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Health in Islington 2003/2004 – Introduction

This is the first annual public health report from Islington Primary Care Trust (PCT). Following on from the work of its predecessor authorities, the focus of the public health department, and the PCT as a whole, is to improve the health of the population of Islington and particularly to improve the health of those with most need. For this reason, this year’s report focuses on health inequality.

The aim of the report is to set out a baseline for Islington against key measures of health and the factors that influence it. The report of the former Chief Executive of Nat West, Derek Wanless, published earlier this year has highlighted the need to focus on health improvement in order to be able to manage demand for health services. Following on from that, the Choosing Health? Consultation has asked where responsibility for health should lie and the White Paper that results from these publications, expected in the autumn, should help us to focus on the broader determinants of health in a way that has not been achieved before. This represents a continuing move towards a broader definition of health and well-being.

The report opens with a chapter on the demography of Islington and what changes are expected in the population structure over the coming years. Comparisons are made between Islington and the other PCTs in the north central sector, London as a whole, and England where relevant. This is continued throughout the report and gives us some representative comparators as well as helping to identify where we should be targeting services and resource. Chapter 2 sets out the inequalities targets on life expectancy and infant mortality and summarises where Islington stands at the moment. The following chapter looks at the determinants of poor health and describes ward and below ward level differences on a number of measures that estimate deprivation. For example, Islington has a much higher proportion of lone parent households when compared to the rest of London and England as a whole. We know that these children are likely to experience higher levels of poor health, use alcohol and drugs, become teenage parents, have fewer qualifications and find it harder to get jobs. Addressing the underlying causes of these problems will be important to the long-term improvement in health we are working towards.

Chapter 4 looks at the incidence and prevalence of key diseases in Islington, highlighting the excess deaths experienced by our residents from a number of conditions including heart disease and the large numbers of people living with mental health problems.

The creation of the PCT shifted responsibility for the management of both infectious disease and non-infectious hazards to a new organisation – The Health Protection Agency. The report includes figures on infectious disease notifications as they represent an important part of the overall state of the health of Islington’s population and we are working closely with the new agency to ensure that support in this area continues to work well.

Some of the omissions in the report are around the provision of primary care and the measurement of lifestyle factors. The introduction of the new general medical services contract (nGMS) for General Practitioners, should mean that future reports can include important information, for example, on smoking and hypertension, in a way we have never been able to do before. Moving the management of chronic disease to the primary care setting is a major strand of the PCT’s work and we hope to be able to reflect this in the information we produce.

Taking on the challenge of addressing health inequality in its widest sense cannot be done by health services on their own. We must work closely with our partners in the Council and across the voluntary sector to change things. In the final section of the report we make some recommendations about the focus of public health work to address this wide agenda over the coming year.

Writing annual reports is always a challenge, but has been particularly difficult this year with major change in the personnel within the department. It is therefore important to acknowledge those that have had to do the bulk of the really hard work in writing the report. Firstly, to Tesfaye Gemechu, who has been the sole guardian of public health information and has managed to keep on top of the demands we have made on his time. Secondly, to Kate Parry who has patiently taken the suggestions for editing and overseen the development of the report. Thirdly, to Ian Forde and Stephen Conaty who stepped in to help when short of capacity. Finally, thanks go to Dagmar Zeuner without whom we would never have started.

Sarah Price
Director of Public Health
Islington PCT
Health services in Islington

Key
- Doctors/GPs
- Dentists
- Chemists
- Opticians
- Hospitals
- Underground
- Rail
1 Demography of Islington

2001 mid-year estimates indicate that there are 179,821 residents in Islington. This is expected to rise by 10.5% to 198,865, over the next 10 years – more than the 7.0% predicted growth in London’s population.

The population of Islington is younger than the population of England, due to the larger proportion (44%) of young adults between the ages of 20 and 39 years. This is almost 10% higher than the proportion of young adults in England and Wales.

The GP registered population in 2004 is 217,800, or 17% larger than census-based estimates for Islington. The difference is greater for men (26%) than for women (9.5%), and greatest for the age group 35-54. This is explained by list inflation and high population mobility.

There are approximately 2500 births in Islington each year and 1350 deaths; 350 deaths are among those aged 15-65. Age and sex adjusted death rates in Islington have fallen over the last decade in line with rates in England and Wales.

Each year 16,000 people move from Islington to other parts of the UK; 14,550 migrate from other parts of the UK to Islington.

1.1 Population Size
The office for National Statistics (ONS) mid-2002 estimates place London’s population at 7.36 million. The resident population of Islington measured by the 2001 census was calculated at 175,797, equivalent to 82,281 households. However, ONS mid-2002 estimates place the population at a slightly higher figure of 181,213, a 3% difference. The projected population for Islington in 2004 is 185,568 (Greater London Authority Round Demographic Projections 2003, scenario 8.1). This is projected to increase by 7% by 2011 (13,117 more people from 2004), and a further 4% by 2016 (8084 more people from 2011). Projections predicting population size become increasingly inaccurate the further into the future they forecast, so we do not provide 2021 estimates.

According to the GLA Scenario 8.1 (on which London planning has been based), amongst the 32 London boroughs and the City of London, Islington ranks sixth in terms of the greatest percentage change in population, and second within the sector.

Figure 1.1(1) shows ward level population change in Islington between 2001 and 2016. The largest population increases are projected to occur in Finsbury Park, Highbury West and Tollington. It is predicted that Clerkenwell and St Mary’s will experience the smallest population increase.

1.2 Sex and Age Structure
Islington’s population has a slightly higher proportion of females to males, 50.6% and 49.4% respectively. The sex distribution reflects that of England and Wales, but is more even compared to London.

Figure 1.2(2): Comparison of sex distribution of resident populations of Islington, London and England and Wales in 2002

<table>
<thead>
<tr>
<th></th>
<th>Islington</th>
<th>London</th>
<th>England and Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>49.4%</td>
<td>48.7%</td>
<td>49.1%</td>
</tr>
<tr>
<td>Women</td>
<td>50.6%</td>
<td>51.3%</td>
<td>50.9%</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics. Mid-year estimates 2002
Islington has a relatively large population of young adults compared to London, and England and Wales. The largest proportion of the population (43.6%) is aged between 20–39 years of age.

**Figure 1.2(3): Comparison of the proportion of resident population by age group in Islington, London and England and Wales in 2002**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Islington (%)</th>
<th>London (%)</th>
<th>England and Wales (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 19</td>
<td>22.8</td>
<td>25.3</td>
<td>25.1</td>
</tr>
<tr>
<td>20 to 39</td>
<td>43.6</td>
<td>36.2</td>
<td>36.3</td>
</tr>
<tr>
<td>40 – 64</td>
<td>24.5</td>
<td>27.6</td>
<td>27.6</td>
</tr>
<tr>
<td>65 – 75</td>
<td>5.8</td>
<td>6.6</td>
<td>6.6</td>
</tr>
<tr>
<td>75 and over</td>
<td>4.4</td>
<td>6.0</td>
<td>6.0</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics. Mid-year estimates 2002

Figure 1.2(3) Shows the percentage of people falling into each age group for Islington and London. Islington has a younger population relative to London. We have not shown England and Wales, as the proportion of people falling into each age band closely follows London.

**Figure 1.2(3) Population pyramid showing the age structure of Islington compared to London in 2001**


Figures 1.2(4)–1.2(6) show the proportions of different age groups by ward in Islington. Finsbury Park, Highbury West and Highbury East are the wards with the largest percentage of children aged 0-4. Hillrise and Canonbury have the largest proportion of 5-14 year olds.
Figure 1.2(7): Projected population growth by age group in Islington and London between 2001 and 2016

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Actual Increase</th>
<th>% Change</th>
<th>Actual Increase</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>7244</td>
<td>24%</td>
<td>323291</td>
<td>24%</td>
</tr>
<tr>
<td>15–19</td>
<td>1647</td>
<td>17%</td>
<td>47705</td>
<td>11%</td>
</tr>
<tr>
<td>20–64</td>
<td>18890</td>
<td>15%</td>
<td>619579</td>
<td>13%</td>
</tr>
<tr>
<td>65+</td>
<td>-802</td>
<td>-4%</td>
<td>-50779</td>
<td>-6%</td>
</tr>
</tbody>
</table>

Source: Greater London Authority 2003. Round Demographic Projections scenario 8.1

1.3 GP Registered Population

There is a discrepancy between the projected population estimates of Islington based on 2001 census data and the size of the GP practice registered population of Islington residents. There are 44 GP practices in Islington.

Whilst census projections place Islington’s population at 185,568 in 2004, the registered population of residents derived from GPs registers is 217,800, or 17.4% larger. This indicates that GP lists are inflated – partly due to duplicate registrations, and the time lag in removing those patients who died or have moved out or the borough.

The GP registered population is 9.5% larger for women and 26% larger for men than the resident population. Under 15s are slightly under represented on the GPs register compared to the resident population, whilst all the other age groups are larger amongst the registered population. In particular, the registered population is 30-34% bigger than the resident population between the ages of 35-54.

Junction, Bunhill, and Canonbury, have the highest percentage of people aged over 65. Finsbury Park, Highbury West, Tollington and Hillrise have the smallest proportion of over 65s.

Between 2001 and 2016 in Greater London, projected population growth will be highest in the 0–14 age group (24%). There will be a decline of 6% in over 65s.

This projected pattern of growth is reflected in Islington. The highest percentage growth will occur in the 0-4 age group. Projected growth in the 15-19 age group (17%) is greater than in London as a whole (11%). Islington will also experience a decline in the proportion of the population aged above 65 years; but at 4%, it is slightly smaller than London as a whole.
1.4 Mobility
Population mobility is a major feature of modern urban life. Annually, an average of 16,000 people move away from Islington to other parts of the United Kingdom. However, between 1998 and 2002, an average of 14,550 people per year moved into Islington from other parts of the country.

The data we have used to make these estimates is derived from patients re-registering with NHS doctors in other parts of the United Kingdom. However it fails to account for those people who are not registered with a GP in Islington, people who live in Islington but are registered with a practice outside of the borough, and those people who are registered at more than one practice. This complicates the problem of estimating movement into and out of the borough.

The registration data shows that 65% of people migrating into Islington and re-registering with Islington practices are from other parts of London, and 35% are from outside of London. Around 68% of people moving out of Islington re-register with practices in other parts of London, and 32% move to other parts of the UK. Eighty percent of all migration occurs within the 16-44 age group.

This data shows a net outflow of people from Islington of 1,450 people annually.

1.5 Births and Deaths
Across London, the birth rate will increase by an estimated 13% between 2001-2011 and by a further 2% by 2016. By contrast, the death rate is predicted to decline by 2.5% between 2001-2011, and drop by a further 3% by the year 2016. Combined with net flows for migration into and out of London, this will lead to a population increase of around 7% and 10% between 2001-2011 and 2001-2016 respectively. GLA projections estimate that in Islington in 2004 there were 2646 births. The birth rate is projected to increase by 10% between 2004 and 2011 (with 2927 births in 2011), and rise by a further 3% by 2016 (3020 births in 2016). The death rate is predicted to fall by 4%. In 2004 there were 1306 deaths (350 in those aged 15-65) falling to 1249 in 2011. It will decrease by a further 2% by 2016, with 1220 deaths.

Figure 1.5(2): Annual percentage change in births and deaths in Islington and London 1996-2016


1.6 Standardised mortality ratios for all causes of death
Standardized mortality ratios (SMRs) are a summary measure of overall mortality for a specified period of time. SMRs reflect the number of deaths experienced within a defined population group compared to the expected number that is drawn from the national average, taking variations in age and sex composition into account, and are comparable between areas.

Figure 1.5(1): Projected population increase in Islington, other boroughs in the north central London sector and London

<table>
<thead>
<tr>
<th></th>
<th>2001 population</th>
<th>2011 population</th>
<th>2016 population</th>
<th>2001 - 2011 % increase</th>
<th>2001-2016 % increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>320082</td>
<td>340089</td>
<td>352571</td>
<td>6.3</td>
<td>10.2</td>
</tr>
<tr>
<td>Camden</td>
<td>203002</td>
<td>221332</td>
<td>231202</td>
<td>9.0</td>
<td>13.9</td>
</tr>
<tr>
<td>Enfield</td>
<td>277719</td>
<td>290081</td>
<td>297571</td>
<td>4.5</td>
<td>7.1</td>
</tr>
<tr>
<td>Haringey</td>
<td>221856</td>
<td>247845</td>
<td>260350</td>
<td>11.7</td>
<td>17.4</td>
</tr>
<tr>
<td>Islington</td>
<td>179821</td>
<td>198685</td>
<td>206769</td>
<td>10.5</td>
<td>15.0</td>
</tr>
<tr>
<td>London</td>
<td>7307911</td>
<td>7856659</td>
<td>8108102</td>
<td>7.5</td>
<td>10.9</td>
</tr>
</tbody>
</table>

Source: Greater London Authority 2003. Round Demographic Projections Scenario 8.1
### Figure 1.6(1): Standardised mortality ratios for all causes of death, all persons all ages, for Islington, London, England and Wales 2001

<table>
<thead>
<tr>
<th></th>
<th>SMR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Islington</strong></td>
<td>117</td>
</tr>
<tr>
<td><strong>London</strong></td>
<td>100</td>
</tr>
<tr>
<td><strong>England and Wales</strong></td>
<td>100</td>
</tr>
</tbody>
</table>

**Men**

<table>
<thead>
<tr>
<th></th>
<th>SMR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Islington</strong></td>
<td>127</td>
</tr>
<tr>
<td><strong>London</strong></td>
<td>101</td>
</tr>
<tr>
<td><strong>England and Wales</strong></td>
<td>100</td>
</tr>
</tbody>
</table>

**Women**

<table>
<thead>
<tr>
<th></th>
<th>SMR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Islington</strong></td>
<td>107</td>
</tr>
<tr>
<td><strong>London</strong></td>
<td>98</td>
</tr>
<tr>
<td><strong>England and Wales</strong></td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Department of Health. Compendium of clinical Indicators 2002

The all cause SMR for all persons of all ages in Islington in 2001 was 17% higher than would be expected; for men it was 27% higher and for women it was 7% higher relative to England and Wales. The SMR for those aged 15-65 is 131. So there are 31% more deaths in this age group than would be expected if rates were the same as the rest of England and Wales.

### Figure 1.6(2): Directly standardised mortality rates per 100,000 population for all persons, all ages, 1993–2001

Figure 1.6(2) shows that mortality rates for all causes have fallen overall in Islington, and this reflects the trend for England and Wales and London. Whilst rates are comparable between London and England and Wales, in Islington, they have remained higher over time than the national average.

### Figure 1.6(3): Standardised mortality ratios for all causes of death for women of all ages, by ward in Islington, 1998-2002 pooled data

### Figure 1.6(4): Standardised mortality ratios for all causes of death for men of all ages, by ward in Islington, 1998-2002 pooled data

### Figure 1.6(5): Standardised mortality ratios for all causes and all ages for men and women, and all persons across each ward in Islington. They show that the highest number of deaths from all causes, taking age into account, occur in Holloway, Tollington, and Canonbury for women, and in Tollington and Bunhill for men. The SMR is lower than expected for women in Hill Rise, and in Highbury East for men.

### Figure 1.6(6): Standardised mortality ratios for all causes of death for men of all ages, by ward in Islington, 1998-2002 pooled data

Source: London Health Observatory

Source: London Health Observatory

Source: Department of Health. Compendium of clinical Indicators 2002
All cause SMRs for all persons of all ages are lower than expected in Highbury East and Canonbury, but 31-40% higher than expected in Tollington, where differences in age and sex have been taken into account.

Figure 1.6(5): Standardised mortality ratios for all causes of death, for all persons of all ages, by ward in Islington, 1998-2002 pooled data

Figure 1.6(6): Deaths by major cause in Islington, 2001-2003 annual average

Figure 1.6(6) and 1.6(7) show deaths by major causes. Circulatory diseases and cancer are the major causes of death. Both diseases accounted for approximately 63% of all deaths between 2001 and 2003. Pooled data 2001-2003 show that over this period, there were on average of 2490 deaths due to coronary heart disease, and 103 deaths due to stroke. These accounted for 77% of all deaths due to circulatory diseases and 27% of all deaths.

Figure 1.6(7): Actual numbers of deaths by major cause in Islington, 2001-2003 annual averages

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual number of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>All causes</td>
<td>1286</td>
</tr>
<tr>
<td>All circulatory diseases</td>
<td>450</td>
</tr>
<tr>
<td>CHD</td>
<td>243</td>
</tr>
<tr>
<td>Stroke</td>
<td>103</td>
</tr>
<tr>
<td>Cancer</td>
<td>362</td>
</tr>
<tr>
<td>Injury</td>
<td>67</td>
</tr>
<tr>
<td>Suicide</td>
<td>15</td>
</tr>
<tr>
<td>Diabetes</td>
<td>18</td>
</tr>
<tr>
<td>Other causes</td>
<td>387</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics. Public Health Mortality Files

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Office for National Statistics. *Public Health Mortality Files*
2 National Inequality Targets

Life expectancy at birth is 73.5 years for men and 79.1 years for women. It is lower than life expectancy for Londoners as a whole (75.7 and 80.7) and compared to England and Wales as a whole. London-wide, Islington has sixth lowest life expectancy for men and fifth for women.

Pooled 2001-2002 data show that the infant mortality rate in Islington was 5.6 per thousand live births – similar to the infant mortality rate in London (5.7 per thousand) and England and Wales (5.4 per thousand).

Pooled 2000-2002 data show that the perinatal mortality (stillbirths and deaths within seven days of birth) rate was 9.6 per 1000 live births in Islington. Although numbers are small and chance variation high, this is substantially different from the England and Wales average of 8.1 per 1000. These differences have been observed consistently over at least the last 7 years.

Pooled 1999-2001 data shows that 8.3% of infants were born with a birth weight of less than 2500g (6.9% low birth weight, 1.4% very low birth weight). These proportions are similar to the Inner London average.

There are two national targets for health inequalities. These are:

1) Infant Mortality: To reduce by at least 10 per cent the gap in mortality in children under one year, between manual groups and the population as whole by the year 2010.

2) Life Expectancy: By the year 2010, health authorities are to reduce by at least ten percent the difference between the quintile of areas with the lowest life expectancy and the population as a whole.

2.1 Life Expectancy in Islington

Life expectancy is an estimate of how long a baby would be expected to live if current age specific mortality rates remain constant. It is not a forecast of how long babies born will actually be expected to survive, as it is unlikely that age specific rates will remain constant for an extended period of time. It is best interpreted as a summary measure of mortality.

Figure 2.1(1): Life expectancy for men and women in Islington, other boroughs in the north central London sector, London, and England and Wales, 1999-2001 pooled data

<table>
<thead>
<tr>
<th>Borough</th>
<th>Life Expectancy</th>
<th>London wide ranked life expectancy (out of 32 boroughs and the City of London)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>Barnet</td>
<td>77.6</td>
<td>81.8</td>
</tr>
<tr>
<td>Camden</td>
<td>74.3</td>
<td>80.4</td>
</tr>
<tr>
<td>Enfield</td>
<td>76.9</td>
<td>80.9</td>
</tr>
<tr>
<td><strong>Islington</strong></td>
<td><strong>73.5</strong></td>
<td><strong>79.1</strong></td>
</tr>
<tr>
<td>Haringey</td>
<td>74.6</td>
<td>80.0</td>
</tr>
<tr>
<td>London</td>
<td>75.7</td>
<td>80.7</td>
</tr>
<tr>
<td>England and Wales*</td>
<td>76.0</td>
<td>80.6</td>
</tr>
</tbody>
</table>

Source: London Health Observatory and Office for National Statistics 2003

* 1997-2001 pooled data
Life expectancy for men in Islington is 73.2 years, and 78.8 years for women. Life expectancy is lower in Islington than across London as a whole, and England and Wales. The difference in life expectancy between Islington and London is greater for men (2.2 years) than for women (1 year). Men and women in Islington have the lowest life expectancy of all the boroughs in the sector.

Figure 2.1(2): Comparison of life expectancy at birth for men and women in Islington, other boroughs in the north central London sector, London, and England and Wales, 1999-2001 pooled data

The difference between male and female life expectancy across London as a whole is 4.9 years. In Islington it is 5.6 years, the same as Haringey. Sector-wide, differences in male and female life expectancy are greatest in Camden, and least in Barnet. Of the 32 London boroughs and the City of London, Islington ranks tenth for the largest difference in life expectancy between men and women.

Figure 2.1(3): Female life expectancy by ward in Islington, 1998-2002 pooled data

Figure 2.1(3) shows those wards in Islington with the highest and lowest life expectancy for women. Female life expectancy is lowest in Tollington, Holloway, St Mary’s, Barnsbury, and Clerkenwell. The difference in life expectancy for women living in Islington’s wards is 3.5 years, ranging from 77.2 years in Tollington to 80.7 years in Bunhill.
In Islington, life expectancy for men and women has risen in line with national trends. Since 1991, the gap between female and male life expectancy has narrowed. Men in Islington are expected to live 2.2 years, and women 1.1 years, more from birth, than in 1991.

### 2.2 Infant Mortality

Infant mortality rates measure deaths in infants of less than one year, per 1000 live births. Sometimes specific rates are calculated for babies less than twenty-eight days, per 1000 live births. Perinatal mortality rates are defined as the sum of stillbirths and deaths within seven days of birth per 1000 total births.

Infant mortality is one of the government’s key targets for reducing health inequalities since it shows pervasive differences across social class.

Factors associated with infant mortality are smoking during pregnancy; smoky environments; maternal nutritional status before and during pregnancy; low birth weight; young and old maternal age; a poor physical or material environment; lack of breast feeding; and lack of infant healthcare such as immunisation.

The infant mortality rate in Islington is 5.6 per 1000 live births. These confidence limits indicate that this is not significantly different to London (5.7 per 1000 live births), or England and Wales (5.4 per 1000 live births).
Figure 2.2(3): Comparison of infant mortality rates in Islington, other boroughs in the north central London sector, London and England and Wales, 1999-2001 pooled data


Sector wide, Islington has the fourth highest infant mortality rates. By comparison, Haringey has the highest rate, and Barnet the lowest.

In London, the number of infant deaths has fallen over the last decade. Three year averaged data shows that for 1990-1992 the infant mortality rate was 7.3 per 1000 live births falling to 5.7 in 2000-2002. This pattern has been reflected at sector level. In Islington there was an average of 14 infant deaths in 2000-2002, falling from 25 in 1990-92 (9.1 per 1000 live births). While Islington rates dropped below the London average in the mid 1990s, they have since increased.

Figure 2.2(4): Trends in infant mortality rates in Islington, Camden and London, 1990-92 to 1998-2001 pooled data.


Between 2000-2002, the perinatal mortality rate in Islington (9.6 per 1000 live births) was slightly higher than London (9.1 per 1000 live births). The rate in Islington was second highest in the sector after Haringey (10.9 per 1000 births). However, there are big fluctuations due to the small numbers.

Figure 2.2(5): Perinatal mortality rate per 1000 live births in Islington, Camden, London, and England and Wales, 2000-2002 pooled data

<table>
<thead>
<tr>
<th></th>
<th>Average number of deaths per year</th>
<th>Rate per 1000 live births</th>
<th>95% confidence intervals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Islington</td>
<td>25</td>
<td>9.6</td>
<td>7.7</td>
</tr>
<tr>
<td>Camden</td>
<td>23</td>
<td>8.3</td>
<td>6.6</td>
</tr>
<tr>
<td>London</td>
<td>959</td>
<td>9.1</td>
<td>8.8</td>
</tr>
<tr>
<td>England and Wales</td>
<td>4898</td>
<td>8.1</td>
<td>8.0</td>
</tr>
</tbody>
</table>


1 We have used three year pooled data because the number of actual deaths per year is small, making it difficult to distinguish real trends. Confidence intervals indicate the degree of certainty that the true value is contained within the confidence limits. The larger the population in question, the greater the certainty, and the smaller is the confidence interval. There is less certainty around small numbers, and confidence intervals tend to be wider.
2.3 Low Birth Weight

Low birth weight (LBW) is defined as weighing less than 2500g. Sometimes a sub-category is defined for babies weighing less than 1500g where mortality and morbidity risks are considerably higher. LBW is strongly associated with deaths in infancy (as well as poorer health in adulthood) and can be used as a proxy indicator for infant mortality.

Smoking is one of the main risk factors for LBW with twice as many LBW babies born to smokers compared to non-smokers. The other main risk factor is maternal weight prior to pregnancy. Low birth weight correlates with social class, and health inequalities. Infants born to families experiencing relatively higher levels of material deprivation are more likely to be born prematurely and to be of low birth weight.

In Islington, there were 7588 live births, and 7554 live births with birth weight recorded between 1999-2001. Out of these, 521 weighed less than 2500g (6.9%) and 105 weighed less than 1500g. Figure 2.3(1) shows that the proportion of low birth weight babies (<2500g) born in Islington does not differ significantly to the rest of the sector or London, indicated by the overlapping confidence limits.
Figure 2.3(2): Percentage of low birth weight babies in Islington by ward, (with 95% confidence Intervals), 2000-2002 pooled data

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Source: Office for National Statistics Public Health Mortality File; Analysis by London Health Observatory
3 Determinants

Islington is the sixth most deprived borough in England and the third most deprived borough in London. At super output level, Islington’s wards are very heterogeneous in terms of levels of deprivation.

One quarter of Islington’s population classify themselves as non-white, and half of these are black/black British. The age structure of the black minority and ethnic population in Islington is younger relative to the white population.

Between 2003-2004 there was an average of 1990 asylum seeker in Islington. Almost half are children.

In the 2001 census, 5.8% unemployed in Islington were unemployed – higher than England and Wales as a whole (3.4%).

Only 38.5% of pupils achieved 5 or more GCSE grade A-C passes in 2003 – 14% lower than the national average.

Approximately 40% of primary school children in Islington are entitled to free school meals because their parents are in receipt of benefits. In England and Wales less than 20% receive free school meals.

Forty percent of children in Islington speak at least one other language at home. There are approximately 120 different languages spoken in the borough.

The London Borough of Islington 2002 housing needs survey found that 23.3% of households reported living in sub-standard accommodation.

In 2003 there were 1413 households accepted as homeless by the LBT and placed in temporary accommodation.

The main health problems in Islington’s two prisons are drug use, mental health, communicable diseases, asthma, CHD, diabetes and epilepsy.

9.4% of households in Islington are lone parent households with dependent children – greater than the 7.6% London average.

In 1999 when the last local booster survey of the Health Survey of England was conducted on local Islington residents:

- 36% of men and 30% of women were smoking
- 30% of men and 18% of women were drinking more alcohol than the recommended weekly limit – similar to the proportions in England and Wales
- 32% of men and 27% of women engaged in regular physical activity lower than the proportion of regularly exercising men in England Wales (38%), and similar to the proportion of regularly exercising women (25%)
- 20% of men and 24% of women were clinically obese, compared with 19% and 21% in England and Wales.

In 2001/02 638 Islington residents were in drug treatment.

The conception rate in under 18 year-olds girls in Islington in 2001 was 64 per 1000, 7th highest amongst London boroughs, and higher than London as a whole and England and Wales.
3.1 Deprivation

Figure 3.1(1): Summary of the domains of the index of multiple deprivation 2004

<table>
<thead>
<tr>
<th>Domain</th>
<th>Domain Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income Deprivation: the proportion of the population in Income Support households and those receiving other benefits such as Job Seekers Allowance and Working Families Tax Credit.</td>
<td>22.5%</td>
</tr>
<tr>
<td>Employment Deprivation: the proportion of working age people claiming unemployment, incapacity benefit, or Severe Disablement Allowance. Also those participating in the New Deal.</td>
<td>22.5%</td>
</tr>
<tr>
<td>Health Deprivation and Disability: based on rates of premature death; ratios of comparative illness and disability, admission to hospital emergency departments, and the proportion of those over 60 suffering anxiety or mood disorders.</td>
<td>13.5%</td>
</tr>
<tr>
<td>Education, Skills and Training Deprivation: for children and young people this is based on indicators such as Key Stage results and numbers going into Higher Education. For adults it is based on percentage with low or no qualifications.</td>
<td>13.5%</td>
</tr>
<tr>
<td>Barriers to Housing and Services: Wider barriers include overcrowding; geographical barriers include distance from GP premises, primary school etc.</td>
<td>9.3%</td>
</tr>
<tr>
<td>Crime: based on the incidence of burglary, theft, criminal damage and violence.</td>
<td>9.3%</td>
</tr>
<tr>
<td>Living Environment Deprivation: based on “indoor” indicators such as proportion of housing with no central heating, and “outdoor” indicators such as air quality.</td>
<td>9.3%</td>
</tr>
</tbody>
</table>


There are a number of measures of deprivation. We use the index of multiple deprivation for England (IMD 2004). It has been recently updated from the IMD 2000, and incorporates new measures. The seven domains of the IMD 2004 are summarised in figure 4.1(1).

The IMD 2004 is designed to measure, on a small area level, the main factors of multiple deprivation. Underlying this idea is the assumption that deprivation has distinct dimensions within a given area, and these dimensions can be measured separately.

Each of the seven domains outlined encompass a number of indicators. These indicators are designed to directly measure that particular form of deprivation. The different domains have been assigned relative weights in the overall measure. There is a strong association between deprivation and health. Those who experience high levels of deprivation also experience increased morbidity and mortality. There is a consistent gradient of health status that spans the whole socio-economic spectrum. This association has been demonstrated for a wide range of conditions for example cancer, CHD, mental health and injuries.

Islington scores 42.65 on the index of multiple deprivation. It is the sixth most deprived borough out of the 354 in England, and third most deprived in London. The most deprived wards are Finsbury Park, Holloway, Mildmay and Tollington; and the least deprived are Clerkenwell, Highbury East, Highbury West, and St Mary’s. Islington has 118 lower level super output areas. These are units of area at subward level, containing 1000 to 1500 persons used in the collection and analysis of census data. Three quarters of these fall within the most deprived quintile of England (worst 20%); the rest fall within the second worst quintile. Most wards in Islington show a great deal of heterogeneity at super output level for each of the domains of deprivation.
Figure 3.1(2): Index of multiple deprivation 2004 by super output area in Islington, ranked according to national percentiles

Figure 3.1(2) above shows that a large number of super output areas fall within the 10% of the most deprived areas nationally.

Figure 3.1(3): Index of multiple deprivation 2004 by super output area in Islington, quintiles ranked within Islington

Figure 3.1(3) shows that Islington is geographically very heterogeneous in relation to relative levels of deprivation within Islington. Most wards show large disparities between areas that fall into the highest quintile of deprivation which are adjacent to those in the lowest quintile. Holloway is amongst those with the most uniformly deprived super output areas falling into the lowest quintiles.

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Office of the Deputy Prime Minister, Office for National Statistics. Index of Multiple Deprivation 2004

3.2 Ethnicity
Ethnicity is a dynamic concept. It involves the alliance of individuals to social groups on the basis of social history, shared cultural beliefs, attitudes, values, language, lifestyle, religion and food. How people define themselves or others relates to prevailing social and political circumstances.

The collection of ethnic data plays an important role in ensuring equal access to services by all groups and levelling inequalities in health. The most comprehensive source of information on ethnicity is the 2001 census. Since the 1991 census, census defined ethnic categories have changed. The new classification has a separate section for people from mixed backgrounds, where previously people would have selected a specific ethnic group, or categorised themselves as ‘other’. The other new sub-group added was ‘white-other’, allowing indication of the extent of the white population that does not consider itself to be British or Irish. In Islington, this may particularly apply to Turkish and Cypriot sections of the population.

Ethnicity is associated with poorer health mainly through its links with deprivation markers such as low income, unemployment, poor housing etc. Higher prevalence of disease or behaviour and lifestyle with differential health risks accounts for some inequalities in health between ethnic groups. For example mortality rates from coronary heart disease are higher in South Asian and white populations, but lower in Caribbean populations, and sickle cell anaemia is prevalent in African and Caribbean populations. Other factors are differential access to, and uptake of services.
Ethnicity in Islington
London is the most ethnically diverse city in the UK. Census population statistics indicate that around 40% of Londoners belong to black or minority ethnic groups, whilst 43% of Islington's population classify themselves as non White-British. Compared to London as a whole, Islington's population has proportionately larger White, Mixed, Black/Black British, and Chinese/Other fractions, and a smaller Asian/Asian British contingent.

Figure 3.2(1): Comparison of breakdown by ethnicity of Islington's residents with London, and England and Wales in 2001.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Islington Number</th>
<th>Islington %</th>
<th>London %</th>
<th>England and Wales %</th>
</tr>
</thead>
<tbody>
<tr>
<td>White – British</td>
<td>99,784</td>
<td>56.8</td>
<td>59.8</td>
<td>87.0</td>
</tr>
<tr>
<td>White - Irish</td>
<td>10,057</td>
<td>5.7</td>
<td>3.1</td>
<td>1.3</td>
</tr>
<tr>
<td>Other White</td>
<td>22,623</td>
<td>12.9</td>
<td>8.3</td>
<td>2.7</td>
</tr>
<tr>
<td>Total White</td>
<td>132,464</td>
<td>75.4</td>
<td>71.1</td>
<td>90.9</td>
</tr>
<tr>
<td>White &amp; Black Caribbean</td>
<td>2,329</td>
<td>1.3</td>
<td>1.0</td>
<td>0.5</td>
</tr>
<tr>
<td>White &amp; Black African</td>
<td>1,241</td>
<td>0.7</td>
<td>0.5</td>
<td>0.2</td>
</tr>
<tr>
<td>White &amp; Asian</td>
<td>1,543</td>
<td>0.9</td>
<td>0.8</td>
<td>0.4</td>
</tr>
<tr>
<td>Other Mixed</td>
<td>2,121</td>
<td>1.2</td>
<td>0.8</td>
<td>0.3</td>
</tr>
<tr>
<td>Total Mixed</td>
<td>7,234</td>
<td>4.1</td>
<td>3.2</td>
<td>1.3</td>
</tr>
<tr>
<td>Indian</td>
<td>2,851</td>
<td>1.6</td>
<td>6.1</td>
<td>2.1</td>
</tr>
<tr>
<td>Pakistani</td>
<td>912</td>
<td>0.5</td>
<td>2.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>4,229</td>
<td>2.4</td>
<td>2.1</td>
<td>0.6</td>
</tr>
<tr>
<td>Asian or Asian British – other</td>
<td>1,492</td>
<td>0.8</td>
<td>1.9</td>
<td>0.5</td>
</tr>
<tr>
<td>Total Asian &amp; Asian British</td>
<td>9,484</td>
<td>5.4</td>
<td>12.1</td>
<td>4.6</td>
</tr>
<tr>
<td>Caribbean</td>
<td>8,550</td>
<td>4.9</td>
<td>4.8</td>
<td>1.1</td>
</tr>
<tr>
<td>African</td>
<td>10,500</td>
<td>6.0</td>
<td>5.3</td>
<td>1.0</td>
</tr>
<tr>
<td>Black or Black British – Other</td>
<td>1,806</td>
<td>1.0</td>
<td>0.8</td>
<td>0.2</td>
</tr>
<tr>
<td>Total Black or Black British</td>
<td>20,856</td>
<td>11.9</td>
<td>10.9</td>
<td>2.3</td>
</tr>
<tr>
<td>Chinese</td>
<td>3,074</td>
<td>1.7</td>
<td>1.1</td>
<td>0.4</td>
</tr>
<tr>
<td>Other ethnic group</td>
<td>2,685</td>
<td>1.5</td>
<td>1.6</td>
<td>0.4</td>
</tr>
<tr>
<td>Total Chinese or others</td>
<td>5,759</td>
<td>3.3</td>
<td>2.7</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Figure 3.2(2): Proportion of Islington’s population by ethnicity in 2001

Figure 3.2(3) shows the ethnic breakdown of the population of each borough in the sector. Islington has the second largest White, Mixed, and Black/Black British populations. It has the third largest ‘Chinese/Other’ populations out of all the boroughs in the sector. Islington has the smallest Asian/Asian British Population in the sector.

Figure 3.2(3): Comparison of ethnic breakdown of Islington’s population with other boroughs in the north central London sector in 2001

Figures 3.2(4) to 3.2(7) show the distribution of Islington’s main minority ethnic groups at ward level.

Figure 3.2(4): Percentage of population of Black African origin by ward in Islington in 2001

Figure 3.2(5): Percentage of population of Black Caribbean origin by ward in Islington in 2001
The majority of the Asian/Asian British population of Islington are Bangladeshi, accounting for nearly 45% of this group, and 2.4% of the total population. Within the sector, Islington has the second largest Bangladeshi community after Camden (6.4%). By comparison, the Bangladeshi sub group accounts for 2% of London’s population, and 18% of London’s entire population classifying themselves as Asian/Asian British.

Islington has the second largest white population in the north central London sector. However, when this group is broken down into sub-group categories, Islington has the largest Irish population in the sector - constituting 8% of the white ethnic group and 6% of the population. Also 17% of this main group is accounted for by the ‘White-Other’ sub-category. This constitutes 13% of Islington’s population, equivalent to Enfield (13%), less than Haringey and Camden (both comprise 16%), and more than Barnet (11%). The large Turkish and Cypriot communities in Islington and large number of Eastern Europeans mainly constitute this sub-category.

Islington has the third largest number of residents who categorise themselves as Chinese/Other in the sector. As a proportion of this ethnic category, 53% classify themselves as Chinese, and the remainder as Other. Compared to London as a whole, the Chinese population is proportionately bigger in Islington. It also has a proportionately larger black population. The majority of Islington’s Black/Black British population fall into the Black African sub-category, accounting for 6% of the total population.
Figure 3.2(8) shows the proportionate distribution of ages within each ethnic group in Islington. Comparison shows that the non-white ethnic groups in Islington have a much younger age structure than the white section of the population; 35% are under the age of 20 compared to 20% for the white population. The largest proportion of those who categorise themselves as being of Mixed ethnicity, are aged under 19. The majority of all other non-white ethnic groups are under the age of 40. Compared to all other ethnic groups, there are proportionately more people of White ethnicity aged 65 plus.

Figure 3.2(8): Comparison of proportions of people in each ethnic group in Islington by age band in 2001

3.3 Asylum seekers and refugees

In international law, a refugee is someone who has left their country of residence, and is either unable, or unwilling, to return due to a “well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion”. An asylum seeker is someone who has applied to be recognised as a refugee but still awaits the government’s decision on his or her application.

A growing body of literature highlights the particular healthcare needs of asylum seekers in dispersal. They are mainly a young population with a recognised need for mental health, sexual, maternity, and child health services. Decisions on where to disperse asylum seekers are generally based on the availability of accommodation, as opposed to the capacity of services to support the distinctive needs of this group. Asylum seekers experience considerable difficulties in accessing health care and other services. Language difficulties and lack of interpreting services are often significant barriers.

Greater London Authority (GLA) estimates calculate around 350,000 to 420,000 refugees and asylum seekers are currently residents of London (where ‘refugee’ is defined as someone to whom Government has granted refugee status, or the half way status of exceptional leave to remain). This is the equivalent of one in twenty London residents; 30 times the UK average.

Between 1996 and 1999, the majority of asylum applications to the UK were by men (73%), 61% of applications were under 35 years of age. The remaining 28% were by women, of which two thirds were under 35. There is a dearth of data on the demographic make up of the cumulative population of asylum seekers and refugees in London. However, the GLA estimate that London’s refugee population is likely to reflect annual inflow into the UK.

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Between April 2003 and April 2004, the number of asylum seekers receiving benefits in London fell from 42,473 to 26,476 or 37.7%, coinciding with the introduction of section 55 of the Nationality, Immigration and Asylum Act (NIA) 2002. This has resulted in the withdrawal of support from asylum seekers who have not claimed asylum at the earliest opportunity.

Asylum seekers in Islington

Due to the difficulties of estimating the numbers of refugees who are not in touch with local authorities, we have chosen to focus on those applying for asylum and being supported by the local authority. The most readily available data giving indication of the volume of asylum seekers in Islington relates to those in receipt of benefits. Between 2003 and 2004, the average number of asylum seekers supported by the London Borough of Islington (LBI) was 1990. It is likely that this figure underestimates the actual number of asylum seekers resident in Islington, as it does not account for the number housed in the borough by other local authorities. In March 2004 there were 1675 asylum seekers supported by LBI, 46% were children.

The steady decrease in the number of asylum seekers claiming support in Islington since 2000 is likely to be a reflection of the 1999 Immigration and Asylum Act which has led to the dispersal of asylum seekers away from London; and further declines over 2003/2004 resulting from the NIA Act 2002.

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3.4 Unemployment

There are two main sources of information on unemployment in the UK; the claimant count and the International Labour Force Survey. The claimant count is based on all those claiming unemployment related benefits at local employment offices, and provides precise information for defined geographical areas. The data is a snapshot as numbers are calculated on the basis of the number of unemployed claimants on one particular day of each month, as well as those leaving and joining the count. Age of claimant and duration of claim analyses are conducted quarterly. All countries in the European Union are legally obliged to conduct a labour force survey once a year. Around 120,000 people aged over 16 are surveyed on a quarterly basis. Data is collected on respondent’s personal circumstances and activity in the labour market. Classifications are made according to the agreed International Labour Organisation definitions.

Levels of unemployment are a marker of socio-economic inequity, and are reflected in health. Evidence indicates that people who are unemployed are more likely to self-harm, and to suffer from depression and anxiety. They are also more likely to experience higher rates of suicide, morbidity, long-term limiting illness, and premature mortality.

Unemployment, poverty and low income are considerable risk factors for poor health. They can affect health through the consequences of material deprivation - such as changes in health related behaviour, social exclusion, isolation and disruption in longer-term professional attainment, and the role that employment assumes in the formation of social networks. The relationship is reciprocal. Poor health, disability, and long term limiting illness can also affect employment opportunities. Unemployment rates are highest among the under 25s, and are consistently higher amongst black and minority ethnic (BME) groups.

Unemployment in Islington

There are 6,390 claimants in Islington, of whom 4,526 are male and 1,874 are female. In Islington 5.8% of people are unemployed and 56.6% are employed. Unemployment rates vary with age and sex. On the whole rates tend to be lower amongst women than men. Unemployment rates tend to be higher in Inner London, than Outer London. Compared to the London average (4.9%), the overall unemployment rate (claimant-based) in Islington (7.6%) is substantially higher; and this holds for both men and women. Islington has the highest unemployment rate of all the five boroughs in the north central London sector.

The break down of the population’s economic activity is shown in Figure 3.4(2).

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Figure 3.4(1): Claimant count unemployment in Islington, other boroughs in the north central London sector, and London in 2004

<table>
<thead>
<tr>
<th>Borough</th>
<th>Claimant count unemployment (actual numbers)</th>
<th>Claimant count unemployment (Rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males Females</td>
<td>All Males Females All</td>
</tr>
<tr>
<td>Barnet</td>
<td>3,928 1,584</td>
<td>5,512 4.8 2.5 3.8</td>
</tr>
<tr>
<td>Enfield</td>
<td>4,256 1,788</td>
<td>6,044 5.8 3.2 4.7</td>
</tr>
<tr>
<td>Camden</td>
<td>4,138 1,727</td>
<td>5,865 8.6 4.2 6.6</td>
</tr>
<tr>
<td>Haringey</td>
<td>5,523 2,081</td>
<td>7,604 9.5 4.4 7.2</td>
</tr>
<tr>
<td>Islington</td>
<td>4,526 1,874</td>
<td>6,390 9.9 4.9 7.6</td>
</tr>
<tr>
<td>Inner London</td>
<td>63,786 24,486</td>
<td>88,272 9.1 4.3 6.9</td>
</tr>
<tr>
<td>Greater London</td>
<td>120,115 46,766</td>
<td>166,881 6.3 3.1 4.9</td>
</tr>
</tbody>
</table>

Source: Greater London Authority, Office for National Statistics. Claimants count Jan 2004

1 The denominator is defined as the economically active population, consisting of women aged 16-59 and men aged 16 - 64.
Unemployment rates show disparities across different age groups. They are consistently higher across all age groups in Islington compared to Greater London. The rate is highest among 16-24 year olds, and significantly higher in 16–19 year olds. The unemployment rate is lower for women than men of all age groups.

The claimant count estimates unemployment on the basis of those claiming unemployment-related benefits (Job Seekers Allowance (JSA) and National Insurance credits). It is therefore likely to underestimate the true extent of unemployment, since those who are not eligible for JSA will not be visible on the records. Underestimates are most likely amongst women and young people.

Since 2001, the unemployment rate in Islington has fallen moderately in contrast to London as a whole, which has shown a small increase. The rate for men in Islington has fallen from 10.2% to 9.9% since 2001, whereas rates for women have not changed. However, trends over relatively short periods should be treated with caution as unemployment levels show seasonal variation.
At ward level, the highest levels of employment deprivation are clustered mainly in Tollington, St Georges, Bunhill and Barnsbury. However, there is a substantial amount of variation across Islington for areas falling in the highest and lowest quintiles for nationally ranked deprivation.

**Figure 3.4(5): IMD 2004 employment deprivation score ranked according to quintiles within Islington**

Figure 3.4(5) shows super output areas in Islington according to quintiles of deprivation in Islington. Most wards show a substantial amount of variation between areas falling into all quintiles of employment deprivation.

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### 3.5 Education

Education is critical to helping individuals generate and maximise opportunities in life. Education is therefore an important factor in the cycle of deprivation and ill health. Educational attainment can affect determinants such as employment opportunities, levels of income, housing, health-related and health-seeking behaviour, and social support. It is a legal requirement for all children between the ages of 5-16 to study the National Curriculum. This documents the standard level of achievement children are expected to meet at different ages.

**Education in Islington**

**Primary school attainment – Key Stage 2**

Key Stage 2 National Curriculum tests ascertain levels of achievement between the ages of 7-11.

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**Figure 3.5(1): Percentage of 11 year olds achieving Level 4 or above in Key Stage 2 English, Maths and Science 2001–2003**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>82</td>
<td>81</td>
<td>81</td>
<td>78</td>
<td>79</td>
<td>79</td>
<td>82</td>
<td>82</td>
<td>81</td>
</tr>
<tr>
<td>Camden</td>
<td>77</td>
<td>72</td>
<td>78</td>
<td>73</td>
<td>71</td>
<td>73</td>
<td>88</td>
<td>86</td>
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</tr>
<tr>
<td>Enfield</td>
<td>75</td>
<td>74</td>
<td>78</td>
<td>72</td>
<td>74</td>
<td>72</td>
<td>87</td>
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<td>Haringey</td>
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<td>78</td>
</tr>
<tr>
<td>Islington</td>
<td>64</td>
<td>69</td>
<td>69</td>
<td>65</td>
<td>68</td>
<td>68</td>
<td>79</td>
<td>83</td>
<td>80</td>
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<tr>
<td>England</td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>71</td>
<td>73</td>
<td>73</td>
<td>87</td>
<td>86</td>
<td>87</td>
</tr>
</tbody>
</table>


---

**Figure 3.5(2): Primary school summary scores in Islington**

Compared to England, Islington has achieved a much smaller improvement in the number of pupils reaching Level 4 at Key Stage 2. Sector wide, Islington attained the lowest proportion of pupils achieving Level 4 in Key Stage 2, and the second lowest after Haringey for English and Science. In terms of the degree of improvement in the numbers of pupils reaching Level 4 between 1999 and 2003, Islington ranks fourth out of five in the sector for English, Maths and Science.

---

**The Key Stage 2 summary score is based on the proportion of eligible pupils achieving Level 4 or above in English, Maths and Science tests. The three Key Stage 2 test subjects (English, Maths and Science) are combined to produce a composite summary score (maximum score 300).**
Secondary school attainment

Figure 3.5(3): Percentage of 15 year old pupils achieving five or more GCSE grades A*-C passes, by borough and national average, 1999-2003

<table>
<thead>
<tr>
<th>Borough</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>56.9</td>
<td>57.5</td>
<td>55.8</td>
<td>59.2</td>
<td>59.8</td>
</tr>
<tr>
<td>Camden</td>
<td>47.1</td>
<td>51.0</td>
<td>50.3</td>
<td>48.4</td>
<td>49.9</td>
</tr>
<tr>
<td>Enfield</td>
<td>46.8</td>
<td>46.1</td>
<td>47.0</td>
<td>46.3</td>
<td>48.5</td>
</tr>
<tr>
<td>Haringey</td>
<td>30.3</td>
<td>30.3</td>
<td>30.9</td>
<td>35.6</td>
<td>39.0</td>
</tr>
<tr>
<td>Islington</td>
<td>27.4</td>
<td>26.5</td>
<td>28.7</td>
<td>32.9</td>
<td>38.5</td>
</tr>
<tr>
<td>England</td>
<td>47.9</td>
<td>49.2</td>
<td>50.0</td>
<td>51.5</td>
<td>52.9</td>
</tr>
</tbody>
</table>


* No historical data available for London averages

Compared to the national average of over 50% (2003), and the London average of 45.4%(2001/02), only 38.5% of pupils achieved five or more grade A*-C passes at GCSE, a 14.4% difference. Compared to other boroughs in the sector, Islington is achieving the lowest pass rates.

Figure 3.5(4): Percentage of pupils achieving five or more A*-C grades at GCSE

Free school meals
Free school meals are a good proxy indicator of low income and deprivation1.

Figure 3.5(5): Eligibility for free school meals in Islington primary and secondary schools compared with Inner London and England

1 Children, whose parents receive Income Support, Income-based Job Seekers Allowance, or support under part VI of the Immigration and Asylum Act 1999, are entitled to free school meals. Children who receive these benefits in their own right are also entitled to free school meals. From 6 April 2003 families who receive Child Tax Credit, but who do not receive Working Tax Credit and whose annual income (as assessed by the Inland Revenue) does not exceed £13,230 are entitled to free school meals for their children.

Source: Cambridge Education Associates Islington

Figure 3.5(5) shows that the number of children in Islington entitled to free school meals at both primary and secondary level is well above the national and Inner London, average. Overall, the number has not changed significantly since 2001.
Figure 3.5(6) shows areas in Islington according to nationally ranked levels of education, skills and training deprivation. The majority of areas fall into the worst three quintiles for deprivation. Wards with the most deprived 20% are Finsbury Park, Holloway and St Peters. Almost all of Caledonian falls into the second worst quintile. Only three super output areas in Islington fall into the least deprived quintile, and these are in Junction and St. Georges wards.

Figure 3.7(7) shows education, skills and training deprivation ranked according to relative levels in Islington. There is substantial variation within wards. However Caledonian, St Peters and Finsbury Park contain the largest number of people falling into the two worst quintiles of deprivation. Highbury West and Clerkenwell contain the most areas falling into the two least deprived quintiles.

**Camden and Islington Healthy School Scheme**
The Camden and Islington Healthy School Scheme (CIHSS) is part of the National Healthy School Standard, a joint initiative between the Department of Health (DoH) and Department for Education and Skills, which aims to reduce health inequalities, promote social inclusion and raise educational achievement. All local schools are invited to join the scheme on a voluntary basis. On recruitment, each school is required to complete an audit of their practice around health to assist them in identifying areas for development, which may include developing and updating the Sex and Relationship Education Policy, improving access to drinking water or building effective partnerships within the local community. Schools draft their own action plan based on their individual needs. The plan is then implemented, monitored and evaluated, with support from the CIHSS core team.
Chapter 3 Determinants

3.6 Languages

Islington is culturally and ethnically diverse. Knowledge of the diversity of languages spoken is important in service planning and improving access to services for particular groups who may experience cultural and linguistic barriers. Whilst language is an important facet of ethnic identity, ethnicity and language use are not always directly linked.

Detailed knowledge of the proportion of the population speaking languages other than English is not readily available. However two main sources of data help provide a picture of the range of languages spoken, and according service needs in Islington. These are the range of languages used by interpreting services, and school children’s reported language use at home.

There are a number of caveats in estimating the range and distribution of languages spoken. Interpreting services data only gives us a picture of the needs of clients who actually use the interpreting services, and does not necessarily accurately reflect the range of languages really spoken; or give an indication of the degree of competence in English of those who are not in touch with interpreting services. Proxy data on language use derived from school children, has the disadvantage that it ignores those who are not in contact with the education system such as refugee and migrant populations.

Languages in Islington

More than 300 languages are spoken by children in London’s schools, where English is not the primary language spoken or heard at home for almost a third. There are more than 120 languages spoken in the homes of Islington’s school children (aged 5-14). It is estimated that 60% of children have English as their mother tongue. The remaining 40% of the children and parents speak a range of the other 120 reported languages at home. The distribution of languages spoken at home by children and parents is shown in the pie chart below.

Bibliography

Camden and Islington Healthy School Scheme 2004
CEA Islington
Office of Deputy Prime Minister, Office for National Statistics. Index of Multiple Deprivation 2004

Below is a list of the languages most frequently requested for need of interpreting services in Islington:

Turkish  
Tigrigna  
Yoruba  
Bengali  
French  
Urdu  
Somali  
Chinese  
Gujarati  
Arabic  
Greek  
Punjabi  
Spanish  
Italian  
Portuguese  
Albanian  
Polish  

Source: London Borough of Islington Interpreting Services 2003

Bibliography

LBI Interpreting services 2003
Cambridge Education Associates. Islington
3.7 Housing and homelessness

Housing
Low quality housing is linked to poor health. Concerns are to do with lack of amenities, shared facilities and overcrowding, dampness, and inadequate heating. These can impact on the transmission of infectious diseases, respiratory conditions, and mental health. There is some evidence that suggests that poor housing environments in childhood may have implications for health in later life.

Figure 3.7(1): Islington households living in unsuitable housing; self reported survey results 2002.

<table>
<thead>
<tr>
<th>Unsuitable Housing Category</th>
<th>No of Households</th>
<th>Percentage of All Households</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overcrowded</td>
<td>5161</td>
<td>6.3</td>
</tr>
<tr>
<td>Harassment</td>
<td>6383</td>
<td>7.7</td>
</tr>
<tr>
<td>Mobility and health problems</td>
<td>3331</td>
<td>4.0</td>
</tr>
<tr>
<td>Disrepair or unfitness</td>
<td>6913</td>
<td>8.4</td>
</tr>
<tr>
<td>All causes of unsuitability</td>
<td>19206</td>
<td>23.3</td>
</tr>
<tr>
<td>All households</td>
<td>82426</td>
<td>100.0</td>
</tr>
</tbody>
</table>


By contrast, an LBI survey in 2001 estimated that 12.9% of households lived in unsuitable housing. This survey used different criteria; in particular, it did not include harassment.

The barriers to housing and service deprivation domain of the IMD 2004 measures barriers to housing, (such as over crowding or affordability) and key local services (such as distance to GP practices, schools and shops). All of Islington’s wards fall into the worst quintile of this domain, ranked nationally. Figure 3.7(2) shows the distribution of areas falling into each quintile ranked relative to the worst and least deprived areas in Islington. There is a great deal of variation of areas falling into each of the quintiles within wards. Holloway, Finsbury Park, and Highbury West have the most areas falling into the worst quintile of this domain of deprivation. Barnsbury has no areas falling into the two most deprived quintiles, in contrast to all other wards.

Figure 3.7(2): IMD 2004 barriers to housing and services deprivation score by super output area in Islington ranked within Islington

Source: Office of the Deputy Prime Minister, Office for National Statistics

Housing in Islington
The LBI 2002 Housing Needs Survey showed that 19,206 households (23.3%) reported that they lived in unsuitable housing as measured by the ODPM (2000) Local Housing Needs Assessment good practice guidelines. From this, it is estimated that 3,700 households have housing problems which directly impact on health.
Another measure of housing quality comes from the living environment domain of the IMD 2004. This measures quality of the ‘indoor’ living environment, and the condition of housing. It also measures the ‘outdoors’ living environment, including air quality and injuries to pedestrians and cyclists.

Figure 3.7(3): IMD 2004 living environment deprivation score by super output area in Islington ranked according to national quintiles

Figure 3.7(3) shows Islington falls into the two worst quintiles for living environment deprivation ranked nationally, substantially more areas are in the worst quintile.

Figure 3.7(4) shows living environment deprivation ranked according to levels within Islington. Again there is extreme variation within wards for areas that are the least and worst deprived. Clerkenwell, Highbury East, and Highbury West contain the most people living in the worst quintile of living environment deprivation in Islington. However they also contain substantial numbers who live in the least deprived quintile. Caledonian and Hillrise have the largest number of areas that fall into the least deprived 20%.

Homelessness

Homelessness is a broad term. A person may be defined as homeless if they are without anywhere to stay, or if they are vulnerably or inappropriately housed. We consider those who are statutorily accepted as homeless and are placed in temporary, Bed and Breakfast (B&B) or hostel accommodation; those who are defined as being ‘homeless at home’ by their local authority due to overcrowding, and those who are sleeping rough or in night shelters.

Homeless people experience more mental, physical and obstetric health problems compared to housed groups. They also tend to experience difficulties in accessing health services, and have greater need for healthcare due to increased risk of morbidity related to being homeless or living in poor quality accommodation. Homeless people frequently lack social support. There is a reciprocal relationship between homelessness and ill health. Poor physical and mental health can cause a person to become homeless, whilst homelessness can cause poor health or exacerbate existing conditions.

Due to the difficulties of accessing primary care, homeless people make high and inappropriate use of A&E departments, and frequently do not seek treatment until reaching crisis point. This means that health problems have often escalated by the time they reach services, and the impact on their ability to support themselves and their families is greater.
People who sleep rough have a higher risk of mortality due to suicide, accidents, alcohol-related and respiratory illness. They also experience high rates of morbidity, alcohol and drug use, and are more likely than the general population to have a serious mental illness.

Children born to homeless mothers who have been living in temporary accommodation for some time are more likely to be of low birth weight, and miss immunisation. They have a high rate of infections, skin-disorders, and accidents. Due to ill health and inadequate living space, homeless children are less likely to reach the same levels of educational attainment as housed children, and often suffer behavioural difficulties.

Homelessness in Islington
There are an estimated 504 rough sleepers in England on any single night. Estimates of the number of rough sleepers in Islington during June/July 2003 were between 0-10. In 2003, there were on average 1,413 households accepted as homeless in Islington, and 60,738 households accepted as homeless by all of London’s local authorities. Islington therefore supports 2.3% of London’s statutory homeless. About a third of Islington’s homeless are placed in accommodation outside of the borough.

Compared to London, Islington has fewer statutory homeless living in B&B¹ and ‘other’² types of accommodation. It has nearly three times as many people living in self-contained annexes³.

Compared to the general population of Islington, there are a disproportionate number of homeless households from non-white ethnic groups. Compared to London as a whole, Islington has proportionately more non-white households accepted as homeless.

Figure 3.7(5): Ethnic breakdown of homeless households and all households in Islington and London

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>London</th>
<th>Islington</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Households as %</td>
<td>Households accepted as homeless %</td>
</tr>
<tr>
<td>White</td>
<td>78</td>
<td>36</td>
</tr>
<tr>
<td>Black/Black Caribbean</td>
<td>11</td>
<td>29</td>
</tr>
<tr>
<td>Indian/Pakistani/Bangladeshi</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Not Known</td>
<td>*</td>
<td>7</td>
</tr>
</tbody>
</table>

* There is no unknown category in census ethnicity statistics

¹ Accommodation where basic facilities such as toilets, bathrooms, kitchens are shared.
² This category includes hostel accommodation, women’s refuges, private sector housing, and housing association or council stock that is being used for temporary accommodation.
³ Accommodation which is self contained – the occupants do not share facilities with other individuals or families.
The only data that is readily available on the health of homeless people in Islington comes from the Primary Care for Homeless People (PCHP) clinic at St. Pancras Hospital. Between February 2003 and January 2004, PCHP provided care for 1,783 people without a permanent home, and who experienced difficulties in registering with a practice. The majority of attendees are male (75%) fall within the ages of 26 to 55. The largest proportions of people attending the clinic are rough sleepers followed by people who have been living in a hostel for less than six months, or staying with relatives and friends.

Figure 3.7(6) shows that for clinic attendees, the most common health problems are drug and alcohol abuse, mental health, and dermatological and respiratory conditions.

Figure 3.7(6): Most common health problems amongst clients seen at Primary Care for Homeless People clinic at St Pancras Hospital 2003/2004 financial year

3.8 Crime
Crime is associated with social disorganisation, deprivation, and health inequalities. Crime affects quality of life, long-term, short-term mental and physical well-being. The psychological and physical damage inflicted on individuals who are the victims of crime involves direct costs to the NHS.

There are five main forms of crime which impact on the health service. Domestic violence often results in injury and is frequently witnessed by children, bearing long-term repercussions. Physical and sexual abuse of children, results in both short and long term mental, social and behavioural difficulties. Rape causes serious emotional and mental health problems, and impacts on sexual health. The fear of crime can reduce community involvement and foster social isolation. Lastly, drug and alcohol misuse often co-exists with high levels of deprivation and elevated levels of certain types of crime and directly impacts on physical and mental health status.

Crime in Islington
The main types of crime in Islington are ‘all other theft’, violence against the person and motor vehicle crime. Islington shows similar levels for different crime-types by comparison with London. However it has slightly larger proportion of ‘all other theft’, but less robbery and street crime relative to London.

Figure 3.8(1): Proportion of different types of crime committed in Islington during 2003

Bibliography
London Borough of Islington. Housing Needs Survey; 2001
Office for National Statistics. Census 2001
Greater London Authority. Homeless in London

*This includes autocrime, theft from the person, theft from shops, handling of stolen goods, theft of pedal cycles and any other theft.
However Finsbury Park, St George’s and Holloway wards show the most uniformly high levels of crime. Highbury East has most people living in areas falling in the smallest quintile for levels of crime, although it also has areas experiencing the highest quintile.

Figure 3.8(3) shows that relative to national levels, a large number of Islington’s super output areas fall within the two highest national quintiles for crime levels. Most wards are mixed in terms of the level of crime, and there is no clear geographical pattern.

Bibliography
London Health Observatory. www.lho.org.uk
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Metropolitan Police 2003
3.9 Prisons

There are different levels of punishment for crime within the English criminal justice system, including community service and prison sentences. Prisons can hold convicted and unconvicted (remand) prisoners. Prisons are always single sex, usually holding adults over the age of 20. Those under 20 are held in young offender institutions (YOI) that are frequently on the same site as the main prison. Younger juveniles normally go into other forms of secure accommodation.

There are different levels of prison security classification, ranging from Category A to Category D, with Category A being the most secure. A mother and baby unit is a separate part of a prison which enables prisoners to keep their baby with them, but only if it is considered to be in the best interests of the child. There are mother and baby units in five women’s prisons in the country.

There is an established link between deprivation and crime. Those entering the criminal justice system are more likely to have poor health, and this is often further compounded by prison life, and difficulties in health service use due to rapid movement through the judicial system.

Prisons in Islington

There are two prisons in Islington, HMP and YOI Holloway Prison and Pentonville Prison. Both are category B, and accommodate remand and sentenced prisoners.

Holloway prison for women has an operational capacity of 532 individuals. It also has a mother and baby unit with 17 places for babies up to nine months, and a 40 prisoner capacity for young female offenders. Around 12,000 women pass through Holloway prison each year, 65% of whom are on remand. The average length of stay is 28 days. A snapshot survey of place of residence of Holloway’s prisoners in 1999 showed that 39% were from London, 22% had no fixed abode, and the remaining 39% came from outside of London.

Pentonville men’s prison has an operational capacity of 1205. It has a throughput of 30,000 people each year, of whom 60% are sentenced, and 23% are new receptions. Out of those who are sentenced, 30% serve sentences of one year or less. The majority of prisoners come from the North London catchment area.

Pentonville Prison has 80% of prisoners report having taken a Class A drug in the five days before, 250 prisoners a month enter the detoxification, and 13% are psychotic. In Holloway, 50% of new receptions are referred for detoxification, 76% of prisoners have at least one mental illness and 60% have personality disorders. Other physical illnesses are communicable diseases such as Hepatitis C, HIV, and TB, asthma, epilepsy, CHD and diabetes. Six percent of female prisoners in Holloway were pregnant at the time of the needs assessment (2003).

Compared to the population of London, and Islington borough, the prison population has proportionately more people who classify themselves as non-white.

The main health problems among the prison population are mental health and substance misuse. On arrival at Pentonville prison, 80% of prisoners report having taken a Class A drug in the five days before, 250 prisoners a month enter the detoxification, and 13% are psychotic. In Holloway, 50% of new receptions are referred for detoxification, 76% of prisoners have at least one mental illness and 60% have personality disorders. Other physical illnesses are communicable diseases such as Hepatitis C, HIV, and TB, asthma, epilepsy, CHD and diabetes. Six percent of female prisoners in Holloway were pregnant at the time of the needs assessment (2003).
3.10 Lone parents

Lone parent households are those headed by the mother or father without a spouse, who are not cohabiting, with child dependents under the age of 16, or children aged 16-19 in full time education.

The rising prevalence of lone parent households is a key issue in addressing the determinants of health. Children from single parent families are more likely to experience poor health, use alcohol and drugs, become teenage parents, do poorly in school and have difficulty in finding employment. Single-parent families are more likely to have lower incomes than two parent families. Poorer levels of income are also likely to pre-dispose families to living in areas with higher levels of relative deprivation, and according elevated risks of crime, violence, drug misuse, inadequate housing and pressure on public services and education. Lone parents are more likely to smoke, and lack support in giving up. Smoking is a major contributing factor to the cycle of deprivation as poor health reduces the capacity to work, family income and social networks.

Although the number of father-only families has grown, women head the majority of single-parent families. Nine out of ten lone parent families are headed by a woman and nearly half of all lone mothers are single (never married). Half of lone mothers with dependent children live in social sector housing. Lone mothers are more likely than lone fathers to be living in rented accommodation.

Lone Parents in Islington

Compared to London as a whole, Islington has a much higher proportion of lone parents with dependent children. In north central London, it has the second largest percentage of households headed by a lone parent. There are 7710 lone parent households in Islington with dependent children, the majority, or 7134, are headed by female lone parents, and 576 by male lone parents.

There is a substantially larger proportion of female lone parents than male lone parents across London as a whole, and within Islington. The proportion of female lone parents in Islington (9%) is greater than the London average (7%), and the second largest percentage in the north central London sector after Haringey.

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**Figure 3.10(1): Proportion of households headed by lone parents in Islington, other boroughs in the north central London sector, London and England and Wales in 2001**

<table>
<thead>
<tr>
<th></th>
<th>All lone parent households with dependent children (% of all households)</th>
<th>Male lone parent: Total (% of all households)</th>
<th>Female lone parent: Total (% of all households)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>6.18</td>
<td>0.46</td>
<td>5.72</td>
</tr>
<tr>
<td>Camden</td>
<td>6.78</td>
<td>0.68</td>
<td>6.10</td>
</tr>
<tr>
<td>Enfield</td>
<td>7.48</td>
<td>0.51</td>
<td>6.97</td>
</tr>
<tr>
<td>Haringey</td>
<td>9.82</td>
<td>0.61</td>
<td>9.21</td>
</tr>
<tr>
<td><strong>Islington</strong></td>
<td><strong>9.37</strong></td>
<td><strong>0.70</strong></td>
<td><strong>8.67</strong></td>
</tr>
<tr>
<td>London</td>
<td>7.60</td>
<td>0.61</td>
<td>6.99</td>
</tr>
<tr>
<td>England and Wales</td>
<td>6.46</td>
<td>0.62</td>
<td>5.85</td>
</tr>
</tbody>
</table>


Just under a third of all lone parents in Islington are in employment. More are in full time employment than part time employment, and this reflects London as a whole, and other boroughs in the sector. In Islington, there are 1470 female, and 205 male lone parents in full time employment. In part time employment, there are 987 female, and 41 male lone parents. By comparison there are proportionately more male lone parents, than female lone parents in full time employment.
Figure 3.10(2): Proportion of households headed by lone parents in full or part time employment out of all households in 2001 in Islington, other boroughs in the north central London sector, London and England and Wales in 2001

<table>
<thead>
<tr>
<th></th>
<th>Male lone parents</th>
<th>Female lone parents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-time employment</td>
<td>Part-time employment</td>
</tr>
<tr>
<td>Barnet</td>
<td>0.22</td>
<td>0.04</td>
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<tr>
<td>Camden</td>
<td>0.25</td>
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<tr>
<td>Enfield</td>
<td>0.26</td>
<td>0.04</td>
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<td>0.25</td>
<td>0.05</td>
</tr>
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<td><strong>0.05</strong></td>
</tr>
<tr>
<td>London</td>
<td>0.30</td>
<td>0.04</td>
</tr>
<tr>
<td>England and Wales</td>
<td>0.34</td>
<td>0.04</td>
</tr>
</tbody>
</table>


Bibliography
Oxford handbook of public health
Office for National Statistics. *Focus on Gender*. www.statistics.gov.uk

3.11 Smoking
Cigarette smoking causes an extensive range of diseases including cancer of various sites, respiratory disease, diseases of the circulatory system, and digestive diseases. London-wide, nearly 2 million people smoke; equivalent to 31% of men and 26% of women. This is slightly higher than the national average of 28% for men and 25% for women. Smoking prevalence is highest amongst younger adults, peaking in men aged 25-34, and 16-24 year old women. The prevalence of smoking is higher in men than in women across all age groups apart from 16-24 year olds, where almost equivalent numbers smoke (33% of women and 34% of men) and the oldest age group.

One in ten children in London aged 11-15 currently smoke cigarettes, with more secondary school girls than boys being regular smokers. Smoking prevalence in London school children increases with age; 2% of 12 year olds smoke compared with 25% of 15 year olds.

Death rates due to smoking are much higher amongst more disadvantaged groups than the well off. Smoking rates show a good correlation with a number of markers of disadvantage such as education, employment status, housing tenure, car ownership and social class.

Smoking in Islington
The most recent local data available comes from Health Survey for England local booster survey 1999. This showed overall rates in Islington were 32.8%. Rates were higher amongst men (36.4%) than amongst women (30%). A crude estimate of the actual number of smokers in Islington, places the number at around 47,600.

Overall these rates are higher than for England and Inner London. Rates are comparatively high for men in Islington compared to Inner London and England. Rates for women in Islington do not substantially differ to London.

Figure 3.11(1): Synthetic estimates for trends in smoking rates in Islington

<table>
<thead>
<tr>
<th>Islington</th>
<th>1999</th>
<th>2000-02*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>36.4%</td>
<td>34.6%</td>
</tr>
<tr>
<td>Women</td>
<td>30.0%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Total</td>
<td>32.8%</td>
<td>31.3%</td>
</tr>
</tbody>
</table>

Source: Camden and Islington Health Authority, Health Survey for England Local booster survey 1999-2000

Due to the lack of recent local level data, we have made synthetic estimates based on smoking prevalence for 2002 from the Health Survey for England. This assumes that social, economic and demographic characteristics remain stable across London’s population. On this basis we estimate current smoking rates in Islington are 31.3% overall, 34.6% for men, and 28.6% for women.
In the mid 1970s around 49% of adults in London smoked and this has fallen to below 30%. Proportionately the rate has declined more for men than for women.

In 2001, smoking was the cause of 1360 hospital admissions in Islington, with the cost of over £3 million. Out of these, 870 were for men (64%) and 490 for women (36%). Compared to London, the number of admissions for cancer, respiratory, and circulatory conditions was higher in Islington. Admission rates are given in Figure 3.11(3).

Figure 3.11(2) shows that across London, 18% of all deaths are due to smoking related illnesses. The percentage of deaths is greater among men (23%) than women (13%). In Islington, there were 270 deaths caused by smoking (21% of all deaths) and Islington ranked third out of all the boroughs in London in terms of the highest standardised death rate caused by smoking.

In north central London, the percentage of cancer and respiratory admissions due to smoking were highest in Islington. Along with Haringey, Islington shows the highest rates of admission for circulatory conditions due to smoking, after Enfield, which has the highest rates in the sector.
In Islington 2003/04, there were 1701 individuals who enrolled in the smoking cessation programme. 772 men and 929 women set a quit date. Out of these, 355 (46% of) men and 353 (38% of) women had quit at four-week follow up. The percentage of pregnant women who had quit at four weeks was 32%. Altogether 374 (22%) people entering the smoking cessation programme were lost to follow up or it was not possible to identify their smoking status. The fall out rate for men and women was similar.

**Figure 3.11(4): Quitters and non-quitters at four week follow up on Islington’s Smoking cessation programme 2003/04 financial year**

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Pregnant Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number setting a quit date</td>
<td>772</td>
<td>929</td>
<td>31</td>
</tr>
<tr>
<td>Number who had successfully quit at four week follow-up</td>
<td>353</td>
<td>355</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>46%</td>
<td>38%</td>
<td>32%</td>
</tr>
<tr>
<td>Number who had not quit at four week follow-up</td>
<td>260</td>
<td>367</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>34%</td>
<td>39%</td>
<td>32%</td>
</tr>
<tr>
<td>Number not known or lost to follow-up</td>
<td>159</td>
<td>207</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>21%</td>
<td>22%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Source: Department of Health. Smoking Cessations Services Quarterly Monitoring Returns 2003/04

**Figure 3.11(S) Proportion setting a quit date by ethnicity in 2003/04 financial year**

- White 77%
- Mixed 3%
- Asian or Asian 3%
- Black or Black British 6%
- Other 11%

Source: Department of Health. Smoking Cessations Services Quarterly Monitoring Returns 2003/04

Figure 3.11(S) shows the proportion of those who set a quit date in Islington’s smoking cessation programme by ethnicity. Both white and non-white groups are proportionately represented relative to Islington’s population. However, both Asian/Asian British and Black/Black British categories are under represented, and the number who classify themselves as ‘other’ is proportionately larger relative to Islington.

**Bibliography**

- Camden and Islington Health Authority. *Camden and Islington Health survey 1999-2000*
- Department of Health. *Health Survey for England 2002*
- Department of Health. *Smoking Cessation Services Quarterly Monitoring Returns 2003/04*
3.12 Obesity

The faculty of public health define obesity as “an excess of body fat frequently resulting in a significant impairment of health and longevity”. Body Mass Index (BMI) is the most commonly used measure of body fatness and is the individual’s weight in kilograms divided by their height in metres squared. Individuals with a BMI of over 25 are considered overweight, and obese at a BMI of over 30. There is no generally agreed definition of childhood obesity. Two widely used indicators are based on percentiles of UK reference curves; and reference points derived from an international survey.

Obesity results when people consistently consume more energy than they are able to expend through daily activities. Whilst energy expenditure has dramatically fallen as a consequence of modern lifestyles, energy-dense foods have become increasingly available. Energy-dense foods are foods that have a high calorie content without being filling.

Obesity is a risk factor for heart disease, diabetes, kidney failure, osteoarthritis, back pain, psychological problems hypertension, and premature death. Obesity is also a major preventable risk factor for cancer.

Around two thirds of the population of England are overweight or obese. Over the last decade the prevalence of obesity has grown by almost 50%. England has experienced the fastest growth in obesity in Europe, and childhood obesity has tripled in twenty years, although obesity remains more common in older age groups. According to the National BMI percentiles classification, about one in ten young men (9.2%) and women (11.5%) were obese, whilst one in three young men (32.2%) and young women (32.8%) fell into the category of either overweight or obese.

As well as age and sex differences, the prevalence of obesity varies across social class and ethnic group. The Health Survey for England (2001) showed that 14% of men and women in professional groups are obese, compared to 28% of women and 19% of men in manual groups. Obesity levels are 50% higher than the national average amongst Black Caribbean women and 25% higher amongst Pakistani women (HSE 1999).

It is estimated that the problem of obesity and overweight could incur economic costs of anywhere between £6.6–7.4 billion per year. If rising prevalence of obesity continues, it is a major concern that it will soon outstrip smoking as the greatest cause of premature life loss.

**Obesity in Islington**

Figure 3.12(1) shows that in 1999, 20.4% of all people in Islington were clinically obese and a further 31.0% were overweight. This means that 51.4% of all people in Islington are either overweight or obese compared with 56.8% across England and 50.0% in Inner London. Whilst Islington has a greater percentage of people suffering from obesity (20.4%) compared to Camden (14.7%), there are proportionately more overweight people in Camden (34% compared with 31%) in Islington.

<table>
<thead>
<tr>
<th></th>
<th>Total %</th>
<th>Lower Limit %</th>
<th>Upper Limit %</th>
<th>Men %</th>
<th>Lower Limit %</th>
<th>Upper Limit %</th>
<th>Women %</th>
<th>Lower Limit %</th>
<th>Upper Limit %</th>
</tr>
</thead>
<tbody>
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<td>Islington*</td>
<td>20.4</td>
<td>16.2</td>
<td>24.5</td>
<td>16.5</td>
<td>11.2</td>
<td>21.8</td>
<td>23.9</td>
<td>17.6</td>
<td>30.1</td>
</tr>
<tr>
<td>Camden*</td>
<td>14.7</td>
<td>11.4</td>
<td>17.9</td>
<td>11.8</td>
<td>7.6</td>
<td>15.9</td>
<td>17.2</td>
<td>12.3</td>
<td>22.1</td>
</tr>
<tr>
<td>Inner London 1998</td>
<td>19.8</td>
<td>15.5</td>
<td>24.0</td>
<td>16.1</td>
<td>10.5</td>
<td>21.8</td>
<td>22.6</td>
<td>16.5</td>
<td>28.6</td>
</tr>
<tr>
<td>England 1998</td>
<td>19.1</td>
<td>18.3</td>
<td>19.8</td>
<td>17.0</td>
<td>16</td>
<td>18</td>
<td>20.8</td>
<td>19.8</td>
<td>21.8</td>
</tr>
</tbody>
</table>

* Camden and Islington Health Authority, Health Survey for England Local booster survey 1999-2000
Figure 3.12(2): Percentage of people defined as overweight but not obese (BM1>25) in England, Inner London, Camden and Islington 1998, 1999-2000

<table>
<thead>
<tr>
<th></th>
<th>Total %</th>
<th>Lower Limit %</th>
<th>Upper Limit %</th>
</tr>
</thead>
<tbody>
<tr>
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<td>36.0</td>
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<tr>
<td>Camden*</td>
<td>34.0</td>
<td>29.3</td>
<td>38.7</td>
</tr>
<tr>
<td>Inner London 1998</td>
<td>30.2</td>
<td>25.0</td>
<td>35.5</td>
</tr>
<tr>
<td>England 1998</td>
<td>37.8</td>
<td>36.8</td>
<td>38.8</td>
</tr>
</tbody>
</table>


* Camden and Islington Health Authority, Health Survey for England Local booster survey 1999-2000

Obesity rates are consistently higher in women than in men, and this is true across England, Inner London, and at borough level.

Due to lack of recent local level data, we have used national data from the Health Survey for England 2002, to provide synthetic estimates of current obesity rates in Islington.

Figure 3.12(3): Synthetic Estimates of Obesity in Islington 2002

<table>
<thead>
<tr>
<th></th>
<th>Total %</th>
<th>Men %</th>
<th>Women %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Islington*</td>
<td>21.2</td>
<td>18.6</td>
<td>24.1</td>
</tr>
<tr>
<td>England 2002</td>
<td>21.4</td>
<td>20.8</td>
<td>22</td>
</tr>
</tbody>
</table>


* These estimates are made from 2000-2002 data for obesity rates across England drawn from the HSE 2002

Figure 3.12(4): Comparison of trends in obesity rates; 1994-2002 pooled data

Figure 3.12(4) shows that obesity rates have risen amongst men and women across England, London, and across the North Central London Sector between 1994-96 and 2000-2002. In 2002, the prevalence of obesity was greater in England, and London compared to the North Central London Sector.

Rates for men and women across the sector have shown a very pronounced convergence, and were higher for men in 1999-01 than for women, although they appear to have tailed off, whilst rates amongst women have continued to climb. This contrasts with the pattern for London, which shows a divergence between the rates for men and those for women. Whilst the rate is rapidly rising for women, it is increasing more slowly for men. Across England, male and female obesity rates are converging more slowly than across the sector.

Bibliography

- Department of Health. Health Survey for England 2002
- Department of Health. Health Survey for England: Cardiovascular Disease 1998
- Camden and Islington Health Authority. Health Survey for England local booster survey 1999-2000
3.13 Alcohol

Alcohol consumption above recommended limits is associated with raised levels of morbidity and mortality. The recommended weekly limit of alcohol is 14 units for women and 21 units for men.

The medical consequences of excess alcohol consumption include effects on the liver; the gastrointestinal system; the heart and circulatory system; the nervous system; the respiratory system; the reproductive system; and nutritional status. Unborn children may also be affected.

Alcohol is a contributing factor to increased service use, including attendances at accident and emergency departments, ambulance call outs, hospital admissions and primary care. Around 1% of hospital admissions are due to alcohol. There are more admissions for males amongst the 25-54 age group; and for females amongst the 15-24 age group. It is also a contributing factor to crime, such as violence against the person and public disorder. The British Crime Survey (2000) suggested that alcohol is related to 47% of violent crime. It also contributes to accidents and injuries including those due to drink driving.

Alcohol is a contributing factor to psychiatric morbidity. The psychiatric morbidity survey carried out by OPCS found that over twice as many dependent drinkers had a neurotic disorder compared with 14% of non-dependent drinkers. Around 10-54% of suicides are associated with chronic heavy drinking.

The relationship between social status, alcohol consumption and ill health is well established. People in non-manual households are more likely to consume over recommended levels of alcohol than people in manual households, although non-manual groups have a lower mortality rate due to alcohol related illness than manual groups. It is difficult to separate how far this pattern reflects the interaction of factors such as higher incomes, better diet, better access to treatment and stress related to deprivation.

Alcohol in Islington

Islington is among those boroughs in London experiencing the highest admission rates attributable to alcohol; over 30 per 100,000 people. Figure 3.13(1) shows areas of London experiencing the highest age standardised admission rates due to alcohol in 2001. In Islington the age standardised mortality rates for diseases directly related to alcohol between 1998-2000 was over 18 per 100,000.

Figure 3.13(1): Age standardized admission rates where primary reason for admission was a disease directly related to alcohol 2001

Around half of all alcohol related deaths are among those aged 45-64, 15-20% occur in 34-44 age group, and 15-20% in 64-74 year olds. The age profile for females is slightly older than males.

Figure 3.13(2): Percentage of people consuming more than the weekly-recommended allowance of alcohol in Inner London and England 1998, and Islington 1999-2000

<table>
<thead>
<tr>
<th></th>
<th>Men (%)</th>
<th>95% Confidence Intervals</th>
<th>Women (%)</th>
<th>95% Confidence Intervals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1998 Lower</td>
<td>Upper</td>
<td>1998 Lower</td>
<td>Upper</td>
</tr>
<tr>
<td>Islington</td>
<td>30*</td>
<td>25</td>
<td>36</td>
<td>18*</td>
</tr>
<tr>
<td>Inner London</td>
<td>26</td>
<td>19</td>
<td>33</td>
<td>20</td>
</tr>
<tr>
<td>England and Wales</td>
<td>31</td>
<td>30</td>
<td>32</td>
<td>18</td>
</tr>
</tbody>
</table>

* Camden and Islington Health Authority: Health Survey for England local booster survey 1999-2000
Figure 3.13(2) shows that in 1999 30% of men, and 18% of women aged between 16-64 in Islington exceed recommended weekly limits of alcohol. This is not greatly different to England and Wales. However rates are slightly higher amongst men in Islington than across London as a whole. By contrast, rates amongst women in Islington are comparatively lower than London as a whole.

Due to the lack of recent local level data we have used national data from the HSE (2002) to make synthetic estimates. They indicate that levels of over consumption have not changed greatly since 1999. We would therefore expect that 19,669 men and 12,376 women in Islington currently consume more than the recommended weekly allowance of alcohol.

3.14 Exercise

Physical fitness is a physiological condition. It is a set of attributes which people have or can acquire relating to the ability to perform physical activity. Fitness levels are partly determined by hereditary factors but are also acquired through physical activity.

Levels of physical activity and fitness are declining nationally with increasingly sedentary lifestyles. There has been a sharp rise in obesity, coinciding with decreased energy expenditure. There has also been a rise in the prevalence of risk factors and ill health pre-disposed by physical inactivity and high Body Mass Index.

Physical activity reduces the risk of coronary heart disease and stroke by 25%. It aids weight loss and maintenance, and lowers the risk of diabetes, high blood pressure, osteoporosis, obesity, depression, and some types of cancer.

Considering the rising prevalence of obesity in school children, it is a particular concern that levels of physical activity in children are also declining. National studies indicate that the decline in activity levels is more marked amongst girls aged 11-15 than for boys. The Allied Dunbar National Fitness Survey (1992) identified young women aged 16-24, middle-aged men, and the over 50s as being particularly sedentary. There are also socio-economic differences in activity levels. People with higher incomes or in non-manual groups tend to participate more in active leisure pursuits than those with lower incomes.

Differences in levels of physical activity exist across ethnic groups. Amongst the highest proportions reaching the recommended levels are Black Caribbeans and Whites. Pakistanis and Bangladeshis are least likely to be reaching recommended levels. Whilst Black Caribbean men are twice as likely to be reaching the recommended level of activity as Bangladeshi men, Black Caribbean women were four times as likely to be reaching the recommended levels as Bangladeshi women.

Current recommendations are that adults should do 30 minutes of moderate activity at least 5 days per week, and children should do 60 minutes moderate activity at least five days per week.

Bibliography


London Health Observatory and Greater London Alcohol and Drug Alliance

Camden and Islington Health Authority. Health Survey for England local booster survey 1999-2000

Figure 3.14(1): Percentage of adults undertaking regular physical exercise by gender 1998, 1999 in Camden and Islington, Inner London and England and Wales

<table>
<thead>
<tr>
<th></th>
<th>Men (%)</th>
<th>95% Confidence Intervals</th>
<th>Women (%)</th>
<th>95% Confidence Intervals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent</td>
<td>Lower</td>
<td>Upper</td>
<td>Percent</td>
</tr>
<tr>
<td>Islington</td>
<td>32</td>
<td>27</td>
<td>38</td>
<td>27</td>
</tr>
<tr>
<td>Camden</td>
<td>28</td>
<td>23</td>
<td>33</td>
<td>27</td>
</tr>
<tr>
<td>Inner London</td>
<td>31</td>
<td>24</td>
<td>38</td>
<td>24</td>
</tr>
<tr>
<td>England and Wales</td>
<td>38</td>
<td>36</td>
<td>39</td>
<td>25</td>
</tr>
</tbody>
</table>

Camden and Islington Health Authority: Health Survey for England local booster survey 1999-2000

Figure 3.14(1) shows overall levels of activity in Islington are below the average for England and Wales, but more than Inner London. Compared to Camden, Islington has slightly higher activity levels. However men in Islington report higher levels of physical activity than women. While men in Islington are on the whole less active than men across England and Wales as a whole, women in Islington report higher levels of physical activity relative to the average for women across England and Wales.

Bibliography
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Health Education Authority. Black and Minority Ethnic Groups in England: the second health and lifestyle survey 1999

3.15 Drug misuse
Although drug use is a major concern in London, and has been outlined as a key priority for the Mayor of London, the Department of Health and the Home Office, it is difficult to get an accurate picture of its use and impact, as data is patchy and often comes from incongruent sources. Drug use does however, impact on health, crime, community development and regeneration and social care. Direct health impacts of drug use include the increased risk of transmission of blood borne viruses through injecting drug use, drug related mortality, ambulance call outs and hospital admissions, as well as drug induced psychosis. The indirect impacts on health are associated with increased levels of crime, and decreased community cohesion.

Illegal drug use is most prevalent in the 16-29 age group. Drug use tends to be concentrated in urban areas, and rates of use are relatively high in London. The British Crime Survey (2001) found that in London 22% of young Londoners aged 16-29 had taken an illegal drug in the last month compared with 16% in England and Wales.

Whilst the prevalence of drug use has not increased overall over the last five years, Class A drug use has increased. The number of seizures of Class A drugs in London is double that for England, and this difference is largely explained by seizures of cocaine and crack.

The age standardised mortality rate from drug misuse is significantly higher in Inner London than for England as a whole.

Islington drug treatment
The most comprehensive source of data on drug misuse is treatment data from the national drug treatment monitoring system. There were 683 Islington residents in drug treatment between April 2001/March 2002: 31% female, and 69% male. There are more women, and fewer men in treatment in Islington relative to London as a whole. This is reflected across the north central London sector.
### Figure 3.15(1): Residents in treatment for Islington, other boroughs in the north central London sector and London, 2001 /2002 financial year

<table>
<thead>
<tr>
<th>Total no of residents in treatment</th>
<th>% Female</th>
<th>% Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>373</td>
<td>28.4</td>
</tr>
<tr>
<td>Camden</td>
<td>1357</td>
<td>25.4</td>
</tr>
<tr>
<td>Enfield</td>
<td>266</td>
<td>19.9</td>
</tr>
<tr>
<td>Haringey</td>
<td>296</td>
<td>32.8</td>
</tr>
<tr>
<td><strong>Islington</strong></td>
<td><strong>683</strong></td>
<td><strong>31.3</strong></td>
</tr>
<tr>
<td>Inner London</td>
<td>10852</td>
<td>24.9</td>
</tr>
<tr>
<td>London</td>
<td>18769</td>
<td>24.5</td>
</tr>
</tbody>
</table>

Source: National Drug Treatment monitoring system. Analysis by Centre for Research on Drugs and Health, London Health Observatory, Greater London Authority.

Islington has a higher treatment rate (6.4 per 1000) for drug misuse relative to London (4.9 per 1000), but comparable rates to Inner London. Compared to other boroughs in the sector, Islington has a much lower rate than Camden, and considerably higher than Haringey, Enfield and Barnet.

### Figure 3.15(2) Numbers in treatment aged between 15-44 years, and rate per thousand in Islington, other boroughs in the north central London sector and London, 2001 /2002 financial year

<table>
<thead>
<tr>
<th>Numbers</th>
<th>Population 15-44</th>
<th>Rate per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>339</td>
<td>142,018</td>
</tr>
<tr>
<td>Camden</td>
<td>1209</td>
<td>108,962</td>
</tr>
<tr>
<td>Enfield</td>
<td>242</td>
<td>122,662</td>
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<tr>
<td>Haringey</td>
<td>261</td>
<td>114,311</td>
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<tr>
<td><strong>Islington</strong></td>
<td><strong>618</strong></td>
<td><strong>95,897</strong></td>
</tr>
<tr>
<td>Inner London</td>
<td>9743</td>
<td>1,487,703</td>
</tr>
<tr>
<td>London</td>
<td>16986</td>
<td>3,480,940</td>
</tr>
</tbody>
</table>

Source: National Drug Treatment monitoring system. Analysis by Centre for Research on Drugs and Health, London Health Observatory, Greater London Authority.
Figure 3.15(3) shows the proportion of those in treatment in Islington by the main drug used. Crack, cocaine, methadone, and heroin are the main drugs for which people seek treatment.

Islington has a higher rate of poly drug use (heroin and crack) reported by those in treatment compared to London as a whole, and relative to the rest of north central London. It also has the highest proportion of those in treatment for crack use only in the sector, but relatively smaller proportion in treatment for use of only heroin.

The main problem with this data is that it is drawn from numbers in treatment only, and may not reflect actual prevalence of drug misuse as it only tells us about those who are in contact with services. Treatment figures may also reflect capacity, or other factors affecting service uptake. Equally, there is a clear relationship between social exclusion, drug use, and difficulty in accessing services.

In London, data on people presenting to specialist drug agencies suggests that approximately 75% were white and less than 10% were from black and minority ethnic communities. This contrasts with police data, which suggests a much higher proportion of people from BME groups use drugs; 60% white and 24% non-white. This suggests that there is poor uptake of drug treatment services amongst black and minority and ethnic groups in London. Treatment data show that relative to the ethnic breakdown of Islington’s population, and London as a whole, Asians and people from Black/Black British ethnic groups and the white population are slightly under-represented. This pattern may reflect poor uptake of services, or failure to carry out ethnic monitoring appropriately.

Figure 3.15(4) shows that heroin and crack use are more prevalent amongst Islington residents compared to London as whole. However the prevalence of reported methadone and cocaine use amongst those presenting for treatment is slightly lower relative to London as a whole.
Those accessing services in Islington for drug treatment are mainly aged between 15–45. The largest proportion of those in treatment fall in the 25–34 age group. Islington has a greater proportion in the 25–34 (46%) age group than the London average (42%); but a smaller proportion in the 15–24 (12.4%) age group than London as whole (19.9%). Islington also has a slightly higher proportion of people in treatment in the other age groups than London as a whole.

### Figure 3.15(6): Percentage in treatment by age group and borough of residence for Islington, other boroughs in the north central London sector and London, 2001/2002 financial year

Breast-feeding has many health benefits for both mother and child. For the baby there is less risk of sudden infant death and a variety of infections. Breast-feeding also lowers the risk of allergies and diabetes and improves the cognitive development of babies, especially those with low birth weight. For the mother, breast-feeding reduces the risk of breast and ovarian cancer and hip fractures in old age. The benefits are most pronounced if breast-feeding continues at least until 4-6 months. Exclusive breast-feeding is more beneficial than mixed bottle and breast-feeding, and any breast-feeding is better than none. Breast-feeding is less common among those in disadvantaged circumstances where benefits would be greatest.

### Breast-feeding in Islington

In Islington, the data currently collected can only inform us about feeding practices up to six weeks after birth.

### Bibliography

National drug treatment monitoring system. Analysis by CRDHB, LHO, GLA

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Office for National Statistics. Census 2001

Figure 3.16(2): Proportion of babies being breast fed at six-week check in Islington

Figure 3.16(3): Prevalence of breast-feeding at different ages in Islington and England and Wales.

Prevalence of breast-feeding across England and Wales progressively drops off over time from 71% at birth, to 43% at 6 weeks, and 14% at nine months. Although the prevalence is comparable at birth in Islington (71.1%), it is slightly lower the national average at 6 weeks (39.9%). We do not show a trend line for Islington due to the limitations of our data.

Bibliography
UNICEF UK Baby Friendly Initiative. www.babyfriendly.org.uk
Camden and Islington Health Authority. Public Health Report The Health of Children and Young People in Camden and Islington 1999
Islington PCT. Returns, Health Visiting Team
3.17 Teenage pregnancy

Teenage pregnancy is conventionally defined as the total number of recorded conceptions to teenage women per 1000 women of defined teenage years. Teenage pregnancy is strongly associated with levels of deprivation. One in ten babies in England is born to a teenage mother, and is at greater risk of growing up in poverty as a result of reduced access to education and employment. This impacts on long-term health and social outcomes for both teenage parents and their children. Infant mortality rates are twice the average for children born to mothers under the age of eighteen.

Teenage pregnancy in Islington

In Islington there were 175 conceptions in 2001 to under 18s, out of which 66% led to abortion. We do not provide crude figures for the number of abortions as the proportion of conceptions leading to abortion is based on rough estimates, and would provide an inaccurate estimate if converted. Compared with England and Wales, and London as a whole, Islington has a much higher conception rate in under 18s. The proportion leading to abortion is also much higher than the London average and England and Wales.

<table>
<thead>
<tr>
<th>Borough</th>
<th>Conception Rate in 2001</th>
<th>Proportion (%) leading to Abortion in 2001</th>
</tr>
</thead>
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</tr>
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<tr>
<td>Enfield</td>
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<td>52.6</td>
</tr>
<tr>
<td>Haringey</td>
<td>72.7</td>
<td>53.4</td>
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<tr>
<td><strong>Islington</strong></td>
<td><strong>63.6</strong></td>
<td><strong>66.3</strong></td>
</tr>
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London wide, the teenage conception rate ranges from 21.2 per 1000 in Richmond Upon Thames to 90.8 per 1000 in the borough of Lambeth. Islington ranks seventh out of all the London boroughs for the highest conception rate, and has the second highest rate after Haringey in the north central London sector. The proportion of conceptions that are estimated to lead to abortion is also relatively high in Islington compared to all other London boroughs, and the sector. Islington has the largest number of under 18 conceptions leading for abortion in the sector. We do not have data on live births to under 18s. The data which is available on the actual number of abortions (compendium data 2001) is based on old health authority boundaries.

Figure 3.17(1): Teenage conception rates per 1000 and the proportion which lead to abortion in Islington, other boroughs in the north central London sector and England and Wales in 2001

Figure 3.17(2): Under 18 conceptions (rate per 1000) in Islington by ward in 2001

Source: London Health Observatory

Figure 3.17(2) shows that the wards with the highest conception rates for under 18’s are Finsbury Park, Caledonian, Highbury West, Hill Rise, St Georges, and Bunhill.
Whilst the teenage conception rate has dropped between 1998-2001 across England and Wales, and to a lesser extent across London, it has increased in Islington by 4.8%. In north central London, Haringey and Enfield have also shown an increase; whilst Camden and Barnet have shown a decline in line with the London trend. The proportion of conceptions leading to abortion has increased by 3.7% in Islington – similar to London. Haringey and Barnet have shown comparatively bigger increases.

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Social Exclusion Unit. Teenage Pregnancy 1999
4 Diseases

In the 2001 census 18.1% of Islington women and 17.7% of men reported a long-term limiting illness. These proportions were approximately 27% greater than the average prevalence of self-reported limiting illness in England.

There was an annual average of 523 Islington residents admitted with stroke in 2002 and 2003. Stroke mortality in Islington is 15% lower than England and Wales as a whole.

Approximately 250 deaths per year of Islington residents are attributed to coronary heart disease; accounting for 18% of all deaths. Rates of premature CHD death are 40% higher in Islington than in England and Wales. This is almost entirely due to higher rates of CHD death in Islington men.

Approximately 5,800 people in Islington (3.3%) are estimated to have diabetes. Diabetes mortality rates are 81% higher than in England and Wales.

About 280 Islington residents a year were admitted to hospital for mental health problems in the 2001-2003 period. Standardised first episode admission rates for both schizophrenia and neuroses are twice the average London rate.

About 25-30 people die from suicide and undetermined injury in Islington each year. The suicide rate is 55% higher than the average rate in England and Wales.

666 Islington residents were admitted in 2001/2002 with serious accidental injury. Standardised admission rates are about 20% higher than admission rates nationally.

There are approximately 670 cancer registrations and 390 cancer deaths each year in Islington. The cancer death rate is approximately 23% higher than the cancer death rate in England. Lung, breast, colorectal and prostate account for approximately 50% of all cancer registrations.

There are a little over 100 cases of tuberculosis in Islington each year. The 2003 notification rate of 62.4 per 100,000, is 6th highest in London and almost 6 times the notification rate in England and Wales.

Around 70% of 2-year-old children in Islington are currently immunised with measles, mumps and rubella vaccine. This is 10% lower than the England average and much lower than the 95% coverage needed to prevent a measles outbreak spreading.

There were 760 Islington residents (0.43% or approximately 1 in 240) seen for HIV treatment in the first 6 months of 2003. Prevalence of (treated and untreated) HIV infection is likely to be much higher.

4.1 General health

There are various proxy measures of general health. We use self reported health status, where people rate their health as ‘good’, ‘fairly good’ or ‘not good’ over the preceding twelve months; long term limiting illness (also self reported); and disability living allowance claimant counts showing the number of disabled people registered by Islington council.

Self reported health and long term limiting illness vary according to age, sex, ethnicity, and social class. The Health Survey for England (1999) showed amongst the general population, 25% of men and 26% of women reported a limiting condition. Prevalence was higher among manual social classes, and increased with age. Pakistanis and Bangladeshis had the worst self-assessed health followed by Indian men and Black Caribbean women. Amongst the general population, non-manual classes were significantly more likely to report ‘good’ or ‘very good’ health than manual classes, and this pattern was also reflected across ethnic groups.
**General health in Islington**

Figure 4.1(1) shows that, with the exception of Highbury East and St Mary's wards, the proportion of people reporting good health is lower than national levels of self-reported good health.

**Figure 4.1(1): Population reporting good health by ward in Islington compared to England standardised percentage in 2001**

In the 2001 census, 114,510 men and 16,157 women in Islington reported a long term limiting illness (18.1% of women compared to 17.7% of men). These rates are similar to the London rate of 18.2%. The age adjusted standardised percentage of people with a long term limiting illness was 127 (CI: 125-129) for men and 126 (CI: 124-128) for women. This means that compared to the national average across England of 100, around 27% more people in Islington report long term limiting illness. Within Islington, Holloway and Finsbury Park were amongst the wards with the highest proportion of people with limiting long-term illness. Highbury East had the least, but still more compared to national levels. There were around 3,700 adults claiming disability living allowance for the month ending February 2004.

**Figure 4.1(2): IMD 2004 Health Deprivation and Disability score according to national rank by super output area in Islington**

Figure 4.1(2) shows that most of Islington falls into the two worst quintiles for health and disability deprivation. The wards with the largest number of households falling into the worst 20% for health and disability deprivation are Caledonian, Finsbury Park and Tollington. Barnsbury has the least number of households falling into the worst 20% of all wards in Islington.
Figure 4.1(3): IMD 2004 Health Deprivation and Disability score within Islington by super output area in Islington

The main risk factors for stroke are high blood pressure, smoking, poor diet, lack of exercise, and excessive alcohol consumption.

**Stroke in Islington**

There was a yearly average of 523 admissions for stroke amongst Islington residents for the years 2002 and 2003, comprising equal numbers of men and women, most of whom (61.8%) were over 70. Of these, 335 were first strokes.

Admission rates for all ages by ward are presented in figure 4.2(1). There is almost a three-fold difference in rates of stroke admission between wards in Islington. After taking age and sex into account, Mildmay and Canonbury wards have the highest admission rates for stroke in the borough (297 and 291 admissions per 100,000 respectively); Barnsbury and Bunhill have the lowest (111 and 148 admissions per 100,000 respectively).

**4.2 Stroke**

Stroke occurs when blood supply to the brain is disrupted. This usually happens when a blood clot blocks an artery carrying blood to the brain. Some strokes can be caused by a burst blood vessel within or around the brain.

Over 100,000 people a year in England and Wales have a first stroke. Stroke is the third most common cause of death, with 60,000 deaths per year attributable to it. It is also the most common cause of disability.

Mortality rates from stroke differ across ethnic groups, and are higher in some ‘Black/Caribbean’ ethnic groups. One of the key risk factors for stroke is high blood pressure, with raised levels amongst African Caribbean populations. The Health Survey for England (1999) found that for almost all cardiovascular conditions with the exception of diabetes, Chinese men and women had lower rates than the general population. All South Asian groups showed higher rates, but Pakistanis and Bangladeshis showed higher rates than Indians. There are also differences in mortality by social class, with higher rates occurring among more deprived groups.
Approximately 100 deaths a year due to stroke occur in Islington, comprising of roughly equal numbers of men and women. This equates to 8% of all deaths in Islington. Out of these, there were 13 men and 15 women under the age of 65.

The SMR for stroke in Islington is 85, similar to London as a whole, which has an SMR of 88. London has lower stroke mortality than the rest of the country, although the reason for this is not clear. The mortality ratio for men and women in Islington is the same.

Most strokes occur after the age of 65 years, rising dramatically over 75 years. Men die at an earlier age from stroke than women. Compared to England and Wales, the death rate is higher in men aged 65-74 in Islington, but is comparatively less at 75 and above. The death rate in women aged 65-74 is comparatively smaller than England and Wales, and this difference increases substantially over 75 years.

Nationally, there has been a downward trend in stroke mortality over recent years. This has been seen in Islington as well as other parts of London, but the trend is less clear due to the smaller numbers of deaths.
4.3 Coronary Heart Disease
Coronary heart disease is a narrowing of the coronary arteries that supply the heart. Coronary Heart Disease (CHD) includes angina (chest pain on exertion), heart attacks (myocardial infarction) and heart failure.

CHD is the leading cause of death in England and Wales. In 2001, it accounted for 10,684 deaths in London. Estimates suggest that around 80-90 cases per 10,000 population are diagnosed each year, with incidence being twice as high for men as for women. Each year, CHD kills more than 110,000 people in England, and more than 41,000 of these are under 75. Nationally the prevalence of CHD is 7.1% amongst men and 4.6% amongst women (HSE 1999).

CHD reflects inequalities in health. For example, men in unskilled occupations are three times more likely to die prematurely of heart disease than men in professional or managerial occupations. Angina and heart attacks are also more common amongst the manual classes. There are also manifest differences in mortality across ethnic groups. For instance, the death rate from coronary heart disease amongst people born in the Indian subcontinent is around 40% higher than for the population as a whole. Risk increases with age. Women are at lower risk of CHD than men until after the menopause. The main risk factors for CHD are smoking, poor diet, high blood pressure, diabetes, overweight and lack of physical activity.

Coronary Heart Disease in Islington
According to national prevalence rates, estimates show that 6356 men and 4218 women in Islington would be expected to have CHD. Approximately 250 deaths occur in Islington each year due to CHD, equivalent to 18% of all deaths. In 2003, 727 Islington residents were admitted to hospital with CHD; 60% were men and 40% were women. Just under a third were over the age of 74.

### Figure 4.3(1): Mortality from coronary heart disease (ICD10 I20-I25) for all ages: indirectly standardised ratios (SMR and 95% confidence intervals), 1999-2001 pooled data

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</tbody>
</table>

Source: Department of Health. Compendium of Clinical and Health Indicators 2003

The SMR for CHD in Islington is 115. Historically, mortality from cardiovascular disease in London has been lower than average; although mortality rates tend to be high in Inner London, particularly amongst younger people. This is reflected in Islington’s significantly higher rate by comparison with London.

At all ages, Islington men have a higher SMR than Islington women. SMRs for deaths under 75 are presented in figure 4.3(2):

### Figure 4.3(2): Mortality from coronary heart disease aged under 75 years (ICD10 I20-I25): indirectly standardised ratios (SMR and 95% confidence intervals), 2001-2002 pooled data

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</table>

Source: Department of Health. Compendium of Clinical and Health Indicators 2003
Islington compares even less favourably when looking at deaths under 75 (a measure of premature death), with an SMR of 140. This is significantly higher than either Camden, or London as a whole.

SMRs for Islington are presented in the map below. There is wide variation amongst wards. Most wards have rates higher than expected but Mildmay, Canonbury and St Mary’s wards have lower rates than expected.

Figure 4.3(3): Standardised mortality ratios for coronary heart disease, for all persons, all ages by ward in Islington, 1998-2002 pooled data

The prevalence of CHD, and the mortality it causes, rises steeply with age. Men die from CHD at a younger age than women. Relative to England and Wales, Islington experiences higher death rates in all age groups for both men and women.

Figure 4.3(4): Mortality from coronary heart disease (ICD10 I20-I25): age specific death rates per 100,000 for men in Islington and England and Wales, 1999-2001 pooled data

Figure 4.3(5): Mortality from coronary heart disease (ICD10 I20-I25): age specific death rates per 100,000 for women in Islington and England and Wales, 1999-2001 pooled data
Figure 4.3(6): Trends in mortality from coronary heart disease (ICD10 I20-I25): directly age standardised mortality rates per 100,000, from 1993 to 2001

Nationally, there has been a downward trend in CHD mortality. This has also occurred in Islington, as well as other parts of London. However the rate of decline in Islington has been less than that in London and England and Wales as a whole.

4.4 Diabetes

Diabetes mellitus occurs when the body’s regulation of glucose levels is impaired leading to high blood sugar levels. It is a chronic and progressive disease. There are two main types of diabetes: Type 1 and Type 2 diabetes. With Type 1 diabetes, the pancreas is no longer able to produce insulin. With Type 2, the body’s response to insulin is impaired.

Both types of diabetes are becoming more common. Type 1 diabetes develops most frequently in children, young people and young adults. About 15% of people with diabetes in England have Type 1. Type 2 diabetes is most commonly diagnosed in adults over the age of 40, although it is increasingly appearing in young people and young adults. About 85% of people with diabetes in England have Type 2, which in many cases could either have been prevented or delayed. Many are overweight or obese.

Life expectancy is reduced, on average, by more than 20 years for people with Type 1 diabetes, and by up to 10 years for people with Type 2 diabetes. As well as damage to the eyes, kidneys and nerves, people with diabetes (particularly Type 2) are at a significantly increased risk of coronary heart disease, stroke, and blockage of the large blood vessels supplying the lower limbs.

Type 2 diabetes is up to six times more common in people of South Asian descent and up to three times more common in those of African and African-Caribbean descent, compared with the white population. The prevalence of diabetes rises steeply with age; one in twenty people over the age of 65 in the UK has diabetes, and this rises to one in five in people over the age of 85.

Type 2 diabetes is more prevalent among less affluent populations. Those in the most deprived fifth of the population are one-and-a-half times more likely than average to have diabetes at any age. Both mortality and morbidity increase with deprivation. Morbidity resulting from diabetes complications is three-and-a-half times higher in social class V than social class I. The frequency of diabetes in England is higher in men than women. However, women with diabetes are at relatively greater risk of dying than men.
Diabetes in Islington

Using the Brent Diabetes Prevalence model and 2001 Census age and ethnicity structure, we estimate that 5,817 people in Islington have diabetes (3.3% prevalence), of which 647 would have Type 1 and 5,170 Type 2 diabetes. Of the Type 2 diabetics, 1723 (33%) will be undiagnosed.

Figure 4.4(1): Mortality from diabetes (ICD10 E10-E14) for all ages: indirectly standardised ratios (SMR and 95% confidence intervals), 2001-2002 pooled data

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Source: Department of Health. Compendium of Clinical and Health Indicators 2003

There are approximately 25 deaths a year in Islington due to diabetes, with roughly equal numbers for men and women. This equates to between 1 and 1.5% of all deaths in Islington, although the range from year to year is wide.

The SMR for diabetes in Islington is 181, meaning Islington has 81% greater mortality compared to England and Wales. Islington also compares badly with London (SMR=106) and Camden (SMR=74).

Figure 4.4(2): Mortality from diabetes (ICD10 E10-E14) for all ages: age specific death rates (per 100,000) for men in Islington and England and Wales, 1999-2001 pooled data

Source: Department of Health. Compendium of Clinical and Health Indicators 2002

The prevalence of diabetes, and the mortality it causes, rises steeply with age. Men die from diabetes at a younger age than women. After the age of 65, more deaths occur in women. Compared to England and Wales the death rate in men due to diabetes is higher between 35-74. For women, it is substantially more over the age of 65.

4.5 Mental Health

Mental health problems include a wide spectrum of conditions ranging from anxiety and stress, to severe and enduring psychosis and organic disorders such as Alzheimer’s disease.

One adult in six suffers from one or other form of mental illness. Anxiety and depression are most frequent; but one person in 250 will suffer a psychotic illness such as schizophrenia or bipolar affective disorder (manic depression). Half of all women and a quarter of all men will be affected by depression at some period during their lives. Compared with the general population, there are higher rates of mental health problems amongst poorer households, certain ethnic groups, and the prison population. Groups that are particularly vulnerable to mental health problems, include people who are unemployed; homeless; victims of domestic violence; or those who have a physical illness; or drug and alcohol problems.
Mental Health in Islington
Over the years 2001–2003, there was a yearly average of 277 Islington residents admitted to hospital for mental health problems; 46% were men.

The graph shows that although admissions rise steeply with age, there is a first peak in male psychiatric admissions at age 20-24, and for females at aged 35-50.

Figure 4.5(1): Admissions for first episode psychiatric diagnoses (ICD10 F00-F99): age specific inpatient admission rates for Islington residents, using 2002 mid year population estimates, 2001-2003 pooled data

Source: Islington PCT. Health care purchase system admissions data

Admission rates for all psychiatric diagnoses are shown below for Islington wards.

Figure 4.5(2): Directly age standardised hospital admissions per 100,000 European population by ward in Islington, 2001-2003 pooled data

Source: Islington PCT. Health care purchase system admissions data

The most hospital admissions occur among residents from Junction, St George’s, Holloway, and Mildmay wards. The least admissions are for residents living in Hillrise, Barnsbury, Clerkenwell, St Mary’s, and St Peter’s.

In the financial year 2001/02, there were 273 first hospital episodes for schizophrenia amongst Islington residents.

Figure 4.5(3): Hospital episodes for schizophrenia (ICD10 F20, F21, F23.2, F25) ages 15-74: directly standardised rates per 100,000 population, 2001/02 financial year

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Source: Department of Health. Compendium of Clinical and Health Indicators 2002

Compared to Camden, London, and England, Islington has a higher standardised first episode rate for schizophrenia. Men in Islington are also more likely to be admitted to hospital for schizophrenia than women.

In the financial year 2001/02, there were 54 first hospital episodes for neuroses amongst Islington residents.
The standardised episode rate for neuroses in Islington does not differ greatly from Camden and England. The fact that the rate for London as a whole is so low may reflect worse access to care in other parts of London rather than better mental health. Women in Islington are more likely to be admitted to hospital for neuroses than men.

Twenty-five to thirty people die each year in Islington from suicide or undetermined injury. This represents 2% of all Islington deaths.

Since suicide and undetermined injury only cause a small number of deaths, we would expect the variation in death rates from year to year to be quite large. The general downward trend in London and England and Wales however, has not occurred in Islington.
4.6 Accidents

Every year 10,000 people die in England from accidental injury. The burden of injury is greatest from falls in older people, followed by road traffic accidents and residential fires. It is the leading cause of death among children aged 0-14. In addition, there are many millions of non-fatal accidents each year. Around 2.8 million of them occur in the home. Over 300,000 people are hurt in road traffic accidents, 5% of whom are children.

Some groups experience a higher risk for accidents. Boys aged 0-14 are twice as likely to die from injuries than girls, and men are at a 20% higher relative risk of injury at work compared to women, even after job characteristics are accounted for. Fifty percent of accidental injury deaths occur in people aged over 65, with age specific death and admission rates increasing exponentially beyond this age. Disadvantaged groups experience a disproportionate risk of accidental death and injury; for instance child pedestrian deaths are five times greater in social class V compared to social class I.

Accidents in Islington

In 2001/02, 666 Islington residents, comprising roughly equal numbers of men and women were admitted to hospital with serious accidental injury.

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Source: Department of Health. Compendium of Clinical and Health Indicators, 2003

The standardised admission rate for Islington is higher than both London and England. Men in Islington are more likely to be admitted to hospital because of serious accidental injury than women.

Figure 4.6(1) shows hospital admission rates for serious accidental injury, by ward in Islington in 2003.

Figure 4.6(2) shows admissions for serious accidental injury by ward. Hospital admission rates for serious injuries are highest in Hillrise, Holloway, Park and Caledonian, and Clerkenwell. They are least in Finsbury Park and Highbury East.

Figure 4.6(3) shows standardised admission rates for Islington and England over the last few years. There has been no progress in achieving a reduction in incidence of serious accidental injury.
Approximately 25-30 men and 13-17 women die each year in Islington because of accidents. This equates to 3% of all deaths.

The SMR for accidents in Islington is 127. Both men and women in Islington have a significantly higher death rate compared to London or nationally, although they experience fewer accidents than Camden.

The death rate from accidents rises steeply with age. At all ages men in Islington are at a greater risk of death from accidents than women. The small excess of accidental deaths in 1-4 year olds nationally is not seen in Islington.

Since accidents only cause a small number of deaths, we would expect the variation in death rates from year to year to be quite large. However, almost every year, Islington exceeds the death rate seen in North Central London, London as whole and England and Wales.

Around 4-5 men and 2-3 women die on Islington’s roads each year, equivalent to 1% of all deaths.

Figures 4.6(5) and 4.6(6) show age specific mortality rates per 100,000 for males and females. Islington compares very well against national rates for deaths due to accidents amongst children and younger adults, but has more deaths for adults over 35.
Figure 4.6(8): Mortality from land transport accidents (ICD10 V01-V89) all ages: indirectly standardised ratios, (SMR and 95% confidence intervals), 1999-2001 pooled data

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Source: Department of Health. Compendium of Clinical and Health Indicators 2002

The SMR from land transport accidents is 48. This means that there are 52 fewer deaths in Islington compared to what we would expect if rates were the same as the rest of England. This likely to be a reflection of greater safety on Islington’s roads.

4.7 Cancer

Cancer arises when cells grow out of control and invade, erode and destroy normal tissue. There are over 200 different types of cancer that can occur anywhere in the body. There are many causes, though often a combination of genetic, environmental and lifestyle factors are at play.

Nationally one in three people will develop cancer during their lifetime and one in four will die from it. Between 1971 and 2001, the age-standardised incidence of cancer in England and Wales increased by around 20% in males and 39% in females, whereas mortality changed very little. The incidence of different cancers varies considerably by age and gender, but risk rises significantly with age. About 65% of all cancers in this country occur in people over 65 years. Similarly survival rates differ markedly by cancer type, age, sex, and a range of other factors such as social class. The most important cancer sites are lung, breast, colorectal and prostate: these cause more than 50% of all cancers. Cervical cancer is of special interest because of the national screening programme.

Cancer in Islington

In the ten-year period from 1992-2001, there were 6,718 cancer registrations in Islington, or an average of 672 cancer registrations each year. The most frequently occurring cancer sites during this period are shown in the pie chart below.

Figure 4.7(1): Most frequently occurring cancer sites, annualised average 1992-2001

Source: Cancer in Islington PCT 1992-2001; Thames Cancer Registry

In 2002 there were 387 cancer deaths in Islington; 208 men and 179 women, accounting for 28% of all deaths. Forty-two percent of cancer deaths in males and 38% of deaths in females occurred in residents above the age of 75. Age standardised rates for cancer deaths occurring under the age of 75 are high for Islington compared with other boroughs in the sector, London and England.

Source: Cancer in Islington PCT 1992-2001; Thames Cancer Registry
Figure 4.7(2): Mortality from cancer for under 75 years: age standardised death rates for men and women in Islington, other boroughs in the north central London sector, London and England, 2000-2002 pooled data

<table>
<thead>
<tr>
<th></th>
<th>Men Number</th>
<th>Rate per 10^5</th>
<th>Lower</th>
<th>Upper</th>
<th>Women Number</th>
<th>Rate per 10^5</th>
<th>Lower</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>513</td>
<td>126</td>
<td>115</td>
<td>137</td>
<td>452</td>
<td>98</td>
<td>90</td>
<td>107</td>
</tr>
<tr>
<td>Camden</td>
<td>321</td>
<td>148</td>
<td>133</td>
<td>164</td>
<td>246</td>
<td>104</td>
<td>92</td>
<td>117</td>
</tr>
<tr>
<td>Enfield</td>
<td>416</td>
<td>113</td>
<td>103</td>
<td>124</td>
<td>460</td>
<td>115</td>
<td>115</td>
<td>105</td>
</tr>
<tr>
<td>Haringey</td>
<td>328</td>
<td>142</td>
<td>127</td>
<td>156</td>
<td>286</td>
<td>111</td>
<td>99</td>
<td>124</td>
</tr>
<tr>
<td>Islington</td>
<td>330</td>
<td>175</td>
<td>156</td>
<td>193</td>
<td>307</td>
<td>148</td>
<td>132</td>
<td>164</td>
</tr>
<tr>
<td>London</td>
<td>12323</td>
<td>141</td>
<td>139</td>
<td>144</td>
<td>10679</td>
<td>112</td>
<td>110</td>
<td>114</td>
</tr>
<tr>
<td>England</td>
<td>105279</td>
<td>141</td>
<td>141</td>
<td>142</td>
<td>88965</td>
<td>112</td>
<td>112</td>
<td>113</td>
</tr>
</tbody>
</table>

Source: Department of Health Compendium of Clinical and Health Indicators 2003

The SMR for premature cancer death in Islington is 123 (115-130) or 23% higher than England as a whole. The standardised mortality ratios for each borough ward are illustrated below. A large proportion (26%) of these deaths are caused by lung cancer.

Figure 4.7(3): Standardised mortality ratios for all cancers, all persons of all ages, by ward in Islington using England and Wales as standard, 1998-2002 pooled data

Figure 4.7(4): Two year cancer deaths in Islington by age and site, 2001-2002 pooled data

There is a small decline in age-adjusted rates of overall cancer mortality for both males and females of all ages. Rates are notably higher for Islington males.

The distribution of deaths by main cancer site and age is illustrated in figure 4.7(3).
Breast cancer

In the two-year period 2001-2002, there were 52 breast cancer deaths in Islington. Rates of breast cancer deaths were no higher or lower than other boroughs in the sector, London or England.

Prostate cancer

In the two-year period 2001-2002, there were 40 deaths attributed to prostate cancer. Rates of prostate cancer death are no higher or lower than other boroughs in the sector, London or England.

Cervical cancer

In 2001-2002 there were six deaths in Islington due to cervical cancer. Because numbers of deaths were small, it is difficult to draw a meaningful comparison between other boroughs and London and England figures.
Colorectal cancer
In the two-year period 2001-2002, there were 44 deaths in males and 31 deaths in females caused by cancer of the colon or rectum.

Figure 4.7(9): Standardised mortality ratios for colorectal cancer for all persons of all ages, in Islington, other boroughs in the north central sector, London and England, 2001-2002 pooled data

<table>
<thead>
<tr>
<th>Area</th>
<th>Men Number</th>
<th>SMR</th>
<th>Lower</th>
<th>Upper</th>
<th>Women Number</th>
<th>SMR</th>
<th>Lower</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>70</td>
<td>85</td>
<td>66</td>
<td>107</td>
<td>77</td>
<td>98</td>
<td>77</td>
<td>122</td>
</tr>
<tr>
<td>Camden</td>
<td>52</td>
<td>127</td>
<td>95</td>
<td>166</td>
<td>37</td>
<td>106</td>
<td>75</td>
<td>146</td>
</tr>
<tr>
<td>Enfield</td>
<td>64</td>
<td>93</td>
<td>71</td>
<td>118</td>
<td>65</td>
<td>101</td>
<td>78</td>
<td>129</td>
</tr>
<tr>
<td>Haringey</td>
<td>30</td>
<td>77</td>
<td>52</td>
<td>110</td>
<td>40</td>
<td>114</td>
<td>81</td>
<td>155</td>
</tr>
<tr>
<td>Islington</td>
<td>44</td>
<td>131</td>
<td>95</td>
<td>176</td>
<td>81</td>
<td>109</td>
<td>74</td>
<td>155</td>
</tr>
<tr>
<td>London</td>
<td>1576</td>
<td>95</td>
<td>91</td>
<td>100</td>
<td>1414</td>
<td>95</td>
<td>90</td>
<td>100</td>
</tr>
<tr>
<td>England</td>
<td>14294</td>
<td>100</td>
<td>98</td>
<td>101</td>
<td>12788</td>
<td>100</td>
<td>98</td>
<td>101</td>
</tr>
</tbody>
</table>

Source: Department of Health. Compendium of Clinical and Health Indicators 2003

Lung cancer
Just over a quarter of all cancer deaths in Islington are caused by lung cancer. In the two-year period 2001-02, there were 131 deaths in males and 71 deaths in females caused by lung cancer. Lung cancer mortality in males was approximately 70% higher than the England ratio.

Figure 4.7(10): Standardised mortality ratios for lung cancer in all persons of all ages, in Islington, other boroughs in the north central sector, London and England, 2001-2002 pooled data

<table>
<thead>
<tr>
<th>Area</th>
<th>Men Number</th>
<th>SMR</th>
<th>Lower</th>
<th>Upper</th>
<th>Women Number</th>
<th>SMR</th>
<th>Lower</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>164</td>
<td>88</td>
<td>75</td>
<td>103</td>
<td>92</td>
<td>74</td>
<td>60</td>
<td>91</td>
</tr>
<tr>
<td>Camden</td>
<td>97</td>
<td>104</td>
<td>85</td>
<td>127</td>
<td>65</td>
<td>111</td>
<td>86</td>
<td>142</td>
</tr>
<tr>
<td>Enfield</td>
<td>131</td>
<td>83</td>
<td>69</td>
<td>99</td>
<td>93</td>
<td>90</td>
<td>92</td>
<td>110</td>
</tr>
<tr>
<td>Haringey</td>
<td>94</td>
<td>105</td>
<td>85</td>
<td>128</td>
<td>55</td>
<td>93</td>
<td>70</td>
<td>122</td>
</tr>
<tr>
<td>Islington</td>
<td>131</td>
<td>170</td>
<td>142</td>
<td>202</td>
<td>71</td>
<td>145</td>
<td>70</td>
<td>122</td>
</tr>
<tr>
<td>London</td>
<td>3939</td>
<td>105</td>
<td>101</td>
<td>108</td>
<td>2462</td>
<td>101</td>
<td>97</td>
<td>105</td>
</tr>
<tr>
<td>England</td>
<td>32590</td>
<td>100</td>
<td>99</td>
<td>101</td>
<td>21153</td>
<td>100</td>
<td>99</td>
<td>101</td>
</tr>
</tbody>
</table>

Source: Department of Health. Compendium of Clinical and Health Indicators 2003
Cancer screening programmes
There are two national cancer-screening programmes: the breast screening programme, and the cervical screening programme.

The participation of women in Islington is lower than in England and Wales as a whole, especially for breast screening, although it is comparable with other inner London boroughs.

4.8 Communicable diseases
Communicable diseases generally refer to diseases that can be transmitted from person to person caused by viruses, bacteria and other microorganisms. Many communicable diseases have ceased to be a concern in the 21st century in the UK, but others have persisted or increased in frequency.

Tuberculosis
Tuberculosis is an infectious disease, classically characterised by fever, cough and weight loss. It is caused by a mycobacterium, and spread from person to person by coughing. Initial infection is usually followed by symptomless latent infection; the mycobacterium remains alive but is kept in check by an effective immune response. Worldwide almost one third of adults are estimated to be latently infected.

The risk of progression from symptomless latent infection to active disease is increased in persons with immune deficiency such as HIV, alcohol use, undernutrition and increasing age. A higher prevalence of latent infection, a higher risk of progression to active disease, and clustering of recent transmission, leads to tuberculosis typically affecting vulnerable and difficult-to-treat groups, such as newly arrived migrants, the homeless, prisoners, and people misusing drugs or alcohol or with HIV. The incidence of tuberculosis has been rising in London since the mid 1980s and now accounts for half of tuberculosis notifications in England and Wales. It has been estimated that 20% of tuberculosis in London is caused by recent local transmission.

Tuberculosis in Islington
In 2003 there were 113 tuberculosis notifications in Islington residents a rate of 62 per 100,000. This is typical of inner city London. By contrast, notification rates across England and Wales were much lower (11 per 100,000).

Figure 4.8(1): Notification data for Islington, other boroughs in the north central London sector, London and England and Wales, in 2003

<table>
<thead>
<tr>
<th>Borough</th>
<th>Notifications</th>
<th>Crude rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>88</td>
<td>28</td>
</tr>
<tr>
<td>Camden</td>
<td>120</td>
<td>58</td>
</tr>
<tr>
<td>Enfield</td>
<td>72</td>
<td>26</td>
</tr>
<tr>
<td>Haringey</td>
<td>106</td>
<td>47</td>
</tr>
<tr>
<td>Islington</td>
<td>113</td>
<td>62</td>
</tr>
<tr>
<td>London total</td>
<td>2785</td>
<td>38</td>
</tr>
<tr>
<td>England and Wales total</td>
<td>6611</td>
<td>11</td>
</tr>
</tbody>
</table>

Source: Health Protection Agency London
About 60% of notifications were for non-white residents. Most ethnic populations with TB have come to Islington from areas of the world with a high prevalence, especially sub-Saharan Africa and the Indian Sub-continent. The male/female ratio is about 60:40, and most cases occur in young adults.

Figure 4.8(2): Notifications of tuberculosis for Islington and other boroughs in the north central London sector between 1982 and 2003

Figure 4.8(2) shows that the number of TB notifications in Islington and other boroughs in the sector has steadily risen over the last two decades. Since 1982, there has been a 23% increase in the number of notifications across London as a whole. Islington has experienced a 55% and Camden a 45% increase in the same time period.

Treatment with a combination of antibiotics takes a minimum of six months. Ensuring compliance with treatment is important to avoid resistance and spread of the disease. Treatment completion for Islington residents is broadly comparable to outcomes for London as a whole.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Islington N (%)</th>
<th>London N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed treatment</td>
<td>79 (77%)</td>
<td>1922 (83%)</td>
</tr>
<tr>
<td>Incomplete</td>
<td>14 (14%)</td>
<td>219 (9%)</td>
</tr>
<tr>
<td>Treatment stopped</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Died</td>
<td>5</td>
<td>110</td>
</tr>
<tr>
<td>Still on treatment</td>
<td>8</td>
<td>95</td>
</tr>
<tr>
<td>Lost</td>
<td>7 (7%)</td>
<td>99 (4%)</td>
</tr>
<tr>
<td>Unknown / Other</td>
<td>2 (2%)</td>
<td>58 (3%)</td>
</tr>
<tr>
<td>Total</td>
<td>103</td>
<td>2314</td>
</tr>
</tbody>
</table>

Source: Health Protection Agency; Communicable Disease Surveillance Centre Collindale; Health Protection Agency London; Tuberculosis treatment outcome surveillance.

Immunisation uptake and vaccine preventable diseases in childhood

The current childhood immunisation schedule includes vaccines that protect against diphtheria, tetanus and pertussis (DTP), polio, Haemophilus influenzae type B (Hib), meningitis C and measles, mumps and rubella (MMR). Most of these childhood diseases have declined to low levels or are completely absent. For example, over the last 40 years in the UK Hib vaccine prevented about 7300 cases of Hib disease and 240 deaths in under 4’s. Since introduction of meningitis C vaccination in 1999, cases have dropped by almost 90% from 811 in 1998 to 98 in 2003.

Prior to the introduction of the measles vaccine in 1968, nearly all children in the UK were infected at a young age. Since 1988 measles immunisation has been administered with mumps and rubella immunisation (MMR), at around 1 year of age, and in 1996 a preschool booster was added. Measles infection, with its sometimes serious complications and occasional fatality, has since been rare. Participation in the MMR uptake has been affected by the suggestion of a relationship between MMR immunisation and autism. Although unfounded, it has eroded public confidence and immunisation coverage has fallen to levels that may be able to sustain a measles outbreak. In 2003 there were 171 confirmed measles cases in London including 13 confirmed cases in Camden and Islington.
Vaccination in Islington

Figure 4.8(4): Percentage uptake of immunisation with childhood schedule vaccines by age 2 in Islington, other boroughs in the north central London sector, London and England and Wales, 2002/2003 financial year

<table>
<thead>
<tr>
<th>Dip</th>
<th>Tet</th>
<th>Polio</th>
<th>Per</th>
<th>Hib</th>
<th>MMR</th>
<th>Men C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>91.8</td>
<td>91.8</td>
<td>91.5</td>
<td>91.5</td>
<td>90.6</td>
<td>72.8</td>
</tr>
<tr>
<td>Camden</td>
<td>88.9</td>
<td>88.9</td>
<td>88.7</td>
<td>88.6</td>
<td>88.6</td>
<td>67.6</td>
</tr>
<tr>
<td>Enfield</td>
<td>87</td>
<td>87</td>
<td>88</td>
<td>87</td>
<td>88</td>
<td>77</td>
</tr>
<tr>
<td>Islington</td>
<td>85.4</td>
<td>85.7</td>
<td>85.2</td>
<td>85</td>
<td>84.4</td>
<td>67</td>
</tr>
<tr>
<td>Haringey</td>
<td>88.2</td>
<td>88.2</td>
<td>87.9</td>
<td>88.1</td>
<td>87.5</td>
<td>74.4</td>
</tr>
<tr>
<td>London</td>
<td>88.5</td>
<td>88.6</td>
<td>88.2</td>
<td>88.1</td>
<td>88.2</td>
<td>72</td>
</tr>
<tr>
<td>England</td>
<td>94</td>
<td>94</td>
<td>93</td>
<td>93</td>
<td>93</td>
<td>82</td>
</tr>
</tbody>
</table>

Source: Health Protection Agency; Communicable Disease Surveillance Centre Collindale. COVER programme statistics

Apart from MMR, uptake of the other childhood vaccinations is reasonably high (about 85%), though Islington is lowest in the sector. Islington coverage follows the London trend of a gradual decline from peak levels in the mid 1990s.

Figure 4.8(5): Coverage of MMR vaccine at age 2 years in Islington, other boroughs in the north central London sector, London and England in 2003

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>67.6</td>
<td>71.1</td>
<td>67</td>
</tr>
<tr>
<td>Camden</td>
<td>64.4</td>
<td>60.2</td>
<td>66.7</td>
</tr>
<tr>
<td>Enfield</td>
<td>67.9</td>
<td>66.7</td>
<td>68.1</td>
</tr>
<tr>
<td>Haringey</td>
<td>69.3</td>
<td>69.0</td>
<td>71.2</td>
</tr>
<tr>
<td>Islington</td>
<td>66.3</td>
<td>60.7</td>
<td>70.6</td>
</tr>
<tr>
<td>London</td>
<td>67.5</td>
<td>67.4</td>
<td>69.4</td>
</tr>
<tr>
<td>England</td>
<td>77.9</td>
<td>78.5</td>
<td>80.2</td>
</tr>
</tbody>
</table>

* MMR coverage for each quarter represents the immunisation coverage of children who had their 2nd birthday in that quarter. Coverage in Jan-Mar 2003 is coverage in children born between January and March 2001. The denominator population is approximately one quarter of the birth cohort.

Most recent coverage data (Figure 4.8(5)) suggests a small improvement in MMR uptake in Islington.

4.8 Sexually transmitted infections and HIV

Chlamydia and Gonorrhoea

Chlamydia and gonorrhoea are both common bacterial sexually transmitted infections. Both infections (especially chlamydia) may be symptomless, and in women may be complicated by pelvic inflammatory disease which can cause infertility.

Between 2002-2003, chlamydia infections increased by 9% nationally, whereas gonorrhoea decreased by 3%. Between 1997 and 2002 diagnoses of gonorrhoea rose by 97%, and diagnoses of chlamydia by 103%. Young people and gay men remain the groups most affected.

Chlamydia and Gonorrhoea in Islington

Data for sexually transmitted diseases in England are collected as anonymised aggregate returns from Genito-Urinary Medicine (GUM) clinics. There is no comparable PCT-based data, only clinic data. Clinic data may include substantial inflows of patients from other PCT areas, so data do not necessarily reflect the local burden of illness. Local aggregate data for episodes of common sexually transmitted diseases such as chlamydia and gonorrhoea are available from the two local sexual health services: Archway Sexual Health Service and the Mortimer Market Centre. Aggregate data here has been combined for both clinics and gives a sense of usual age and sex distribution of gonorrhoea and uncomplicated chlamydial infection.
**HIV in Islington**

Accurate local data for new HIV infections are not available; this information must be estimated because a large number of people infected with HIV remain untested and unaware of their infection. Data is available from clinics for the number of people on therapy for HIV and the number of those with new HIV infection.

In the first six months of 2003 there were 760 people resident in Islington seen at an acute clinic for HIV – a prevalence of known HIV of 0.43%. Thirty-five people were seen for the first time with HIV. The prevalence of HIV infection is broadly similar to other PCTs in north central London, higher than London overall and higher than England.

<table>
<thead>
<tr>
<th>Borough</th>
<th>Actual Number</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>341</td>
<td>0.11%</td>
</tr>
<tr>
<td>Camden</td>
<td>976</td>
<td>0.47%</td>
</tr>
<tr>
<td>Enfield</td>
<td>307</td>
<td>0.11%</td>
</tr>
<tr>
<td>Haringey</td>
<td>681</td>
<td>0.30%</td>
</tr>
<tr>
<td>Islington</td>
<td>760</td>
<td>0.43%</td>
</tr>
<tr>
<td>London</td>
<td>17202</td>
<td>0.23%</td>
</tr>
<tr>
<td>England</td>
<td>29044</td>
<td>0.06%</td>
</tr>
</tbody>
</table>

Source: Health Protection Agency. Survey of Prevalent HIV Diagnosed (SOPHID)

Eighty-six percent of cases were male, 68% were White and 70% were probably infected through sex with another man. These proportions are higher for Islington and Camden than other PCTs in north central London and England and Wales as a whole, and probably reflect gay male communities in these boroughs. The proportion of Black Africans who are HIV-infected is higher in Islington than both London and England as a whole but not as high as other north central London areas.

**HIV**

HIV is a chronic viral infection transmitted through blood and body fluids. After some years, untreated infection progresses to failure of the immune system and a susceptibility to specific infections.

Following the introduction of retroviral therapy, there have been large increases in the number of people living with HIV. In 2002, there were over 5500 new cases in the UK, almost double the number identified in 1997. Most of the new diagnoses (over 3000) were heterosexually acquired, often (around three quarters of cases) in Africa.
Figure 4.8(9): Numbers and proportions of HIV-infected by ethnicity, for Islington, other boroughs in the north central London sector, London and England in 2002

Source: Health Protection Agency. Survey of Prevalent HIV Diagnosed (SOPHID)

Figure 4.8(10): Numbers and proportions of HIV-infected by probable route of infection in Islington, other boroughs in the north central London sector, London and England in 2002

Source: Health Protection Agency. Survey of Prevalent HIV Diagnosed (SOPHID)

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Health in Islington 2003/2004 – Recommendations

In putting together this report it has become clear that there are a number of key issues that need to be looked at in more detail and that allow us to focus the work we will undertake.

The following list of recommendations highlights those and we hope will be followed up in subsequent reports.

Smoking

• Develop prevention strategies
• Target stop smoking services
• Work towards smoke-free work places

If there is one thing that would have an early impact on the health of Islington’s population, it is a reduction in the number of people who smoke. Reducing the number of people smoking will reduce the number of people suffering from circulatory diseases, cancer, asthma and respiratory disease and the numbers of babies born at a low birth weight. The conclusion of Sir Richard Doll’s study of doctors who smoked clearly shows that it is never too late to give up – there is always a health benefit. While we focus on increasing the number of people accessing stop smoking services, we cannot forget the need to work with those at risk of starting in the first place – young people, particularly young girls.

The momentum behind the development of legislation to allow local authorities to support smoke-free workplaces must be something we support in Islington. It is estimated that the reduction in the numbers of people smoking through stopping smoking services is 1%. Evaluations of the workplace bans in New York are suggesting a reduction of approximately 10%.

Diet and exercise

• Develop a care pathway for those who need to improve their diets and increase levels of exercise
• Raise the profile of the Healthy Schools Programme
• Implement a physical activity strategy

We know that eating a healthy diet and taking part in physical activity contributes to a reduction in the risk of a number of conditions- cancer, coronary heart disease, diabetes and osteoporosis for example. The development of the Healthy Schools programme, the implementation of an Islington wide physical activity strategy and looking at the pathways for those that are identified as needing help and support are all important.

Mental health

• Complete a health promotion strategy for mental health
• Undertake an equity audit on the people using mental health services, particularly in primary care

Promotion of mental health and ensuring that it is built into wider strategies is something that needs to be developed in Islington. The high rates of schizophrenia and suicide reported here demonstrate that we need to focus on who is using services and whether there are groups that are not getting the type of support they need at an early enough stage.

Partnership

• Work with the Local Authority to develop their health inequalities strategy
• Support the work of the Islington Health Partnership Board to build mechanisms for improving the health of residents

The health service, on its own, can only make a small impact on health. It is therefore vital that the public health challenges in Islington are tackled across the board, with health inequality a priority for all services.

From 2005, local authorities will be judged on their focus in reducing health inequalities and we need to support their important work.

Significant numbers of health and well-being services are provided through the voluntary sector. Developing effective partnerships across statutory and non-statutory providers will be key.

The Islington Health Partnership Board is an important vehicle through which health strategy can be developed and will be a focus of our work in 2004/2005.
Age specific rate – Number of events, such as deaths, in a specific age group in a specific period of time divided by the number of people in that age group during that period of time (usually estimated by the mid-year population). By convention the usual time period is a year and the rate is multiplied by 100,000 so that the result is per 100,000 per annum.

Body mass index (BMI) – This is one of the common measures used to define overweight and underweight. It is defined as weight (kg) divided by height (metres) squared. In adults overweight is classified as a BMI of over 25, and obesity is defined as a BMI of over 30.

Breast screening coverage rate – the proportion of women aged between 50 and 64 registered with general practitioners and who have had a mammogram with a recorded result at least once in the previous 3 years. It excludes those who are ineligible for clinical reasons such as having had a bilateral mastectomy.

Cervical screening coverage rate – the proportion of eligible women aged 25 to 64 who have had an adequate cervical screening (smear) test within the last 5 years.

Claimant count – a by-product of the benefits system showing a count of those people claiming unemployment related benefits (Job Seeker’s Allowance and National Insurance Credits).

Confidence interval – A range of values around an estimate – such as a rate or percentage – that expresses the uncertainty surrounding that estimate. The 95% confidence interval is the interval, which will include the true population value in 95% of cases. We expect that the 95% confidence interval will not include the true population value 5% of the time.

Correlation co-efficient – A measure of association between two continuous variables (such as weight and height) that indicates the degree to which two variables have a linear relationship. The co-efficient can vary between 1 and −1. A coefficient of 1 shows a perfect positive linear relationship in which one variable increases directly with the other. A coefficient of −1 indicates a perfect negative linear relationship where as one variable increases, the other decreases. A coefficient of 0 shows that there is no linear relationship between the variables.

Crude death rate – An estimate of the proportion of a population that dies during a specified period. It is the number of deaths during the specified period divided by the number of persons at risk of dying during the period (usually the mid-year population) expressed per 100,000 persons per annum in most cases.

Directly age standardised mortality rates – a rate that is adjusted for the underlying age distribution. A weighted average of the age-specific death rates in a study population is taken using as weights the age distribution of a standard (reference) population. The rate represents what the crude rate would have been if that population had the same age structure as the standard population. Age standardised rates calculated by the same method are directly comparable.

Disability – temporary or long-term reduction of a person’s capacity to function in society. The World Health Organisation’s definition of disability is a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or a perception of such impairment.

Disability living allowance – benefit paid to someone who needs help looking after her or himself.

General fertility rate – the number of live births per 1000 women of childbearing age, usually ages 15-44, per year.

General health status – a self reported health indicator showing the number of persons reporting themselves to have ‘good’, ‘fairly good’ or ‘not good’ health on the census day, expressed as a percentage of the population of a ward, borough or any administrative or geographic boundary.

Health Survey for England – an annual nationally representative sample survey of health and associated factors in England. The survey contains a series of core questions and measurements, which are repeated every year, and modules, which change periodically and address a particular health problem or a specific group in the population.
Health Survey for England local boost survey –
Camden & Islington Health Authority commissioned a local ‘boost’ to the 1999 survey (the Camden and Islington Health Survey 1999-2000). A sample survey of nearly 2000 people was undertaken on health and life styles of the Camden and Islington population to generate data, which would not have otherwise been available from routine data sources.

Health deprivation and disability – One of the seven domains of IMD 2004 identifying areas with relatively high rates of people who die prematurely or whose quality of life is impaired by poor health or who are disabled, across the whole population.

Index of multiple deprivation (IMD 2004) –
The Office of the Deputy Prime Minister new index of multiple deprivation 2004 uses seven domains (each based on a range of indicators) to measure deprivation at a small area level. The domains used to construct IMD 2004 are: income deprivation; employment deprivation; health deprivation and disability; education skills and training deprivation; barriers to housing and services; living environment deprivation; and crime. Each domain has a relative weight and is measured using a number of indicators.

Infant mortality rate – is the number of deaths in infants less than 1 year of age per 1000 live births. It is often used as a summary measure of health in a defined population. It reflects the well-being and fitness of the mother, and of society generally.

Infectious disease (communicable disease) –
an illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal, or reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector, or the inanimate environment.

Impairment – a physical or mental defect at the level of a body system or organ.

Key stage 2 – National Curriculum content applicable to children aged 7-11. At 11 years of age, pupils are tested in English, mathematics, and science and the results are used as an independent measure of how pupils and schools are doing compared with national standards in these subjects.

Neonatal mortality rate – the number of deaths in infants under 28 days of age per 1000 live births in a given period.

Life expectancy – The average number of years an individual is expected to live if current mortality rates continue to apply.

List inflation – recognised as occurring when the number of residents recorded on GPs registers is greater than the population derived from census data. List inflation is mainly due to duplicate registrations, and the time lag in removing those patients who have died or have moved out of the borough.

Lone parent family – A lone mother or father with her/his child(ren). It also includes a lone grandparent with his or her grandchild(ren) but with no children in the intervening generation in the household.

Long term limiting illness rate – is a census based measure, it shows the number of persons reporting themselves to have long term limiting illness, health problem or disability which limited their daily activities or the work they could do expressed as a percentage of the population of a ward, LA, or any ONS identifiable boundary.

Low birth weight – Birth weights of under 2500 grams recorded at the time of birth and, in some countries, entered on the birth certificate.

Low birth weight rate – a rate showing the number of children with low birth weight expressed as a percentage of total births in the same area in the same year. It is considered a predictor of infant survival.

Morbidity – Any departure, subjective or objective, from a state of physiological or psychological well-being. Sickness, illness, and morbid conditions are synonymous with morbidity.

PCT registered population – The number of people who are on the registers of GPs within the boundaries of a primary care trust at a particular point in time. Individuals may or may not be resident within the geographic boundaries of the PCT. However, the proportion of residents is usually very high.

Percentiles – A set of divisions that produce exactly 100 equal parts in a series of continuous values, such as children’s heights or weights. A child above the 90th percentile has a greater value for height or weight than over 90% of all children in the series.

Perinatal mortality rate – measures the death rate during the perinatal period, which starts at the beginning of foetal viability (28 weeks gestation) and ends 7 days after birth. The rate is measured as the sum of stillbirths and deaths under seven days of birth per 1000 total births (alive and still) in an area in the same year.

Prevalence – the number of instances of a given disease or other condition in a given population at a designated time.
Quintiles – Ranked or ordered values dividing a given (sample) data set into five equal parts. Health or local authority level statistics can conceal important geographic variations in mortality and morbidity; equally, ward level health rates and ratios can be difficult to interpret reliably due to the small numbers involved. Ward quintiles provide an alternative means of measuring health inequalities which is more statistically robust, but which can still reveal important local differences.

Quit rate (4 week) – The number of people not having smoked within four weeks of their quit date, in a quarter or a year; expressed as a percentage of all those people who set themselves a quit date during the same period.

Rankings – Rankings can be used to show the relative position of Islington PCT and other local PCTs in a national, regional or sectoral context.

Sector – For the purposes of this report the sector covered by the North Central London Strategic Health Authority. London is divided into five strategic health authorities, which manage and co-ordinate the performance of the PCTs and NHS trusts in their areas. The PCTs, which fall within north central London sector are Barnet and Enfield (outer London), and Camden, Haringey and Islington (Inner London).

Socio-economic classification – Generally arrangement of persons into groups according to characteristics such as occupation, education, and income. The current classification is occupationally based and comprises of eight categories ranging from higher managerial and professional occupation to those who never worked and the long-term unemployed. The classification replaces the social class based on occupation and socio-economic groups as of April 2001.

Standardisation – a set of techniques used to remove as far as possible the effects of differences in age, sex, ethnicity or other confounding variables, when comparing two or more populations.

Standardised mortality ratio – The ratio of the number of events (deaths) observed in the study group or population to the number that would be expected if the study population had the same specific rates as the standard population, multiplied by 100. An SMR of more than 100 shows that death in study group or population is more than one would expect given the standard population. SMRs can be viewed in percentage terms – for example, a figure of 110 would indicate that there were ten per cent more deaths than expected.

Super output area – an area containing an average population of 1000 to 1500 persons. There are 118 lower level super output areas in Islington, and each ward contains around 7 super output areas.

Synthetic estimates – Synthetic estimation is the application of model based techniques to combine data obtained from national surveys with a set of associated covariate (predictor) variables available for small areas. The synthetic estimate generated for a small area is the expected outcome for that area based on its characteristics as measured by the variables.

Teenage pregnancy rate – the total number of measured conceptions (abortions, still births and live births) to teenage women per 1000 women of defined teenage years in an area in the same year.

Unemployment rate – the number of unemployed people in an area at a given point in time expressed as a percentage of economically active residents in that area, excluding full time students. The GLA rate is the claimant count in a borough or ward as a percentage of economically active residents in that area, excluding economically active full-time students. ONS (official) rate expresses the local area claimant count figures as a proportion or percentage of the resident working age population (females 16-59, males 16-64).

Ward – A non-overlapping administrative and geographic entity within the local authority boundaries. Islington currently has 16 wards.
Health in Islington 2003/2004 – Acronyms

ASAR – Age standardised admissions rate
B&B – Bed and breakfast accommodation
BME – Black and minority ethnic groups
BMI – Body mass index
CHD – Coronary Heart Disease
CIHSS – Camden and Islington Healthy Schools Scheme
CRDHB – Centre for Research on Drugs and Health
DFES – Department for Education and Skills
DH – Department of Health
ENT – Ear, nose and throat
FCE – Finished consultant episodes
GCSE – General certificate of secondary education
GLA – Greater London Authority
GLA DMAG – Greater London Authority Data Management and Analysis Group
GUM – Genito-urinary medicine
HSE – Health Survey for England
HPS – Health care purchase system
ICD-10 – International statistical classification of diseases and related health problems tenth revision
IMD 2004 – Index of Multiple Deprivation 2004
JSA – Job seekers allowance
LA – Local Authority
LBW – Low birth weight
LEA – Local Education Authority
LHO – London Health Observatory
MMR – Measles, mumps and rubella
NCHOD – National Centre for Health Outcomes Development
ODPM – Office of Deputy Prime Minister
ONS – Office for National Statistics
PCHP – Primary Care for Homeless People
PCT – Primary Care Trust
SHA – Strategic Health Authority
SMR – Standardised mortality ratio
SOPHID – Survey of prevalent HIV infections diagnosed
UNICEF – United Nations Children's Fund