the UK Climate Change Programme and the reduction target agreed by the Climate Change Partnership. Taken together, these result in an overall target reduction of 55,000 tonnes CO_2 by 2010.

It is likely that the LAA for 2009/12 will include National Indicator 186: per capita CO_2 emissions in the [local authority] area, which would continue the high priority given to climate change mitigation and to indicator 188 (measuring local authorities against their level of preparedness for tackling the impacts of climate change).

19.2. CLIMATE CHANGE: THE EVIDENCE

Over the past century, global mean temperatures have increased by 0.74°C and signs of this are now evident in many of earth's natural systems, including changes in our weather patterns and ecosystems. In the UK, 2006 was the warmest of the last 348 years. Met Office data show that in England, mean annual Central England temperatures are now over 2°C higher than the coolest period around 1690. Half of this increase has occurred in the last 40 years (Figure 19.1).

Figure 19.1: Mean Central England temperature annual anomalies 1778-2007



Source: Met Office 2008 (redrawn)

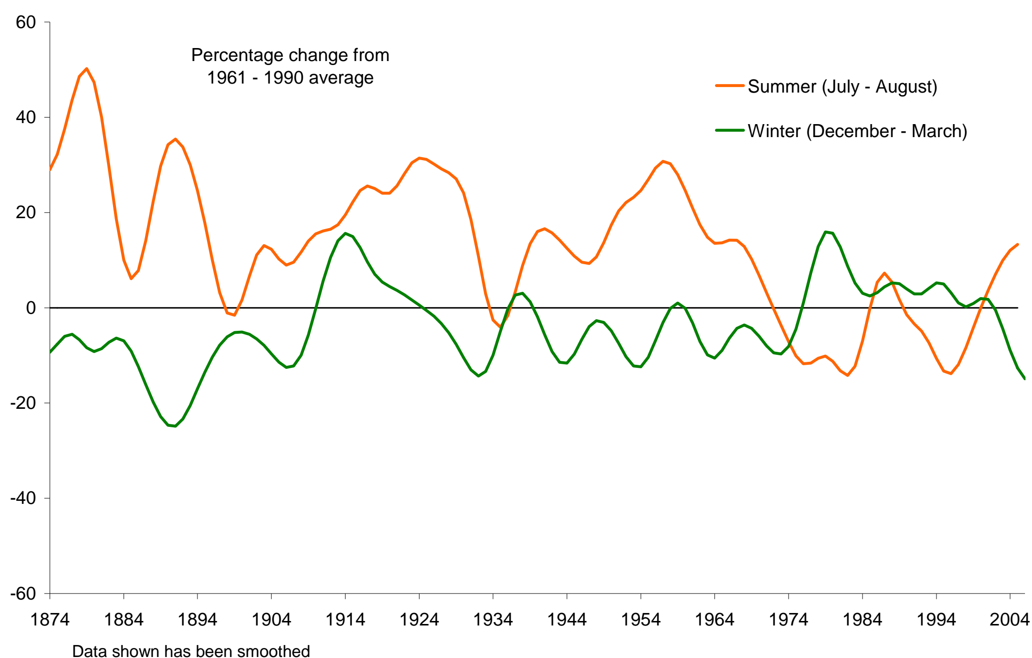
Temperatures in South East England are set to rise by approximately 4.5°C by 2080. These effects are likely to be more extreme in London due to the Urban Heat Island Effect (UHIE), the increased temperature of a built-up area compared to its rural surroundings. Temperatures in London can already be as much as 6°C higher than those in immediately surrounding areas. In Islington this is intensified by the dense, urban environment and limited cooling effect from areas of open space. This effect is likely to increase as average summer temperatures rise as a result of climate change, and may be further exacerbated by the waste heat from increased use of air conditioning in response to higher temperatures.

Higher daytime temperatures will also cause night time temperatures to increase. High night time temperatures are likely to have a major impact on health and contribute to an increase in heat related deaths as they mean there is no "cooling

down" period. Heatwaves will also be more frequent, more prolonged and more intense. Hot spells (where the daily maximum temperature is above 25°C) are projected to be prolonged by up to 10 days in Southern England.

Climate change is also affecting rainfall patterns (Figure 19.2) and the incidence of storms. Over the past 40 years the intensity of UK precipitation has increased during winter, accompanied by more frequent spells of very wet weather and an increase in total precipitation.

Figure 19.2: Seasonal precipitation in England and Wales 1874-2005



Source: Hadley Centre

London is exposed to far greater potential damage from flooding than any other urban area in the UK, since a significant proportion of the city lies within the floodplain of the Thames and its tributaries. Islington's strategic flood risk assessment concludes that although there are no critical watercourses within Islington, there is a moderate risk of flooding from sewer and surface water flooding. Islington has a limited amount of permeable surface which means that rainfall runs off hard surfaces and rapidly enters drains, increasing the risk of them flooding. There is also the potential following very heavy rainfall of sewerage over-spilling and resulting contamination. With predicted increases in episodes of heavy rainfall as a result of climate change, the risk of localised surface water flooding is likely to increase, as is the risk of Islington contributing to flooding elsewhere in London.

19.3. THE HEALTH EFFECTS OF CLIMATE CHANGE

Climate change has both direct and indirect effects on health and wellbeing. Increased summer temperatures may cause an increase in symptoms such as cramps, rash, oedema, syncope, heat exhaustion and heatstroke. Other effects include dehydration and general discomfort due to hot weather, an increase in flies and diarrhoeal diseases and in stinging and biting insects which may cause serious allergic reactions.

Increased summer temperatures may also indirectly impact on health and wellbeing as a result of deterioration in air quality, increased noise, sunburn, food poisoning, pests, viruses, allergens, and, over the long term increased tropical diseases and skin cancer. Increased temperatures are likely to put pressure on open spaces by increasing demand for use which, combined with the direct effect of hot, dry periods, is likely to reduce their quality.

19.3.1. Heatwave

There is good evidence that heatwaves adversely impact on health. During the 2003 heatwave, in which temperatures were higher than 30°C for 10 days in a row, deaths increased by 42% in London with the greatest increase amongst those aged 75 and over. Excess emergency hospital admissions during the period were also higher in London, particularly for over 75s. The probability of a 9-day heat wave averaging 27°C in South East England has been calculated at 1 in 40 by the year 2012. Nationally, this may result in over 3,000 immediate heat-related deaths and 6,350 heat-related deaths throughout that summer in Britain (no local figures are available).

19.3.2. Ultra-violet radiation

Higher summer temperatures for prolonged periods are likely to increase exposure to solar ultra-violet radiation (UVR). Possible health impacts of increased exposure to UVR include sunburn, skin cancer and cataracts. There are no reliable estimates of the likely increase in skin cancers as a result of climate change. However, longer summers and reductions in cloud cover may lead to changes in behaviour that are probably more important for personal UVR exposure than ozone depletion.

There is some health benefit associated with moderate UVR. Exposure to sunlight, at adequate intensity, leads to synthesis of vitamin D, which is important for skeletal health and calcium metabolism. It is estimated that 2% of UK children aged 1½–4½

years old, 20–34% of Asian children aged 2 years old, 10–11% of teenage girls and 13–28% of women of childbearing age have low levels of vitamin D. Vitamin D deficiency is also a concern among older adults. Climate change may therefore provide some health benefit by increasing exposure to moderate UVR.

19.3.3. Food poisoning

Evidence around impacts of increased temperatures on food poisoning is mixed. In recent years targeted action to reduce Salmonella infections has meant that both the absolute and the relative contributions of Salmonella infections to the total burden of food poisoning have declined. However, the Health Protection Agency (HPA) estimates that for each 1°C increase in temperature, there may be a 4.5% increase in cases of food poisoning.

19.3.4. Pests and diseases

Changing meteorological factors due to climate change, such as temperature, rainfall, and humidity influence the transmission vector-borne diseases. Whilst the HPA does not expect more than a very few cases of locally transmitted malaria in the UK over the next 50 years, other viruses previously not seen in this country may become a problem. The Chief Medical Officer has stressed the importance of remaining vigilant against diseases such as West Nile virus infection.

High summer temperatures are also likely to result in an increase in flies and the spread of bacteria, leading to an increase in diarrhoeal diseases. This also applies to flea infestations of domestic animals, which thrive in warm conditions. Increased temperatures, coupled with increased outdoors exposure is also likely to lead to an increase in stings or bites from bees, wasps and horseflies which can cause serious allergic reactions in some people, and can be fatal in a minority of cases. The numbers of urticaceous caterpillars, whose hairs cause painful swellings and rashes on contact with skin, may also increase with increased temperatures.

19.3.5. Air quality

Excess exposure to ozone (O_3) and particles less than 10 microns in diameter (PM10) were recorded in all regions in England in the August 2003 heat wave, most notably in London and the South East. Of the excess deaths recorded during the heat wave, 21-38% could be attributed to O_3 and PM106.

Estimated annual ozone concentrations are expected to increase between 2003 and 2030 in urban areas, resulting in an increase in hospital admissions for respiratory conditions. Evidence on the precise impact on health in Islington is limited.

19.3.6. Crime

There is some research on the impact of increased temperature on crime. Many reports about the association between crime and hot weather are speculative, particularly those that detail high profile events such as riots. There is, however, some evidence that domestic violence and road rage are more common during hot periods. An analysis of data for recorded crime in England and Wales yielded strong evidence that temperature has a positive effect on most types of property and violent crime. The number of burglaries tends to increase during hot weather, when people may be more likely to leave their homes insecure.

19.3.7. Flooding

Floods are associated with few direct deaths, but little is known about their full effect on health in terms of indirect mortality and morbidity due to infectious disease, mental health, and injuries. Potential health impacts include deaths and injury from flooding, illness due to contamination of water supplies or exposure to polluted floodwater and the mental health impact of flood damage to properties. Exposure to polluted flood water can increase the risk of respiratory illness, stomach upsets and high blood pressure.

The health impacts of flooding are often felt long after the event. Damage to properties and subsequent difficult living conditions can have a major impact on an individual's health and wellbeing. This psychological distress may explain the increase in insomnia, depression and non-prescription drugs and alcohol use often seen after a flood event.

19.3.8. Drought

During drought there may be an increased likelihood of contaminated surface water reaching groundwater. The most significant consequence of drought would be a failure of the domestic water supply, resulting in a need for standpipes and other methods of water delivery. This could lead to an increase in intestinal diseases, due to contamination of water and reduced hygiene, but also to civil unrest. Localised water shortages may be particularly important in South East England due to population growth and climate change. .

19.4. ADDRESSING CLIMATE CHANGE IN ISLINGTON

There are a range of services and schemes currently being delivered in Islington to tackle climate change mitigation and adaptation. These include use of planning policy to promote development that is adapted to high temperatures and promotes water efficiency, the Climate Change Partnership and Climate Change Fund, Green Liaison Officers, and development of the Local Development Framework to promote CO_2 reduction. Islington Council has a Carbon Management Plan to deliver a 15% reduction in its own carbon emissions, and there is ongoing promotion of the Green Procurement Code across the council.

Sustainable transport initiatives, including differentiated parking charges for more polluting vehicles, delivery of environmental awareness programmes for local residents, businesses and organisations, including through the Council's Green Living Centre, and Environmental Management Systems are all being promoted.

19.5. RECOMMENDATIONS

Our vision is of a local community fully informed of the implications of climate change for the health and wellbeing of our residents, and working together both to reduce impacts and to prepare for inevitable changes. The key priorities for achieving this vision are:

- Reducing per capita CO_2 emissions within Islington through a range of targeted CO_2 reduction programmes
- Reducing CO_2 emissions from the Council's own estate through delivery of the Council's Carbon Management Plan, Environmental Management Systems and staff behaviour change campaigns.
- Development of a long-term strategy for Islington as a low carbon borough through the range of policies included within the borough's Local Development Framework and development of plans to deliver local heat networks.
- Promotion of sustainable transport through ongoing redesign of the public realm and provision of appropriate facilities to promote walking and cycling, support to public transport improvements and car club development.

- Development and implementation of a climate change adaptation strategy which promotes retrofitting of Council and partner estates and the wider borough to increased temperatures, higher flood risk and reduced availability of water and increases awareness of adaptation amongst local organisations and residents.