ISLINGTON

NHS Islington

ISLINGTON **JOINT STRATEGIC NEEDS ASSESSMENT 2009/10**

Summary version

ISLINGTON

Contents

Foreword

Welcome to the second Joint Strategic Needs Assessment (JSNA) for Islington. As with the first JSNA, this report acts as a single point of assimilation for a range of information which taken together outlines the main health and wellbeing issues facing the people of Islington. The JSNA is a tool to inform the planning and commissioning of world class services that will improve outcomes for our community and reduce unacceptable inequalities.

The 2009/10 JSNA has followed a similar structure to its predecessor, with a range of chapters covering health, risk factors and the underlying determinants of health that shape and influence people's lives. A shortcoming of the previous JSNA was the paucity of engagement with wider stakeholders, particularly the voluntary and community sector who have an important role to play both in gathering intelligence and providing services.

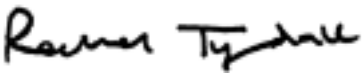
This JSNA is the first attempt to specifically gather information from these sectors to help determine our priorities for health and wellbeing, and we intend to further improve how this process works over forthcoming years.

The 2009/10 JSNA has taken two different formats; a full length web based version on NHS Islington's website and a summary version for publication.

This report represents the summary version and the full length version can be accessed at **http://www.islington.nhs.uk/jsna.htm**

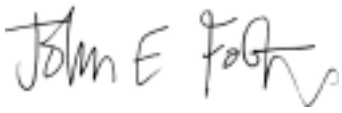
The report is the result of months of close working between Islington Borough Council and NHS Islington. Our thanks to all those who have been involved in producing the JSNA, in particular Dr Renu Bindra, Rachel Maan and all the authors and editors of the sections.

signed



Rachel Tyndall
Chief Executive,
NHS Islington

signed



John Foster
Chief Executive,
Islington Borough Council

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(in addition to those mentioned in the foreword)

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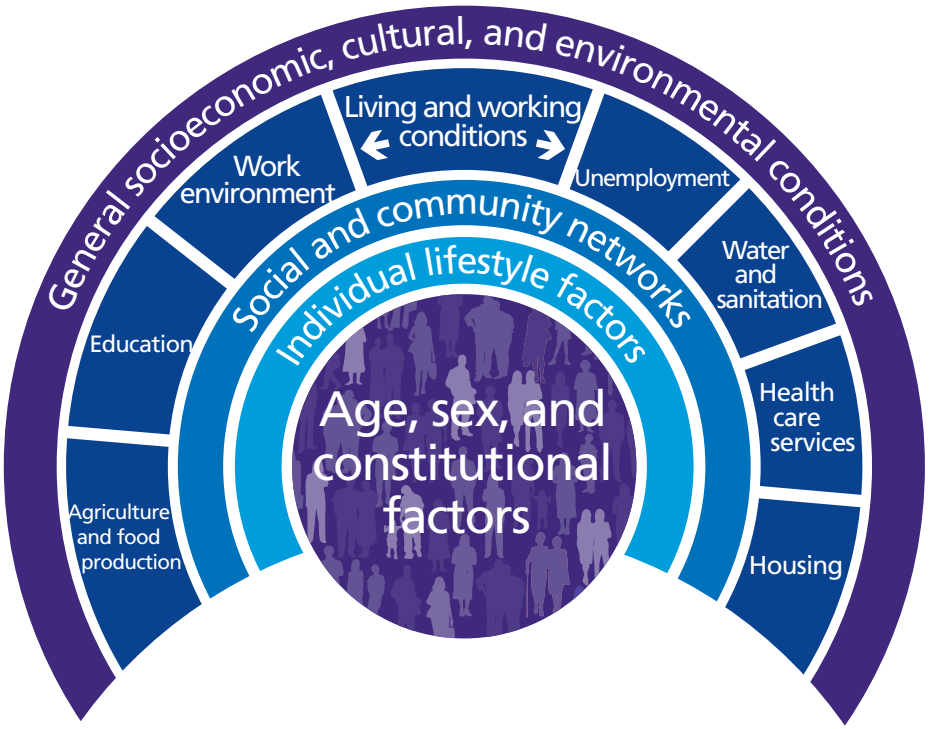
Introduction

The Joint Strategic Needs Assessment (JSNA) process describes the main health and wellbeing issues in Islington and brings together the wide range of factors that directly influence health and wellbeing, such as employment, housing, education and the environment. This is in recognition of the fact that health inequalities cannot be addressed by looking at health and health services alone. The many determinants of health and wellbeing are outlined in **Figure A**.

Figure A. Determinants of health and wellbeing

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



The purpose of the JSNA is to inform the commissioning of health and wellbeing services across the NHS and Islington Council. Therefore the JSNA is primarily a professional document and contains some technical language. The PCT's Commissioning Strategy Plan (CSP), a five-year plan which sets out the strategic priorities for commissioned services, will be directly informed by the priorities identified within the JSNA. Overarching this, the JSNA will also form an important part of the World Class Commissioning (WCC) programme.

This report represents a summary of the 2009/10 JSNA. The full version can be found on NHS Islington's website at **http://www.islington.nhs.uk/jsna.htm**

ENGAGEMENT WITH THE COMMUNITY AND VOLUNTARY SECTOR

In putting together the 2009/10 JSNA, we wanted to include the views of local people. We believe the views and opinions of local people and the experiences of local organisations are vital to the success and credibility of the JSNA. Three main sources of information from the voluntary and community sectors (VCS) were used and the findings from this work should be read in conjunction with the main JSNA chapter findings which bring quantitative and qualitative information together. A copy of the full report containing the findings can be found on the NHS Islington website.

The three strands of work were:

1. A specially commissioned citizens panel questionnaire on health and wellbeing

   We distributed a questionnaire to approximately 1200 residents focusing on their perceptions of health and healthy lifestyles, healthy behaviours, barriers to achieving a healthy lifestyle and actions for NHS Islington and Islington Council to facilitate healthy lifestyles and health improvement within the local population.

2. A 'call for information' from the third sector

   We recognise that many VCS organisations have particular expertise and information as a result of their work with certain communities. We held a formal call for information, where we invited VCS organisations to send in any information that they felt might be relevant to the JSNA.

3. An assimilation of existing sources of engagement activity across NHS Islington and Islington Council

   We felt it could be potentially very useful to consider information that had already been gathered for other purposes, both in terms of the value that it could add to the JSNA, but also as a means of demonstrating our commitment to using and reacting to information that has been gathered from local people.

In addition to the information collated from NHS Islington, Islington Council and the citizen panel questionnaire, we received submissions from sixteen VCS organisations and we would like to thank all those who took the time to send us information. These included:

Disability Action in Islington

Cripplegate Foundation

Mildmay Community Partnership

South Barnsbury Neighbourhood Management (Newlon Fusion)

Bermerton Villages Management Organisation

Packington Neighbourhood Management Group (The Hyde Group)

Islington Bangladesh Association

IMCE Turkish Speaking Women's Group

Age Concern Islington

Victim Support

Voluntary Action Islington

Islington LINk

Improving Reach

Islington Refugee Forum

CARIS Islington

Birth Companions

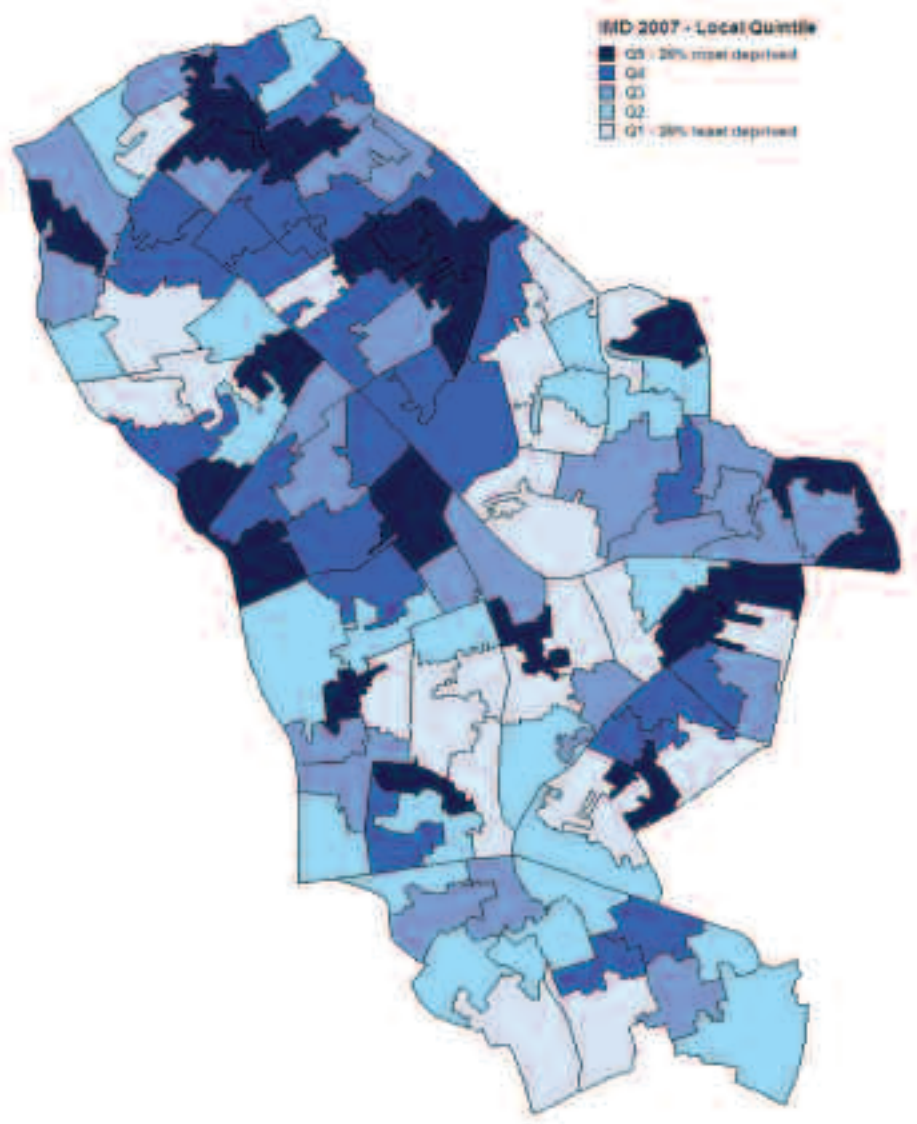
The Islington Population

ISLINGTON AT A GLANCE

Islington is a small, densely populated, inner London borough with a growing, diverse population that is relatively young. Islington is home to a range of ethnic groups including Irish, Somali, Bengali, Turkish, Arabic, Albanian, Portuguese, Spanish, Nigerian and Ghanaian communities.

Figure B. Deprivation in Islington, 2007

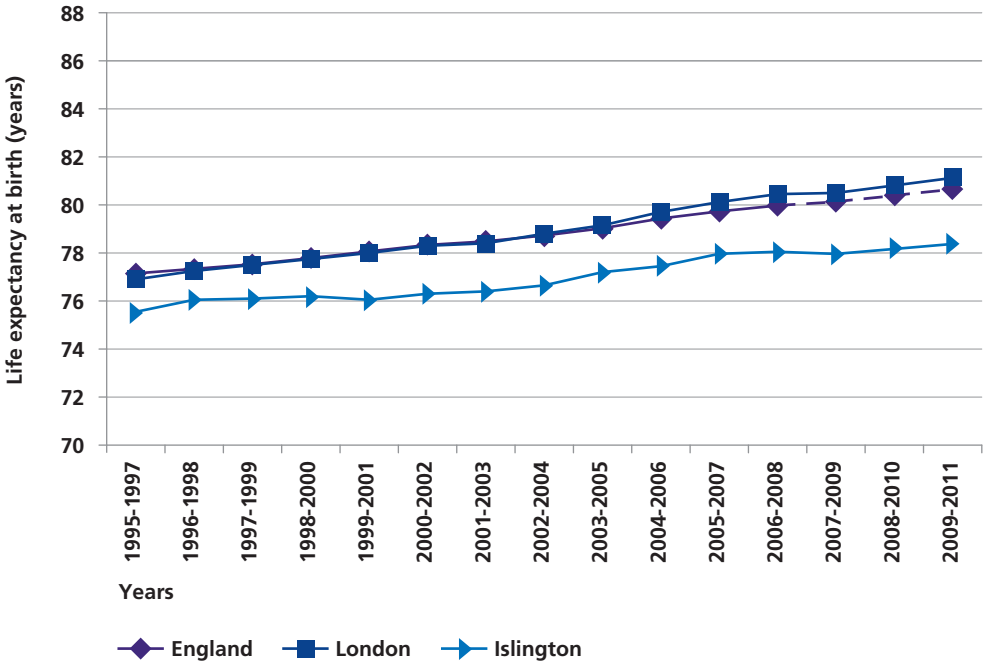
Source: Department of Communities and Local Government, Indices of Deprivation 2007



- The borough covers 14.86 km2.
- There are 13,155 persons per km in 2009.
- There are 195,489 people living in Islington in 2009, set to rise to 213,371 by 2019.
- In 2009, 44% (86,086) of the population is aged 20 to 39.
- The over-65s are projected to rise from 17,055 in 2009, to 20,891 by 2028.
- The over-85s are projected to rise from 2,025 in 2009 to 2,178 by 2028.
- 74% of the population is White.
- 32% of residents were born outside the United Kingdom.
- There were 2,753 live births in 2009.
- There were an average of 1,154 deaths per year between 2005 and 2007.

Figure C. Life expectancy at birth among men and women in Islington, London and England, 1995-97 to 2006-08, with projections to 2010-12

Source: NCHOD



MOSAIC™

Mosiac™ is a geodemographic tool which classifies the UK population into 11 lifestyle groups and 61 types based on different characteristics.

According to Mosaic™ the vast majority of Islington's population fall into three main groups:

- Educated, young single people (56%)
- Those living in social housing (32%)
- Career professionals living in sought after locations (9%)

There is no distinct pattern in the geographical spread of these different types of people in Islington: at a street-level, people with very different characteristics live side-by-side.

SOCIO-ECONOMIC PROFILE

Islington is a borough of stark contrasts with high levels of deprivation coupled with areas of great wealth. In fact, Islington is the eighth most deprived local authority in England and the fourth most deprived in London. The distribution of deprivation in Islington is complex with no clear geographical demarcation between deprived and more affluent areas. **Figure B** shows differences in deprivation between small areas within Islington, compared to the borough as a whole.

HEALTH AND WELLBEING IN ISLINGTON

Life expectancy in Islington is increasing, but remains lower than for England as a whole (**Figure C**). During the period 2006-08, life expectancy at birth in Islington for men was 75.1, compared to 77.9 for England as a whole. The life expectancy gap for women is smaller: during the same period, life expectancy for women was 81.0 years compared to 82.0 years for England as a whole. There are notable inequalities in life expectancy within Islington, depending on level of deprivation.

The main cause of death in Islington is circulatory diseases, followed by cancer however, a higher proportion of premature deaths (deaths in those aged under 75) are caused by cancer than by circulatory diseases.

EQUALITY AND HEALTH AND WELLBEING

There are a number of equality issues related to the health and wellbeing of the Islington population. It is helpful to consider these in terms of six equality strands; age, gender, ethnicity, disability, sexual orientation and religion.

AGE

Islington's JSNA focuses on issues at both ends of the age spectrum from infant mortality to age-related ill health. Although Islington has a young population, an increase is predicted in the elderly population, who are likely to have specific needs such as increased frailty and long-term conditions.
Life expectancy has increased over the last 15 years but morbidity increases with age, presenting challenges in terms of quality of life and access to services. Addressing the health, risk factors and wider determinants for children is the best way to tackle inequality in the long term and to break the inter-generational cycle of poor outcomes.

GENDER

Life expectancy for men in Islington is on average 5.9 years below that of women and is below that of men nationally. However there is evidence of changing trends by gender. For example, the number of women who smoke has also been steadily increasing and the achievement of boys at GCSE was better than that of girls in 2009, for the first time in several years.

ETHNICITY

A range of health outcomes and wellbeing indicators vary according to ethnic origin and migrant status. Some are a result of genetic predisposition; others may be a result of lifestyle factors or difficulties in accessing services due to language and other barriers. Further work is needed to develop culturally relevant social marketing, to commission services which better meet the needs of BME communities and to improve access to services.

DISABILITY

Notable inequalities are often seen amongst disabled people in terms of education, employment (and consequently poverty), access to services and life expectancy. In August 2008, 10,400 Islington residents were receiving disability living allowance, equivalent to 6% of the total population. This compares to 4% for London and 5% for England. In response to poor health outcomes for people with learning disabilities, a new primary care Directed Enhanced Service was introduced in 2009/10 to improve regular GP health checks for people with learning disabilities.

SEXUAL ORIENTATION

Local knowledge and sexual health data suggest that Islington has a relatively large Lesbian, Gay, Bisexual and Transgender (LGBT) population. The 'Revealing LGBT Islington' survey completed in 2007 [1], and studies by Stonewall show a high incidence of homophobic bullying among young people [2], and a higher incidence of suicide and hate crime targeted at LGBT people [3].

RELIGION AND BELIEF

It is likely that behaviour and attitudes towards suicide, serious mental illness and the use of alcohol and drugs varies according to faith. Religious attitudes towards sex, contraception, abortion and sexuality are important in relation to sexual health too.

REFERENCE LIST

(1) Limbrick G. *Revealing Lesbian, Gay, Bisexual, Trans Islington. 2007.*

(2) Schools Health Education Unit for Stonewall. *The School Report. 2007*

(3) Stonewall. *Homophobic Hate Crime: The Gay British Crime Survey.* 2008

PART ONE **HEALTH AND WELLBEING**

1 Cardiovascular disease

INTRODUCTION

Cardiovascular disease (CVD) encompasses diseases of the heart and blood vessels and includes conditions such as coronary heart disease (CHD), stroke, heart failure, peripheral vascular disease and some other less common conditions. CVD is the biggest killer in Islington, accounting for 31% of all deaths in 2008 [1] and 30% of deaths in under 75 year olds. It is one of the main contributors to the inequalities gap in life expectancy between Islington and England as a whole [2].

Lifestyle factors such as smoking, unhealthy diet and lack of physical activity and their consequences such as obesity, high cholesterol, high blood pressure and diabetes, are major risk factors for CVD.

THE ISLINGTON PICTURE

AT RISK OF CVD

Current estimates suggest that 74% of the population aged 35 to 74 who do not have existing CVD have a low risk of experiencing a cardiovascular event in the next 10 years, with 18% estimated at medium risk and 8% at high risk.

PREVALENCE

Modelling suggests that the recorded prevalence of cardiovascular diseases is significantly less than would be expected (**Table 1.1**).

HOSPITAL ADMISSIONS

The rate of elective admissions for CHD in 2007/08 was 125 per 100,000 population, lower than the London and England rates of 233 and 205 per 100,000 respectively. The rate for emergency admissions was 234 per 100,000, comparable to the London rate of 235 but higher than the England rate of 222 per 100,000 [3].

There were 211 emergency admissions for stroke in Islington in 2007/09, a directly standardised rate of 133 per 100,000. This compares to a rate of 103 for London and 98 for England [3].

MORTALITY

Figure 1.1 shows that there are more premature deaths from circulatory diseases among men than women, and that premature death rates have been decreasing since 1993/95.

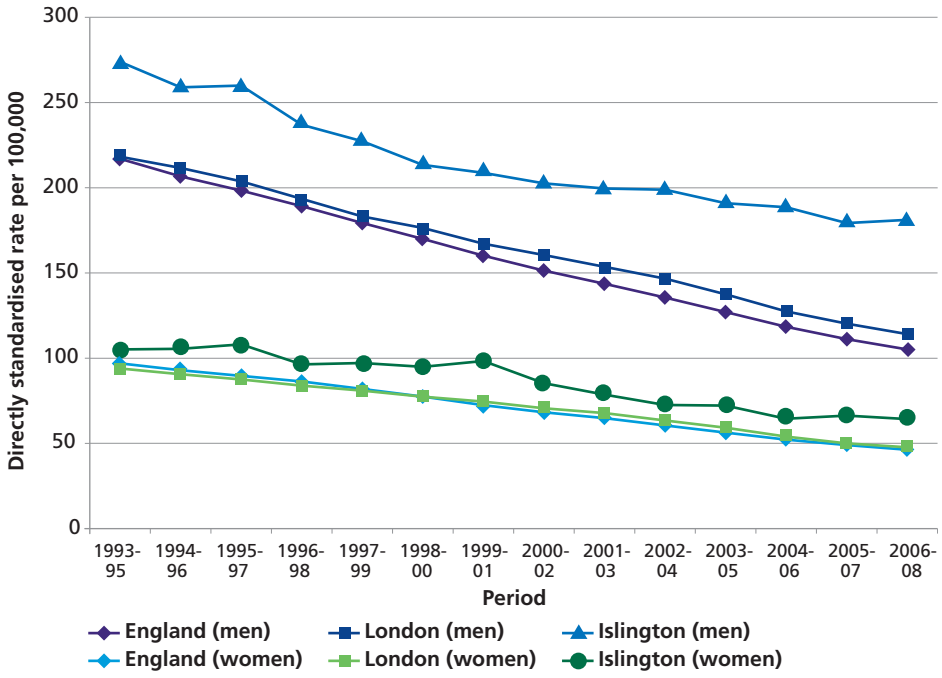
Table 1.1 Observed compared to expected prevalence of cardiovascular diseases, 2008/09 (recorded) and 2007 (expected)

	Prevalence				Observed compared to expected	
	Recorded		Expected			
	Number	%	Number	%	Number	% difference
Coronary heart disease	3,959	1.9	7,379	3.7	-3,420	-46.3
Stroke	2,282	1.1%	3,693	1.9%	-1,411	-38.2%
Hypertension	19,344	9.2	40,993	20.7	-21,649	-52.8

Actual prevalence obtained from QOF records, 2008/09 Expected prevalence estimated using Doncaster models: www.doncasterpct.nhs.uk/phiu-resources.asp?ArticleID=100180

Figure 1.1 Circulatory disease premature mortality, directly standardised rate, under-75s, Islington, London and England, 1993/05-2006/08

Source: Information Centre for Health and Social Care. Compendium of Clinical and Health Indicators.



SECONDARY PREVENTION

Secondary prevention in people with established cardiovascular disease centres on the management of the condition to prevent deterioration. Treatment may include medication, management of lifestyle risk factors and surgery (for example a heart bypass).

EMERGENCIES

Getting to hospital quickly and receiving specialist care is vital for heart attack and stroke. London has eight specialist heart attack centres and for stroke, eight hyper-acute stroke units will provide specialist emergency care from early 2010, supported by 24 stroke recovery units in local hospitals.

NATIONAL DRIVERS FOR SERVICE PROVISION

There are three strategies for the prevention of cardiovascular disease: risk reduction and primary and secondary prevention. In addition, there are treatment services for emergencies, e.g. heart attack or stroke.

RISK REDUCTION IN THE GENERAL POPULATION

This comprises interventions to reduce the prevalence of CVD risk factors in the general population. Interventions include smoking cessation, increasing physical activity and healthy eating, and controlling blood pressure and cholesterol.

PRIMARY PREVENTION AND EARLY DIAGNOSIS

This includes the identification and assessment of patients with established disease or at high risk of CVD with appropriate advice on smoking, diet, physical activity and appropriate medication.

OPPORTUNITIES FOR DEVELOPMENT

Inequalities remain an issue and are an area for priority action.

PRIMARY CARE AND IDENTIFICATION OF HIGH RISK GROUPS

- NHS health checks – assessment of CVD risk with lifestyle and risk factor reduction advice – are due to be fully implemented by 2012/13.
- The known prevalence of CVD is lower than expected, with variation between GP practices.
- Referrals to secondary care need to be made earlier, particularly for heart failure and some complications of CVD.
- The importance of addressing mental health need in Islington in terms of improving cardiovascular outcomes as well as improving mental health is well established [(1)].

SECONDARY CARE

- Islington had very low rates of angioplasty compared to other areas in 2006/07 [(4)] although rates are improving.
- Implantation rates of cardiac resynchronisation therapy (CRT) devices (used to improve the co-ordination of the heart's contractions) for heart failure remain low [(4)].
- More work needs to be done to integrate primary and secondary care regarding heart failure patients.
- Health professionals in hospitals can have a lasting impact on the behaviour of patients and relatives, who are more responsive to health advice when experiencing ill-health [(5)].

RECOMMENDATIONS

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

RECOMMENDATIONS TO ACHIEVE THIS INCLUDE:

- Influencing partnerships to make health promotion an explicit part of all policies across the PCT, Council and the community with an emphasis on tackling socio-economic risk factors for CVD through reducing deprivation and tackling poor mental health, smoking cessation, healthy eating, physical activity and good mental health.
- Working with primary care to improve the completeness and quality of disease registers, improve risk registers, ensure optimal control of hypertension and cholesterol, and to routinely audit all premature CVD deaths at practice level.
- Improving commissioning for quality with an emphasis on health-promoting hospitals to positively influence the behaviour of patients and relatives.
- Research evidence confirms that integrating primary and secondary care is crucial for optimal patient management, and this should be expedited.
- Improving health information to support equity audit, modelling and programme budgeting analysis to inform service planning.

REFERENCE LIST

(1) National Centre for Health Outcomes Development. 2009

(2) London Health Observatory. *The Health Inequalities Intervention Tool for Spearheads.* 2009.

(3) Association of Public Health Observatories. *Hospital Episode Statistics.* 2009.

(4) Green S, Miles R. *Access to cardiac care in the UK.* Oxford Healthcare Associates. 2009.

(5) Groene O, Garcia-Barbero M. *Health promotion in hospitals: Evidence and quality management.* Denmark: World Health Organization Regional Office for Europe. 2005.

2 Cancer and Cancer screening

INTRODUCTION

The incidence of cancer and premature mortality from cancer are higher in Islington compared to the rest of England. Premature mortality from cancer can be reduced through population-based cancer screening programmes. Currently three national cancer screening programmes are offered to eligible populations in Islington: the Breast Screening Programme (NHSBSP), Cervical Screening Programme (NHSCSP) and Colorectal Cancer Screening Programme (NHSCRSP). These programmes aim to detect early stage cancer or pre-malignant disease. Effective treatment at an earlier stage in the disease process greatly improves prognosis and reduces the risk of premature mortality from cancer.

Islington residents are currently not taking full advantage of the opportunity afforded by cancer screening; uptake and coverage are low compared to other local authorities and there are social inequalities in uptake.

THE ISLINGTON PICTURE

PREMATURE MORTALITY

Premature mortality from cancer is 15% higher in Islington than the England average (25% higher in men and 2% higher in women). In 2008, 165 people died prematurely from cancer in Islington compared to 140 premature deaths from circulatory diseases (**Figure 2.1**). Many of these premature deaths were potentially preventable.

BREAST CANCER

Breast cancer is the commonest cancer in the United Kingdom, the commonest cancer in women and accounts for almost one third of all cancer cases. In London, 4,328 women were diagnosed with breast cancer in 2007 and 1,123 people died from the disease in 2008. In Islington, this equated to 98 new cases of breast cancer in 2007 and 26 deaths in 2008.

Women aged 50 to 70 are routinely invited for screening every three years. The breast screening programme in Islington achieved 60.28% in 2007/08, ranking it 20th in London. Screening uptake varies by GP practice.

CERVICAL CANCER

Cervical cancer is the second most common cancer in women worldwide. In London, on average, 275 women were diagnosed with cervical cancer each year between 2005 and 2007, and 87 die per annum from cervical cancer (2006 – 2008). In Islington, there were

on average, seven new cases of cervical cancer per year (2005 –2007) and two deaths in 2008. Women aged 25 to 49 years are screened at three yearly intervals and those aged 50 to 64 at five yearly intervals. For 2008/2009, cervical screening coverage in Islington was 72.7%, lower than the national target of 80%.

COLORECTAL CANCER

Colorectal (bowel) cancer is the second most common cause of cancer death in the United Kingdom, accounting for 10% of all cancer deaths. In Islington, on average, there were 62 new cases of bowel cancer per annum between 2005 and 2007, and 27 deaths each year between 2006 and 2008.

In 2007, the bowel screening programme was rolled out across Islington. Uptake is currently lower than the 60% national expected figure, at around 38% of the eligible population.

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

Figure 2.1 Trend in premature mortality from cancer, Islington, London and England, 1993-1995 to 2006-2008

Source: ONS annual mortality files; analysed by NCHOD

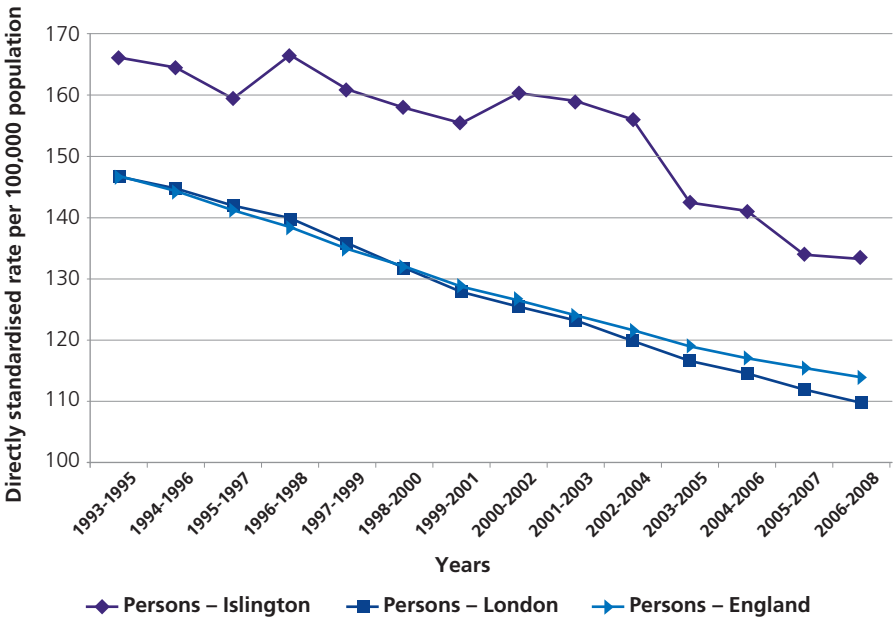


Table 2.1 Breast, cervical, bowel cancer: comparative incidence, mortality, survival, and trends

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

	Breast Cancer	Cervical Cancer	Colorectal Cancer
Incidence rate per 100,000 population (CIs 95%) for NHSI (2005 – 2007)	121.77 (106.8 to 135.5)	8.27 (4.63 to 11.9)	40.79 (34.8 to 46.8)
Number of new cases of cancer per year (2005 – 2007)	98	7	62
Is incidence significantly higher for NHSI than the London average?	No	No	No
Socioeconomic gradient in incidence	Higher in more affluent group – positive gradient	Higher in more deprived group – negative gradient	No gradient
Trend in incidence (1985 – 2007)	Increasing	Decreasing	No change
Number of deaths in Islington due to cancer per year (2006 – 2008)	26 per annum	2 per annum	27 per annum
Mortality rate per 100,000 population (CIs 95%) for NHSI (2006 – 2008)	29.39 (22.6 to 36.1)	2.51 (0.55 to 4.5)	16.78 (13.0 to 20.5)
Is mortality significantly higher for NHSI than the London average?	No	No	No
Socio-economic gradient in mortality	Higher in more deprived group – negative gradient	Higher in more deprived group – negative gradient	For rectal cancer, males higher in more deprived group – negative gradient
Trend in mortality (1993 – 2008)	Decreasing	Decreasing	Decreasing
5 year survival (North London Cancer Network) (CIs 95%) (1998 to 2002)	78.7 (77.0 to 80.3)	69.9 (63.7 to 76.0)	46.5 (44.2 to 48.8)
Socio-economic gradient in 5 year survival	Lower in more deprived group – negative gradient	Lower in more deprived group – negative gradient	For rectal cancer, lower in more deprived group for males and females – negative gradient

NATIONAL DRIVERS FOR SERVICE PROVISION

Cancer screening services should be provided in line with the national standards set out by the Quality Assurance Reference Centre (QARC). Quality Assurance is a fundamental part of the NHS Cancer Screening Programmes. The aim of quality assurance is to maintain minimum standards and to improve the performance of all aspects of cancer screening in order to ensure that the population have access to a high quality screening service wherever they live.

The Department of Health published the Cancer Reform Strategy in 2008 [1], which contained a number of objectives relevant to screening, including:

PREVENTION

- Primary prevention of cancer: smoking, diet, physical activity, obesity, sunlight.
- Primary prevention of cancer: HPV vaccination.

DIAGNOSING CANCER EARLY

- Raise public awareness of the causes, signs and symptoms of cancer.

BREAST SCREENING

- Improve coverage and reduce inequalities.
- Extending the age range for breast screening to provide nine screening rounds between 47 and 93 years.
- Introduction of direct full-field digital mammography by 2010.
- Promotion of self-referral for screening every three years for women over 70 years of age.
- Incorporating the responsibility for the management of surveillance for women at high familial risk of breast cancer, into the NHSBSP.
- Increasing the uptake of screening in poor communities, BME groups, among disabled women and Muslim women.

BOWEL SCREENING

- Improve coverage and reduce inequalities.
- Extending the range for bowel screening from 2010 to invite men and women aged 50 – 59 and 70 – 75 years to take part.
- Increasing the uptake of screening in men, poor communities, BME groups, and among Muslim men and women.

CERVICAL SCREENING

- Improving coverage and reduce inequalities.
- All women to receive their screening test result within two weeks of it being taken.
- Action to tackle the falling participation of younger women aged 25 – 35 years.
- Increasing the uptake of screening in poor communities, BME groups and disabled women.

In addition to implementing national guidance and standards, Islington reviews the evidence for the effectiveness and cost-effectiveness of the cancer screening programmes, what works for increasing coverage uptake and what works for reducing inequity in coverage / uptake, to ensure investment is made in the most appropriate interventions.

RECOMMENDATIONS

We envisage that, by 2020, Islington residents will be aware of the risks, causes and symptoms of common cancers so that they will adopt behaviours that minimise or eliminate risks. Eligible women and men will be aware of cancer screening opportunities and will take advantage of these programmes. Any Islington resident will be able to make a convenient appointment for screening at any screening unit in London.

We will continue to build on the work that we started since the 2008 JSNA including:

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

REFERENCE LIST

(1) Department of Health. *Cancer Reform Strategy.* 2008.

3 Mental Health

INTRODUCTION

Mental ill health is very common, affecting about 1 in 6 of the adult population and 1 in 10 children and young people. It is associated with a wide range of poor physical and mental health outcomes, including significantly increased risk of earlier death, social exclusion and economic hardship.

Mental health needs vary according to gender, ethnicity and age, and are influenced by family, social and environmental determinants. Life experiences and circumstances can increase vulnerability to mental health problems across all groups in society, including bereavement, pregnancy and parenthood, exams, difficulties at work and unemployment.

THE ISLINGTON PICTURE

Islington has a significantly higher level of mental health need than London or England. Rates of psychoses, common mental health problems (such as depression and anxiety) and suicide are significantly higher.

Patients with psychotic disorders on primary care registers in Islington were 1.4% (2,986) of the total registered population in 2008/9: double the national average of 0.7% and significantly higher than the averages for London (0.9%) and other deprived London PCTs (1.1%). Deaths due to suicide and undetermined injuries in 2006-8 in Islington were higher than the London and national average **(Figure 3.1).**

The underlying rate of dementia (which predominantly affects people aged 65 and over) is estimated to be lower in Islington than England since there are relatively few older people in the local population

There are high levels of mental health need among prisoners, significantly higher than estimates for the general population. Improved screening in prison reception in Islington's two prisons, Holloway and Pentonville, means that more mental health conditions among prisoners are identified. However the high turnover of prisoners means that providing treatment within prisons and on release into the community is challenging.

NATIONAL DRIVERS FOR SERVICE PROVISION

Child and Adolescent Mental Health Services' (CAMHS) comprehensive tiered service model provides a stepped approach of intervention. It ranges from lower threshold access in community settings to clinic-based work with children and families through to inpatient care for those with the most serious mental health conditions.

For adults, the National Service Framework (NSF) for Mental Health (1999) is now drawing towards the end of its ten-year implementation plan, which will be replaced by New Horizons (2009) from 2010. National Institute for Health and Clinical Excellence (NICE) guidelines also set out standards and service models for key aspects of adult mental health care.

Delivering Race Equality (2005) sets out a five-year action plan for reducing inequalities in BME patients' access to, experience of, and outcomes from mental health services.

A new national model of service provision for common mental health problems, Improving Access to Psychological Therapies (IAPT), provides increasing levels of intervention according to

seriousness of need. This includes access to guided self help and talking therapy services, linked to additional employment support for those that need it.

The new National Dementia Strategy (2009) and Healthcare for London Dementia pathway (2009) set out the standards and care pathway for dementia care.

OPPORTUNITIES FOR DEVELOPMENT

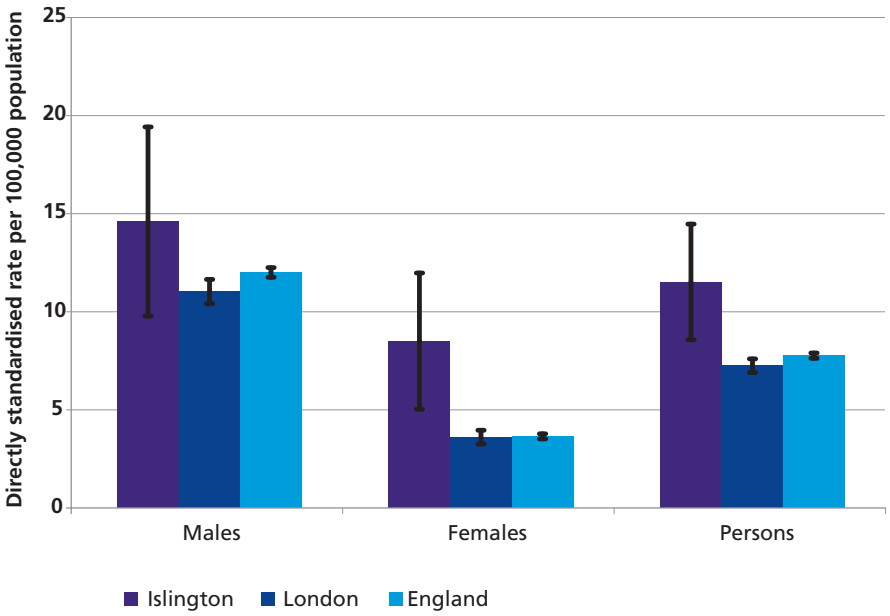
Islington CAMHS has a better coverage than most other areas of London and England. Access relative to need has become more equitable over the past five years, although 11-17 year olds and some BME groups were less likely to be seen than other groups. Continued implementation of the existing CAMHS strategy, with a focus on investment in preventative services, should be a local priority.

Ongoing initiatives within the borough are likely to highlight the needs of people with long-term mental health problems which are more serious than can be met by psychological therapy services alone, but fall below the threshold for community mental health services. A pilot looking at a model of support for this group of patients began during 2009.

There is a continuing need to address mental health stigma and discrimination across services and organisations in Islington and within the community. Local initiatives, such as Mental Health First Aid training, Mental Health Champions and the Time to Change Pledge are important to change the way organisations and people think about and respond to mental health problems.

Figure 3.1 Directly standardised rate of deaths due to suicide and undetermined injury, Islington, London and England, 2006-08

Source: NCHOD, 2009



RECOMMENDATIONS

- A high priority for mental health investment is to address the health and social impact of the current recession with a view to prevent increases in short term mental health problems becoming more serious, long term problems.
- Health services have an immensely important role to play in addressing the health and social impacts of recession. However, integrated partnership action to address child poverty, worklessness and unemployment and build community resilience will be necessary to meet this challenge fully.
- Ensure the development of polysystem models of primary care supports further integration of the management of mental and physical health needs.
- Improve diagnosis, early intervention and support for people with dementia through implementation of the new dementia care pathway.
- Improving Access to Psychological Therapies will become fully implemented during 2010/11. It will be important to review how well it is meeting the needs of different groups in the community.
- Continuing action to promote good mental health skills, promote protective factors in the community and address mental health stigma and discrimination is vital. This will support a phased shift towards earlier intervention to effective treatment and care, and better long term outcomes.

4 Tuberculosis

INTRODUCTION

Tuberculosis (TB) is an infectious, notifiable disease (meaning there is a requirement by law to report it to government authorities) caused by the bacterium Mycobacterium Tuberculosis. In the 1930s, TB was one of the leading causes of death in the UK. After falling steadily, the number of TB notifications in England and Wales has increased over the past 20 years. The main underlying factor in this rise has been infection in people born outside the UK. TB is curable with a full course of treatment.

Figure 4.1 TB incidence rates for Islington, North Central London and London, 1982 – 2008

Source: London TB Register (LTBR), HPA London

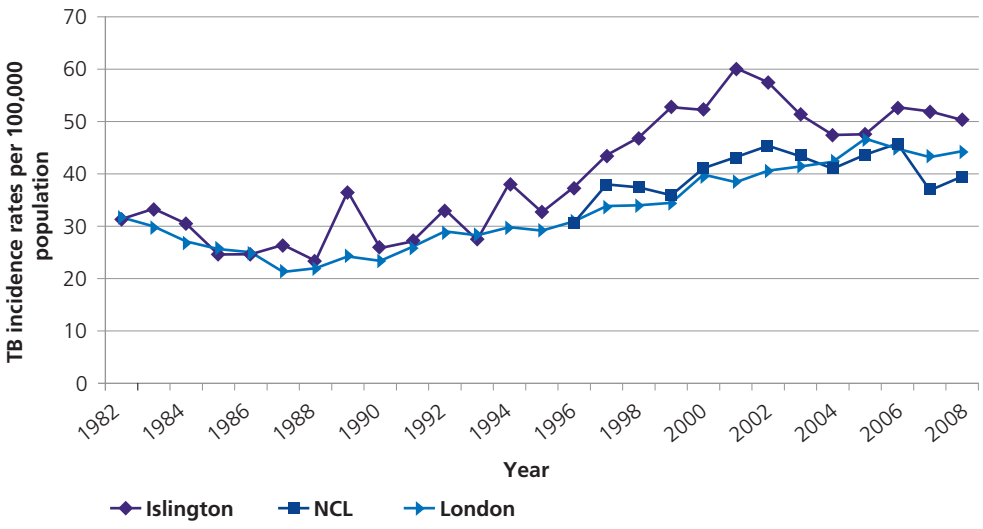


Table 4.1 Incidence of TB per 100,000 population for Islington, North Central London, London and England and Wales, 2002 – 2008

Source: London TB Register (LTBR), HPA London

TB rates	2002	2003	2004	2005	2006	2007	2008
Islington	57.5	51.3	47.4	47.6	52.7	51.9	50.3
NCL	45.3	43.3	41.0	43.7	45.8	36.8	39.5
London	40.6	41.4	42.3	46.7	44.8	43.2	44.3
E&W	13.4	13.5	14.1	15.5	15.5	15.2	14.2

THE ISLINGTON PICTURE

Incidence of TB is high in London, accounting for about 40% of notifications in England [1]. Islington has a higher incidence of TB than North Central London and London as a whole. There has been a downward trend in TB cases in Islington over recent years. (**Figure 4.1** and **Table 4.1**).

Within Islington there is considerable geographical variation in the incidence of TB (**Figure 4.2**).

TB is concentrated in deprived communities in cities and predominantly affects ethnic minority and non-UK born groups, homeless people, younger adults, those with compromised immune systems and problem drug-users [2].

Figure 4.3 shows that in Islington between 2003 and 2008 there was an increase in the proportion of cases of Black African ethnicity and a decrease in cases of Indian ethnicity, while in North Central London as a whole the opposite was true.

Figure 4.2 TB notification rates per 100,000 population by ward, Islington, 2008

Source: North Central London TB Commissioning Group. Mapping by NHS Haringey Public Health

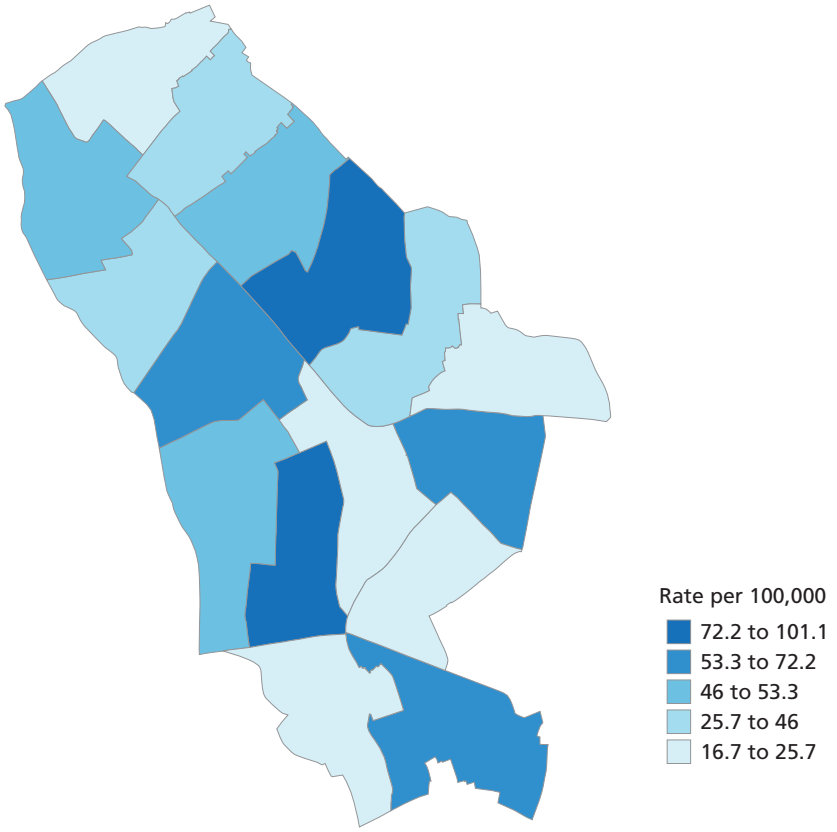
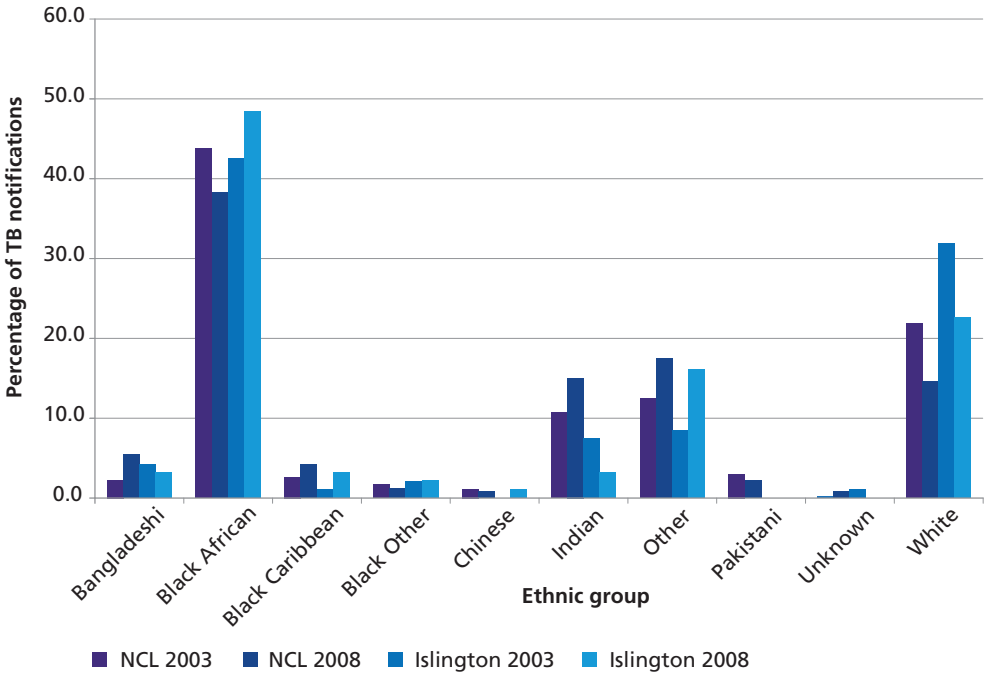


Figure 4.3 TB notification rates per 100,000 population by ward, Islington, 2008

Source: North Central London TB Commissioning Group. Mapping by NHS Haringey Public Health



Resistance to first-line drug treatment for TB is low in the UK and alternative drug treatment options are available [2]. In multiple drug resistant (MDR) tuberculosis the bacteria are resistant to at least two of the most powerful tuberculosis drugs. Across North Central London, the total proportion of cases that are multi-drug resistant is very small.

NATIONAL DRIVERS FOR SERVICE PROVISION

In 2004 the Chief Medical Officer (CMO) produced a National TB Action Plan [3] outlining ten actions to bring TB under control in England, including partnership working, improvements to the organisation of care and raising awareness of TB.

In 2006 the National Institute for Health and Clinical Excellence (NICE) produced guidance for the clinical diagnosis and management of TB and measures for its prevention and control [4].

The Department of Health produced a TB Commissioning Toolkit in 2007 to support the implementation of the guidance from the CMO and NICE [5].

North Central London has a collaborative commissioning group which is supported by the London TB Commissioning Unit. This group engages the PCTs within the sector to secure investment, improve TB service delivery and patient care in line with national guidance.

OPPORTUNITIES FOR DEVELOPMENT

The World Health Organisation Millennium Development Goal for TB is to halve the London 1990 TB rate by 2015. In 1990 the London TB rate was 23.4 per 100,000 population and in 2008 it was 44.3. The ambitious target for the London TB Commissioning Unit is to achieve 11.7 per 100,000 population in the next 6 years through commissioning effective TB services.

The North Central London sector is a national leader in terms of service provision. Although excellent work is well established, challenges remain. Care pathways are being developed for London and these need to be embedded in local practice. Awareness raising activity with high-risk population groups has been ongoing for a number of years but is not having the anticipated impact on reducing TB. New approaches are needed to work with these communities and tackle stigma. There are ongoing challenges in securing patient representatives to input into TB service development in North Central London.

RECOMMENDATIONS

- Conduct a needs assessment to gain a better understanding of the requirements of a TB service
- Achieve the London TB targets covering elements such as diagnostics, waiting times and treatment completion.
- Review paediatric TB services in North Central London to reduce the number of paediatric service providers from five to two, in order to concentrate care in specialist centres.
- Review provision of adult TB services in North Central London in line with World Class Commissioning standards.
- Implement the Directly Observed Treatment (DOT) project by funding a team to improve treatment compliance and patient support. DOT involves observing a patient to ensure they take their medication in the right combination and for the correct duration.

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(4) National Institute for Health and Clinical Excellence (NICE). *Tuberculosis: Clinical diagnosis and management of tuberculosis, and measures for its prevention and control* 2006.

(5) Department of Health. *Tuberculosis prevention and treatment: a toolkit for planning, commissioning and delivering high quality services in England.* 2007.

5 Teenage Pregnancy

INTRODUCTION

The UK has the highest rates of unintended teenage pregnancy in Western Europe. Teenage pregnancy is strongly related to social disadvantage, linked to an inter-generational cycle of exclusion and poor outcomes. The children of teenage parents are more likely to experience a range of adverse health, social and economic outcomes than other children and become teenage parents themselves.

Key risk factors for teenage pregnancy include education-related factors (low educational attainment, disengagement from school and leaving school aged 16 with no qualifications), risky behaviours (early onset of sexual activity, poor contraceptive use, mental health problems, alcohol and drug misuse) and family background (living in care, being the daughter of a teenage mother, and lack of aspirations of parents). Although some ethnic groups are over-represented among teenage conceptions, this is significantly linked to higher levels of deprivation experienced by these groups.

THE ISLINGTON PICTURE

In 2007, there were 125 under 18 conceptions in Islington, equivalent to a rate of 50.5 per 1,000 young women aged 15-17. This was significantly higher than the national average rate of 41.7 per 1,000. Conceptions under the age of 16 accounted for one third of teenage pregnancies in Islington. 62% of conceptions ended in a termination, similar to the London average of 61%, but higher than the national average of 49%. **Figure 5.1** shows how under 18 conception rates have changed in Islington since 1998, compared with London, England and target reductions. Islington showed a reduction of 13.4% between 1998 and 2007, compared with a national reduction of 10.7%. The Islington target is for a 55% reduction between 1998 and 2010 compared with a national target of 50%.

In Islington, young women from white and black communities are at higher risk of becoming teenage mothers. Young women from Asian communities have the lowest risk when compared to other ethnic groups. The majority of wards in Islington have high teenage conception rates compared with national averages. Rates ranged from 29.1 per 1,000

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

Source: Teenage Pregnancy Unit, Feb 2008 (data for 2007 are provisional)

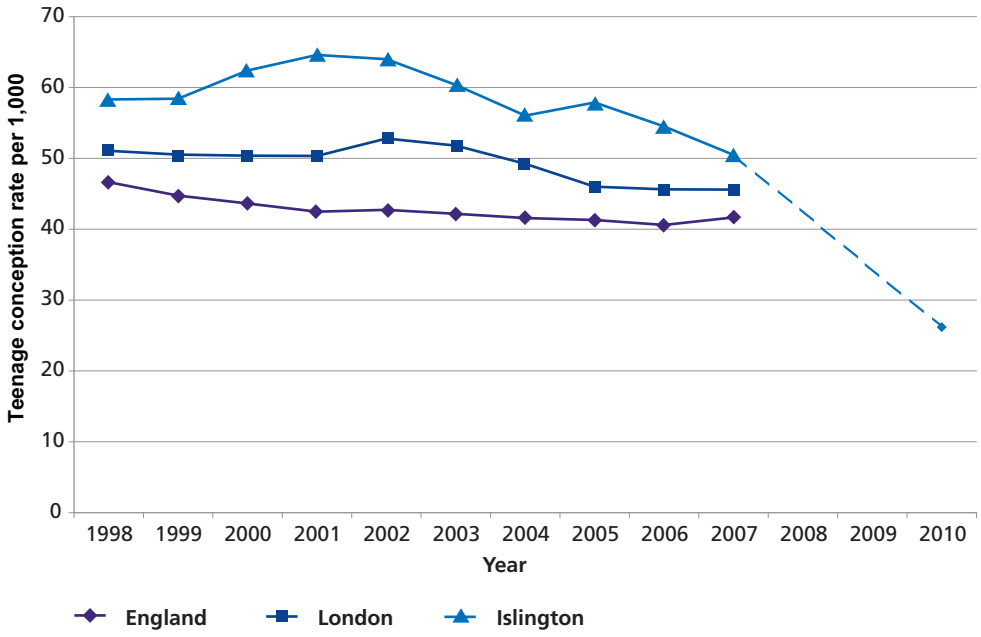
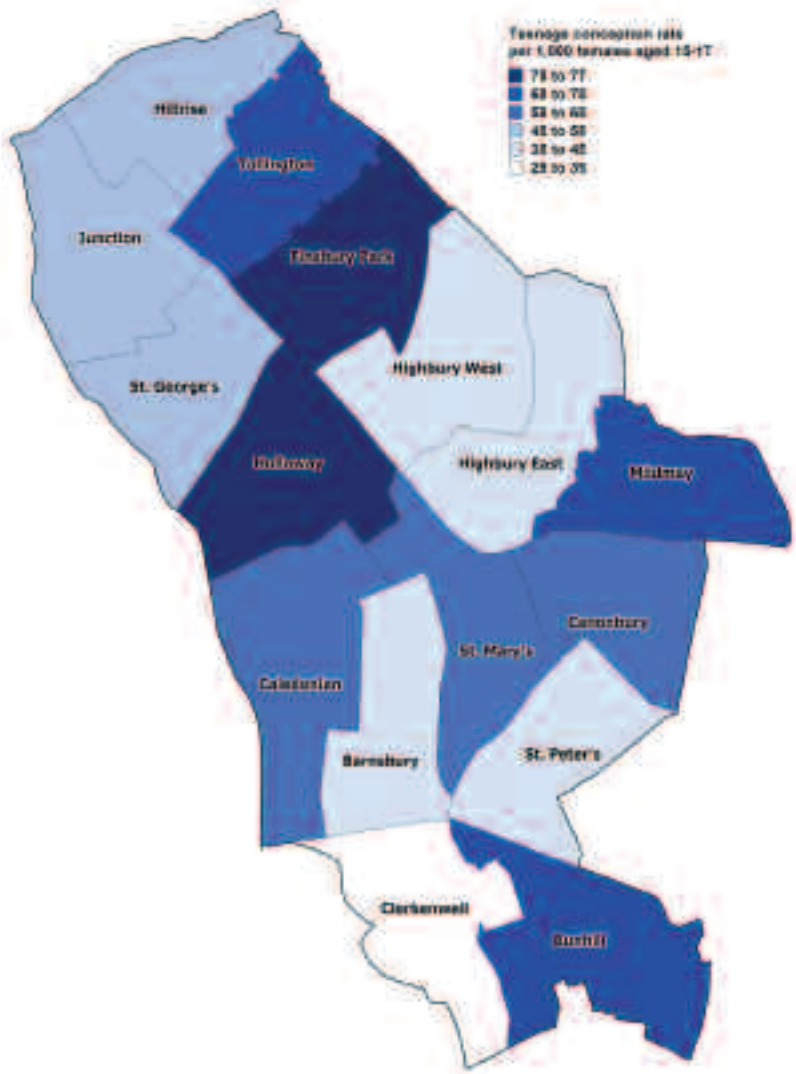


Figure 5.2 Under 18 conception rate in Islington wards in 2005-07

Source: Teenage Pregnancy Unit ward teenage conception rates



women aged under 18 years in Clerkenwell ward, to 76.3 per 1,000 in Finsbury Park and in Holloway wards in 2005-7 (**Figure 5.2**).

NATIONAL DRIVERS FOR SERVICE PROVISION

The most effective interventions for reducing teenage pregnancy and improving support for teenage parents and their children involve multiple approaches. In particular, the needs of the groups most vulnerable to teenage pregnancy need to be effectively addressed through coordinated, multi-agency action to reduce their vulnerability to teenage conception.

A national analysis carried out by the Teenage Pregnancy Unit and Government Office of London (2005) identified the important characteristics of areas that had experienced a significant reduction in teenage pregnancy compared with areas that were not performing well. The analysis concluded that impact was greatest when all the identified aspects for the success of the strategy were present and delivered effectively. Success factors included:

- Active engagement of all of the key mainstream delivery partners who have a role in reducing teenage pregnancies.
- A strong senior champion who was accountable for and took the lead in driving the local strategy.
- The availability of a well publicised young people-centred contraceptive and sexual health advice service.
- A high priority given to Personal and Social and Health Education (PSHE) and Sex and Relationships Education (SRE) in schools.

- A strong focus on targeted interventions with young people at greatest risk of teenage pregnancy, in particular with Looked After Children.
- The availability of SRE training for professionals across all partner organisations.
- A well resourced youth service, providing positive activities and places to go for young people.

Islington's self-assessment 2008-2009 identified that the strategic action plan addressed the key areas for reducing teenage pregnancy but there was a need to ensure delivery was consistent and more fully linked up. Priorities being progressed in 2009/10 are:

- Expanding targeted work with vulnerable young people and teenage parents and those that care and work with them.
- Workforce training so that all staff in children and young people's services can confidently and competently address sex and relationships issues, appropriate to age and need, and signpost to advice and services when needed.
- Working with parents of teenagers, so that parents can feel confident about discussing sex and relationships with their children.
- Communication and information-sharing between professionals and agencies to ensure that support and care is co-ordinated.
- Revised performance management and monitoring arrangements at partnership level.
- Mainstreaming teenage pregnancy funded initiatives and ensuring service provision addresses teenage pregnancy.

RECOMMENDATIONS

Key recommendations include:

- Ensure that all services working with children and young people have made preventing teenage pregnancy a priority, embedded in their service plans and performance management systems.
- Roll out of SRE training for all professionals working with children and young people on addressing sex and relationship issues and signposting for further support, advice and services.
- Promoting and improving contraception awareness and use, ensuring availability of contraceptive information and advice and guidance and contraceptive services in a wide range of settings.
- Ensure all services for children and young people use appropriate existing tools, e.g. Common Assessment Framework, to identify and assess children and young people, both male and female, who are pregnant or at higher risk of teenage pregnancy.
- Specifically target and improve aspiration, engagement and outcomes for groups vulnerable to teenage pregnancy across programmes, including employment, education and training, action to reduce child poverty, detached youth work and positive activities.

6 Sexual health

INTRODUCTION

Sexual health is an important element of physical and mental health. Good sexual health requires relationships to be safe and equitable, with ready access to high quality information and services that reduce the risk of unintended pregnancy, illness or disease.

Sexual health in the UK has deteriorated significantly over the last decade, with increases in many sexually transmitted infections (STIs) and the prevalence of human immunodeficiency virus (HIV). The consequences of poor sexual health include pelvic inflammatory disease, certain cancers, liver disease, unintended pregnancies and abortions. It can also have psychological, educational, social and economic consequences as well as reduced life expectancy.

THE ISLINGTON PICTURE

There are a number of services addressing sexual health within Islington, covering sexual health promotion and HIV prevention, screening, contraceptive provision, termination of pregnancy services and treatment and care of STIs and HIV.

In 2007 a total of 4,447 new cases of STIs were diagnosed in Islington. Rates of Chlamydia, Genital warts, Genital herpes, Gonorrhoea, Syphilis and HIV remain high, with cases of Chlamydia and Genital warts increasing and Gonorrhoea decreasing.

In 2008, Islington had a rate of 8.6 diagnosed HIV infections per 1,000 population (aged 15-59 years). This was higher than the London average of 5.0 per 1,000 and third highest among other London PCTs. The largest group of people living with diagnosed HIV in Islington were gay and bisexual men, although heterosexually-acquired infections in the UK among men and women are increasing. The prevalence of maternal HIV infection also steadily increased between 2003 and 2007.

The national Chlamydia screening programme reached a local coverage in 2008/09 of 18.6%, exceeding the national target of 17%. The HPV vaccination programme reached a coverage of 66% in Islington in 2008/09, slightly higher than London (63%) but lower than England (70%).

In 2007, the standardised abortion rate for Islington women aged 15-44 was 27 per 1,000 women; slightly below the London rate but almost double the national rate. 30% of abortions among women under 25 were repeat abortions, similar to London (31%) but higher than England (24%).

NATIONAL DRIVERS FOR SERVICE PROVISION

The National Strategy for Sexual Health and HIV has been guiding the development of sexual health services locally since its publication in 2001. The strategy, which focuses on reducing transmission of HIV and STI and unintended pregnancies, as well as improving care for people living with HIV, proposes a range of actions including improving information, developing more integrated services and improving access and services on offer.

With regards to contraception, NICE guidance recommends that women requiring contraception should be given information about and offered a choice of all methods including Long Acting Reversible Contraception (LARC) methods. All LARC methods are more cost-effective than the combined oral contraceptive pill, even at one year of use, and increasing the uptake of LARC methods reduces the numbers of unintended pregnancies.

The national strategy described the main elements of a comprehensive sexual health service as comprising:

- Contraceptive care and abortion.
- Diagnosis and treatment of STIs and HIV.
- Prevention of STIs and HIV.
- Services that address psychological and sexual problems.

RECOMMENDATIONS

Taking into account the local pattern of need, national and regional guidance as well as evidence of effectiveness of interventions to improve sexual health, the following actions are recommended to drive improvements in sexual health and HIV in Islington:

- Ensure the importance of sexual health is recognised and incorporated within local planning arrangements.
- Provide high quality Sex and Relationships Education to all local children and young people.
- Ensure sexual health needs are always part of the holistic needs assessment of vulnerable children and young people.
- Use social marketing methods to promote access to services for identified priority groups.
- Promote contraceptive choice and use, including LARC and condom use.
- Promote awareness of and early access to abortion services.
- Ensure the use and appropriate analysis of available data and information.
- Ensure high priority is given to targeted HIV prevention groups, to help reduce STI and HIV infections and improve earlier diagnosis of HIV.

7 Infant mortality

INTRODUCTION

'Infant mortality' refers to the death of a baby before its first birthday. Many deaths in infancy are potentially preventable. There are current government and local policies that focus on reducing infant mortality rates by tackling long standing health inequalities and addressing known risk factors, as well as initiatives to continue to improve services.

There are significant inequalities in infant mortality between social classes and other groups in the community which have persisted for generations. Reducing the gap in infant mortality by at least 10% between routine and manual groups and the population as a whole by 2010 (compared with 1997-99) is one of the key national health inequalities targets. Infant mortality rates have fallen nationally in all social class groups since 1997-99, but have been falling faster in the general population than in routine and manual groups, so that the relative inequalities gap has widened.

THE ISLINGTON PICTURE

Islington has one of the lowest fertility rates in the country, with a total period fertility rate (the average number of children a woman is expected to have over her lifetime given the current pattern of births) of 1.49 births per woman aged 15-44 compared with 1.95 in London and 1.97 nationally. There are currently around 2,800 births a year in Islington. Births are projected to increase to an average of 2,950 a year by 2020. The ethnic diversity of mothers and babies is expected to increase, reflecting wider changes within the population.

As **Figure 7.1** shows, the infant mortality rate in Islington rose from 6.7 per 1,000 live births in 1999-2001 to 6.9 in 2003-05, before falling to 5.2 in 2005-07, when it was not significantly different from the London (4.8 per 1,000) and national (4.9 per 1,000) rates.

Risk factors associated with higher rates of infant mortality in London are:

- Low birth weight babies.
- Sole parent registration of births.
- Mothers living in super output areas (SOAs) of greatest deprivation.
- Mothers born in countries with high infant mortality, particularly East and West African and Afro-Caribbean countries.
- Teenage pregnancies.
- Babies born to couples in routine and manual occupational groups.
- Exposure to secondhand smoke in the home.
- Low immunisation coverage.

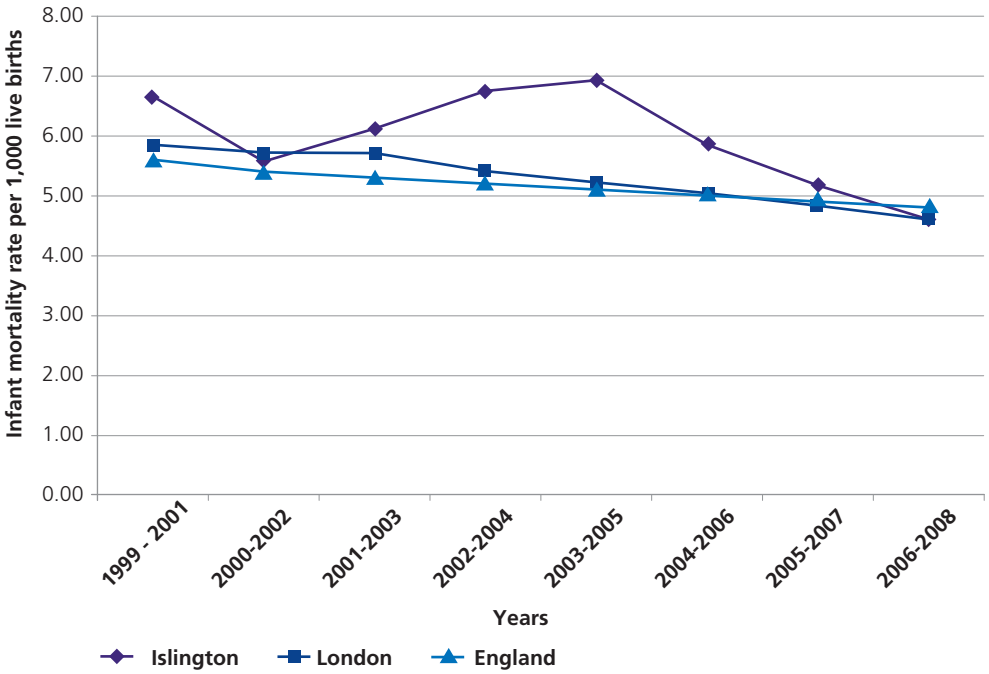
During 2008/9, 8.5% of local mothers reported that they smoked during their pregnancy. This marked a significant downward trend in recent years. In addition, 30% of babies under one year old in Islington are exposed to environmental tobacco smoke in the home.

NATIONAL DRIVERS AND LOCAL OPPORTUNITIES FOR DEVELOPMENT

The two major maternity units that serve Islington are The Whittington and UCLH, which together see over 90% of Islington women for their maternity care. The two units are also responsible for providing community-based maternity care across the borough. Networks of neonatal care provide specialist care for sick and pre-term babies.

Health visiting and other children's health services and community-based maternity services work together with primary care teams and Children's Centres to provide joined-up and easy-to-access services. Health visiting services provide universal care and support to mother, baby and families, including ongoing advice and support for breastfeeding, health promotion checks, and ensuring immunisations and screening are

Figure 7.1 Infant mortality rate per 1000 live births for Islington, London and England, three year average, 1999-2001 to 2006-2008.
Source: Office for National Statistics, 2009



carried out, including for postnatal depression.

Maternity services make an important contribution to all outcomes in pregnancy and reductions in infant mortality. The standards for maternity services are set out in NICE guidelines, the National Service Framework for Children and Maternity Services, and the Department of Health's publication 'Maternity Matters'. These standards include:

- Encouraging early booking so that any health or social problems in pregnancy can be detected early and given the support and care to manage or reduce risk and improve outcomes.
- Providing education, support and advice (e.g. on smoking and alcohol).
- Identifying and managing risks, including screening.
- Taking action to reduce the risk of low birth weight.
- Identifying and supporting women with, or at risk of, mental health problems.

These help to improve the chances of a healthy pregnancy for both mother and baby and can reduce the risk of infant mortality, low birth weight and other serious adverse outcomes.

During the first two quarters of 2009/10, 63% of Islington women were booked by 12 weeks against a national quality standard of 90%. Important actions to encourage early booking with services include:

- Increasing co-location of maternity services in Children's Centres and other community settings such as health centres.
- The establishment at The Whittington of a dedicated maternity team for pregnant teenagers, who as a group are at greater risk of poorer outcomes, late engagement with services and are more likely to report negative perceptions and experiences from services and staff.
- Islington Family Nurse Partnership programme pilot, providing tailored support and advice offered to all young parents in Islington from antenatal care through to age two.

RECOMMENDATIONS

- Ensure the standards set out in 'Maternity Matters' are delivered, including promoting earlier booking to maternity services, access to and uptake of antenatal education, and support and advice for breastfeeding.
- Support healthy lifestyles, pre-conceptually and in pregnancy, including advice and support on smoking cessation, healthy balanced diets, alcohol and drug use.
- Ensure access to high quality sex and relationships education (SRE), contraceptive advice and services to support informed decisions about fertility, particularly for young women and young men from socially excluded communities.
- Promote healthy development and reduce risk of infant death through reducing exposure to smoking, high immunisation coverage, sleeping position advice, timely screening and supporting high levels of continued breastfeeding and healthy weaning.

8 Older people

INTRODUCTION

Islington's population is changing. With only 9% of the population aged 65 and over Islington is a relatively young borough and is unlikely to follow the national pattern of significant growth in the older population. Nevertheless Islington will experience an increase in the 'older old'; a population group which often face distinct challenges such as living with long-term conditions and increased frailty. There is also likely to be an increase in the diversity of need as the number of older people from BME groups expands. This, coupled with high levels of deprivation is likely to trigger increased demand for health and social care services.

Older people make up a significant proportion of social housing households and pensioner households have a considerably lower-than-average income compared to the rest of the borough. There are also high numbers of affluent older adults in Islington many of whom choose to self-fund their social care need. A further challenge for services is to make sure that this wealthier group has relevant information to make informed choices.

There is no formal definition of the age range for the older population as people respond to ageing in different ways. Services are planned and delivered by adopting a person-centred approach.

THE ISLINGTON PICTURE

Four main disability-causing diseases have been identified which are likely to impact on the health of the future older population[1]. These include dementia, coronary heart disease (CHD), stroke and arthritis. Three of these areas are addressed in this chapter. Arthritis will not be considered as there is less evidence available for the prevalence or effective treatment and prevention of arthritis. Instead the issue of falls in older people has been considered, as this is an area associated with morbidity for older age groups.

Table 8.1 Prevalence of dementia, Islington, London Spearhead PCTs, London and England, 2008/09

Source: The Information Centre, QOF performance indicators, 2008/09

	Performance		
Area	General Practice Population	Dementia Register	Dementia Prevalence (%)
Islington	206,977	660	0.3
London Spearhead PCTs	2,898,233	6,846	0.2
London	8,462,084	24,859	0.3
England	54,310,660	232,430	0.4

DEMENTIA

The prevalence of dementia in Islington, based on GP dementia registers, is comparable to London spearhead PCTs, London as a whole and slightly lower than for England (**Table 8.1** and **Figure 8.1**). There were 660 people diagnosed with dementia in 2008/09.

CORONARY HEART DISEASE AND STROKE

There is a higher prevalence of both CHD and stroke within Islington, based on modelled estimates which take into account age, sex, ethnicity, smoking status and deprivation scores across older

Figure 8.1 Prevalence of dementia by Islington, London Spearhead PCTs, London and England, 2008/09

Source: The Information Centre, QOF performance indicators, 2008/09

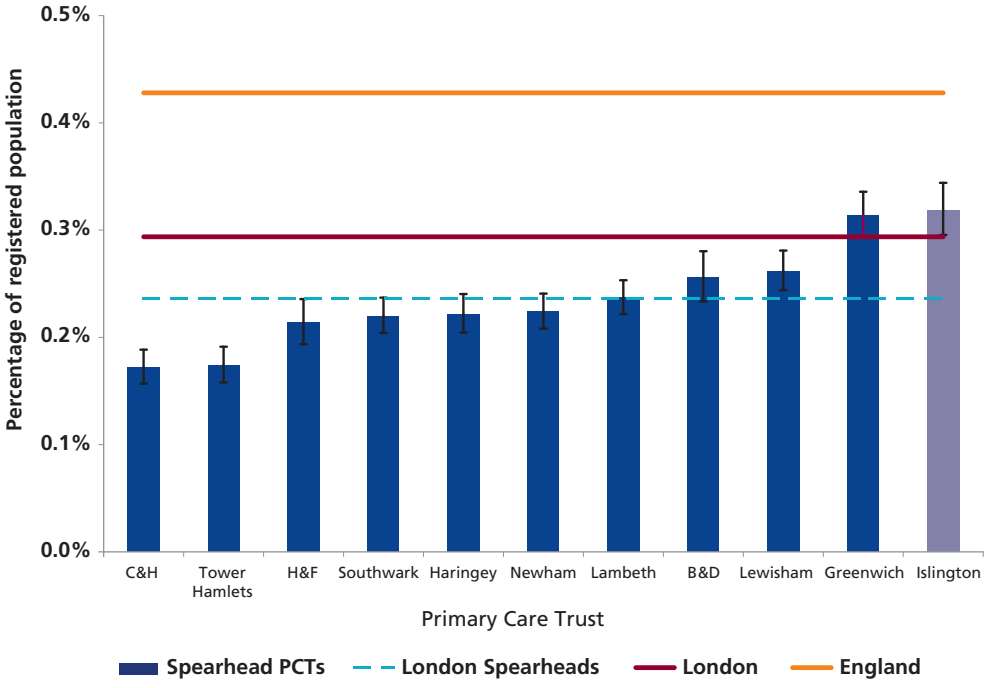


Figure 8.2 Modelled prevalence of CHD by age for Islington resident population (aged 16+), compared to London and England, 2009

Source: Eastern Region Public Health Observatory, November 2008

Please note modelled estimates are based on input data prior to 2006

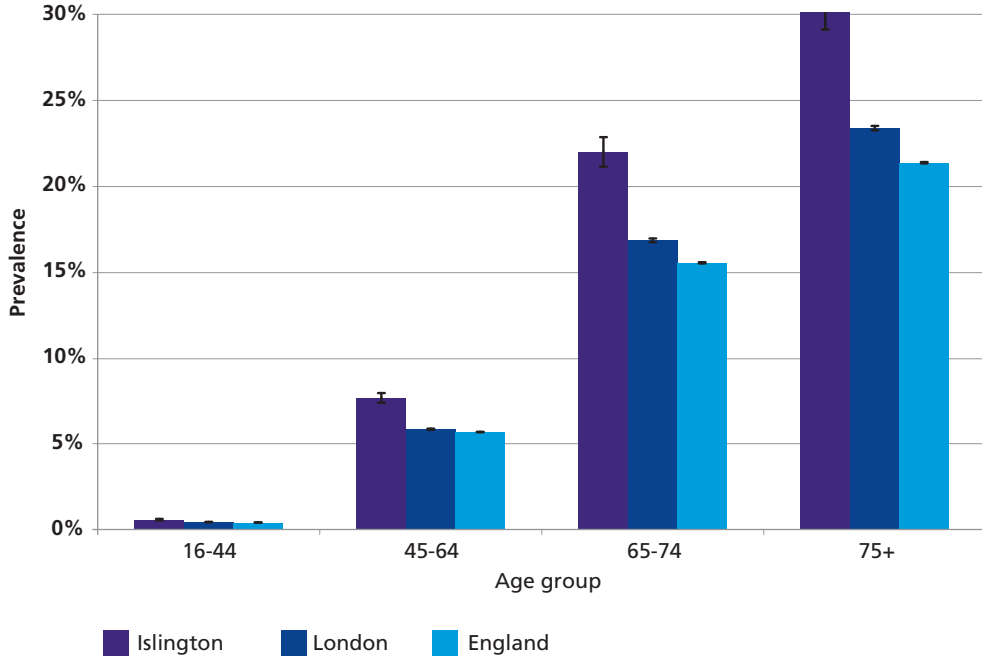


Table 8.2 Age standardised rate per 100,000 of admissions for fractured neck of femur, 2004/05, 2005/06 and 2006/07

Source: London Health Observatory

	2004/05	2005/06	2006/07
Islington	528.3	564.1	540.6
North Central London	498.5	496.8	511.8
London	487	494.6	471.4

age groups compared to London and England (**Figure 8.2** and **Figure 8.3**).

FALLS

The hospital admission rate for fractured neck of femur (fractured hip) for Islington is higher than for North Central London and London as a whole (**Table 8.2**).

THE NATIONAL CONTEXT

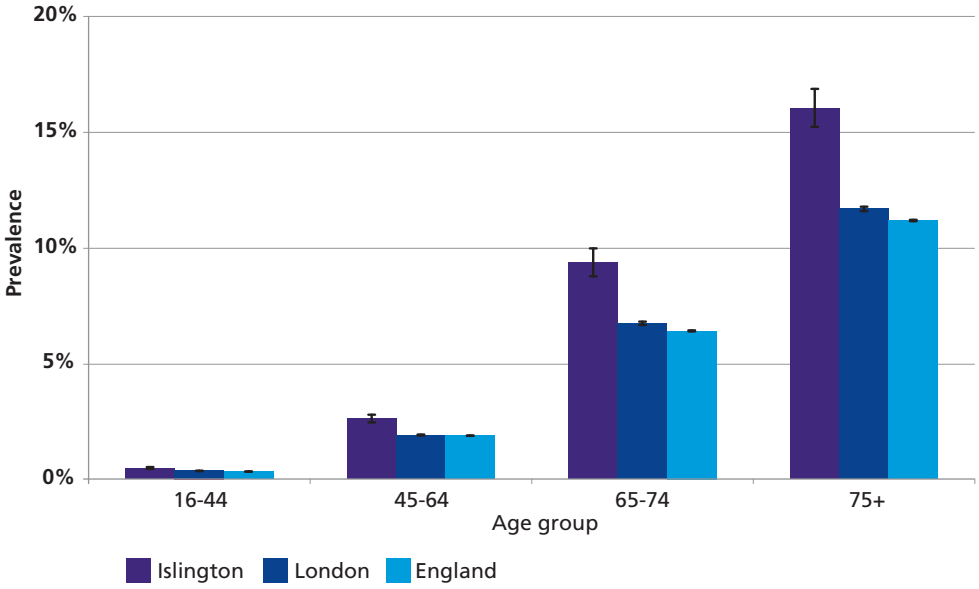
The policy direction signalled by the government in 'Putting People First: a shared vision and commitment to the transformation of adult social care' [2] is supported by a growing body of evidence that we need to shift away from interventions at the point of crisis to a more pro-active and preventative model. This model is based on improved wellbeing, with greater choice and control for individuals. As an increasing range of services become available, there is a greater need for clear and useful advice to be made available to people who fund their own care, as well as those whose care is funded by social services.

The Department of Health has commissioned a study to examine models for predictive risk modelling [3]. The outcomes of this were due to be piloted in 2008/09 with the aim of identifying people at risk of health or social care crises a year early and building the business case for prevention.

Figure 8.3 Modelled prevalence of Stroke by age for Islington resident population (aged 16+), compared to London and England, 2009

Source: Eastern Region Public Health Observatory, November 2008

Please note modelled estimates are based on input data prior to 2007



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[1] A system of equipment and services that support an older person's safety and independence in their own home.

RECOMMENDATIONS

To respond to the demographic change, the wishes of older people to remain at home and the increasing expectations for choice and control, our overarching objectives are to:

- Help people age well.
- Promote independence.
- Support more people at home for longer.

Given the national and local context, recommendations to prevent ill health and improve outcomes for older people include:

- Improving economic well being through higher levels of benefit take up and promoting the benefits of deferring retirement for those approaching 60 or 65.
- Working with voluntary sector partners to develop new opportunities for engagement with older people.
- Working with the voluntary and community sector to develop better outcomes for older adults by making it easier to access preventative, discretionary services.
- Continuing the development of community-based services such as extra care for older people with dementia to enable them to remain independent.
- Continuing the development of personalised health and social care services.
- Increasing access to services that enable people to self manage their care, e.g. telecare (1).
- Reviewing pathways out of hospital to ensure older people are given the opportunity for intermediate care, re-ablement and community support to prevent readmission.
- Piloting the falls pathway with London Ambulance Service and University of Swansea to look at more effective care for older adults with hip fractures.
- Working with partners in the North Central Sector to develop new stroke pathways.

9 Oral health

INTRODUCTION

Oral diseases are among the most common chronic diseases in the UK. Levels of oral diseases in Islington are relatively high with almost half of 5-year-olds suffering from tooth decay [1]. Oral diseases can have serious consequences in both adults and children, causing pain, poor dietary intake and psychological impacts [2] [3]. The distribution of dental decay is increasingly concentrated in vulnerable and socially disadvantaged groups [4]. The strong association between oral diseases and deprivation, and the fact that oral diseases are largely preventable, makes oral health a particularly important public health issue in Islington.

THE ISLINGTON PICTURE

Dental health of young children in Islington is among the poorest in North Central London, with almost half of five year olds experiencing tooth decay [1]. Children with decay have around four to five decayed, missing or filled teeth (dmft) compared to a population average of just under two decayed teeth per child (see **Figure 9.1**). This represents a considerable health inequality for an entirely preventable disease.

There is no local data on the oral health of adults in Islington, except for oral cancer which was no different to London and England [5].

Regional and national estimates suggest that adult oral health is improving in several ways [4]. The number retaining their teeth into older age is rising (see **Figure 9.2**); the average number of decayed teeth has dropped; and the proportion of younger adults, with a sound dentition, has risen dramatically from 9% in 1978 to 30% in 1998.

It is likely that regional and national data underestimate the local picture of dental decay because the borough has higher than average levels of deprivation which are strongly associated with poor oral health. The prevalence of oral diseases in adults is highest in areas of social deprivation (see **Figure 9.3**), similar to children.

NATIONAL DRIVERS FOR SERVICE PROVISION

Interventions to prevent oral diseases should be evidence-based and tackle general as well as oral health wherever possible. The most effective and efficient model for promoting oral health in the community is through the Common Risk Factor Approach (see Figure 9.4) (6). This method involves partnership working to address the risk factors shared by common chronic diseases. The common risk factor approach should be complemented with maximising fluoride delivery, e.g. fluoride toothpaste and varnish, in community settings.

As well as community settings, oral health promotion should actively prevent disease in practice settings. Practice-based oral health promotion should focus on implementing 'Delivering Better Oral Health' [7] – designed for use by the entire primary care dental team to deliver a more preventive approach, including an emphasis on fluoride delivery and the integration of generic health promotion, e.g. smoking cessation in practice settings. This approach is supported by the Healthy Children's Centres and Healthy Schools Programmes.

OPPORTUNITIES FOR DEVELOPMENT

COMMUNITY-BASED ORAL HEALTH PROMOTION

The efforts of the oral health promotion team are currently focused on children and older people. Other vulnerable groups are yet to be targeted [5]. Fluoride varnish is not yet being delivered at a community level due to limited capacity.

PRACTICE-BASED ORAL HEALTH PROMOTION

The model of the entire dental team delivering a more preventive approach in line with 'Delivering Better Oral Health'[7] is not being fully implemented in Islington.

As the impact of practice-based prevention is limited to those who attend a dentist regularly, it must be supplemented with community-based oral health promotion to avoid an increase in oral health inequalities.

Figure 9.1 Comparison of average dmft for 5-year-olds with decay experience versus all 5-year-old children, Islington, London and England, 2007-08

Source: NCHOD (Original data: BASCD co-ordinated NHS Dental Epidemiology Programme survey 2007/08)

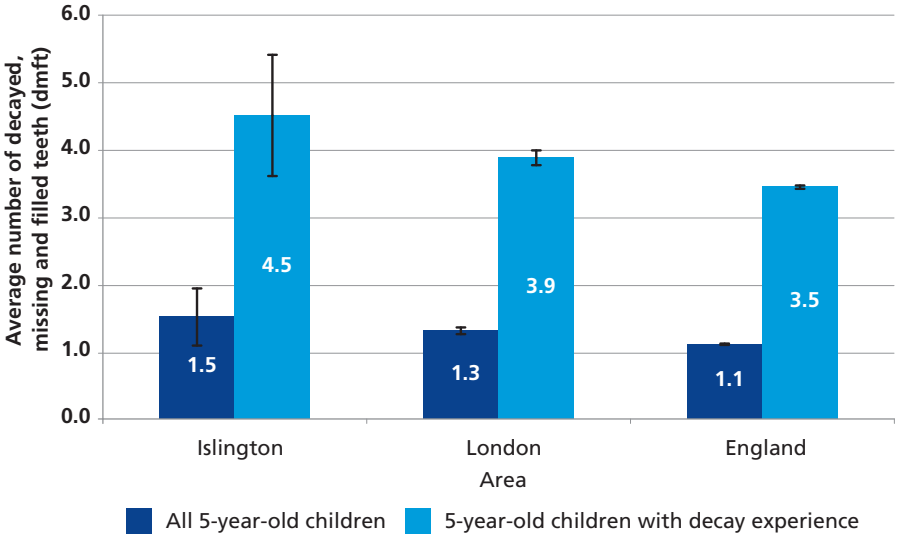


Figure 9.2 Percentage of adults with no natural teeth, England, 1968-1998

Source: National Adult Dental Health Surveys, 1968 to 1998. Kelly M, Steele J, Nuttall N, Bradnock G, Morris J, Nunn J, Pine C, Pitts N, Treasure E and White D (2000). In Choosing Better Oral Health, Department of Health (2005)

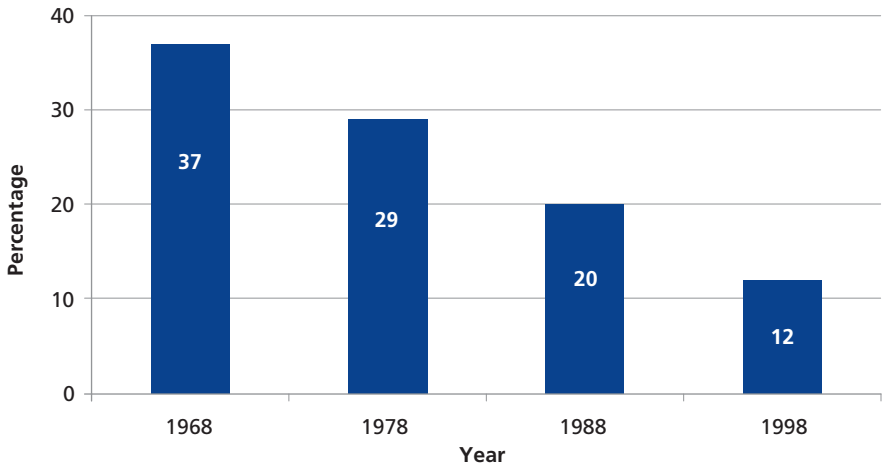


Figure 9.3 Percentage of adults with decayed/unsound teeth or periodontal (gum) disease by social class, United Kingdom, 1998

Source: Kelly M, Steele J, Nuttall N, Bradnock G, Morris J, Nunn J, Pine C, Pitts N, Treasure E, White D. Adult Dental Health Survey. Oral Health in the United Kingdom 1998.

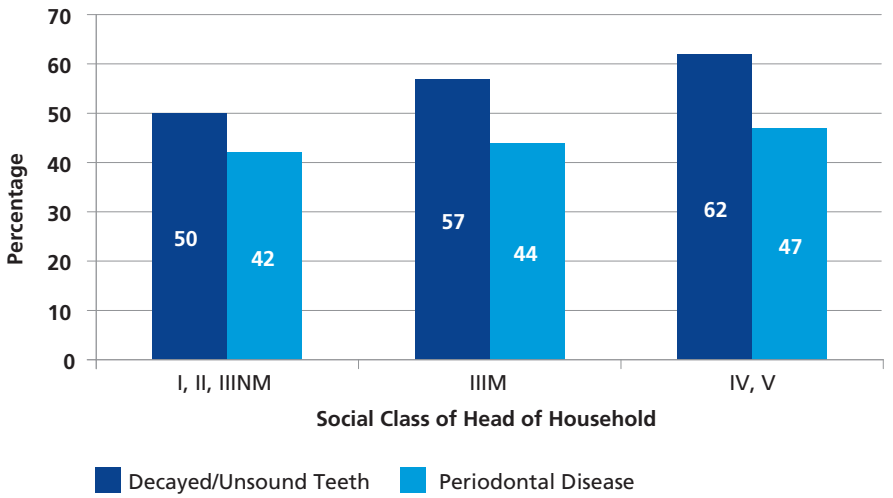
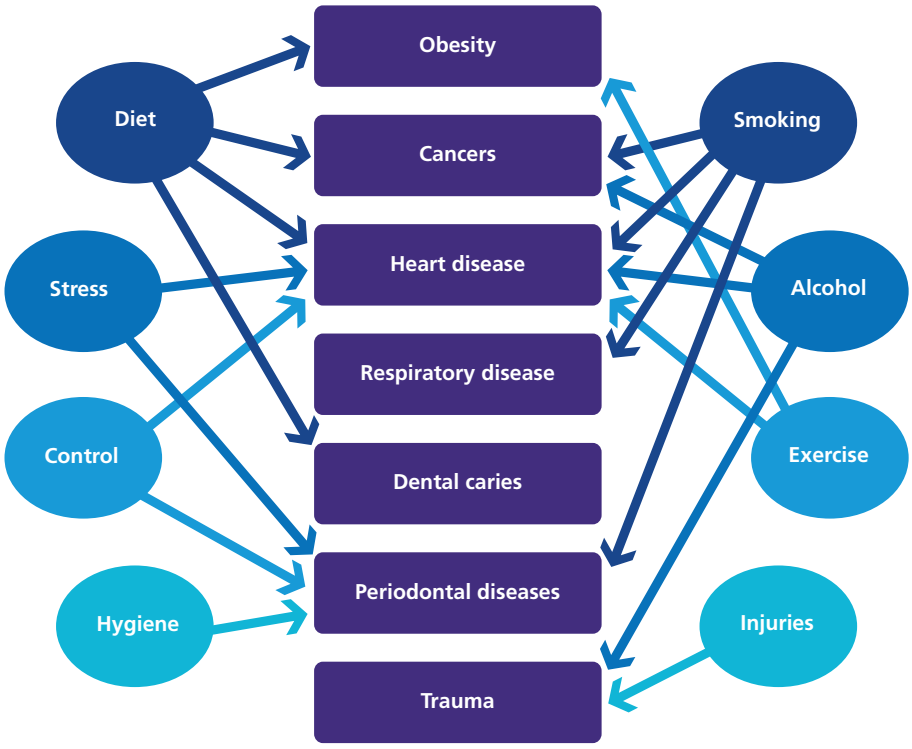


Figure 9.4 The Common Risk Factor Approach

Source: Sheiham and Watt, 2000 in Department of Health Choosing Better Oral Health. An Oral Health Plan for England. 2005.



RECOMMENDATIONS

Given the national context, the local picture in terms of data and the opportunities for development, key recommendations for improving oral health in Islington include:

- Tackling the social determinants of oral disease.
- Implementing the common risk factor approach.
- Actively preventing oral disease through community and practice-based prevention.
- Improving access to dental services, particularly for vulnerable groups.
- Improving the quality of oral health services.

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PART TWO **RISK FACTORS AND WIDER DETERMINANTS**

10 Employment and prosperity

INTRODUCTION

Material deprivation[1] and poverty[2] can affect people at all life stages. Exclusion from sustained employment is one of the main causes of both poverty and chronic ill health. Worklessness and irregular patterns of employment are linked to persistent poverty both during the working life and following retirement. Research suggests that relative poverty (living on less than 60% of median income) results in worse health and a greater chance of premature death (1).

[1] Material deprivation is usually defined as 'ownership of items regarded as "necessities" by the majority of the population'. (Maxine Willitts, Measuring child poverty using material deprivation: possible approaches', DWP Working Paper No. 28, 2006).

[2] Poverty is defined in the Child Poverty Bill in four ways, each related to a specific government target: relative low income; combined low income and material deprivation, absolute low income and persistent poverty. In this paper, 'poverty' refers to people in households below 60% median income (the relative income measure) or those in workless households.

Poverty is described as:

"The most important determinant of health, and also one of the most difficult areas in which to achieve change"(2).

This chapter will focus on the causes and consequences of income poverty and the interventions required to prevent and mitigate persistent poverty.

THE ISLINGTON PICTURE

Poverty, deprivation and worklessness are linked and contribute to poor health outcomes in Islington.

- Islington is ranked as the eighth most overall deprived of 354 English authorities, and the fourth most deprived in London (3).
- Indices of Multiple Deprivation (IMD) data show that the majority of Islington's Lower Super Output Areas (LSOA) fall in the bottom quintile nationally. However the data underestimates the scale of income deprivation in Islington as the figures pre date the current recession and its impact on levels of worklessness.
- Child poverty is measured as the proportion of children living in households on out-of-work benefits – 45.2% of Islington children live in workless households. This measure excludes households in low paid work, therefore underestimating the scale of child poverty in Islington.
- The general employment rate and the proportion of Islington residents on out of work benefits are significantly worse than the national average.
- An important indicator of economic wellbeing for young people is the proportion of those Not in Education, Employment or Training (NEET). Islington's rate of 7.7% is still high compared to the Central London average of 6.6% but has fallen substantially since 2005 when it stood at nearly 16%.

CURRENT SERVICE PROVISION

The Islington Strategic Partnership has set the reduction of poverty as the primary objective of its Sustainable Communities Strategy. Islington Council and

its partners have implemented a range of strategies that aim to maximise the income of local residents, promote employment, reduce fuel poverty and support people with problem debt.

There are a number of initiatives to address poverty and worklessness in Islington, delivered by a range of partners including: Jobcentre Plus, Islington Strategic Partnership, Learning and Skills Council, English for Speakers of Other Languages providers, Connexions, Camden & Islington NHS Foundation Trust, NHS Islington, and Housing and Adult Social Services. Poverty and worklessness have high prominence in Islington's Local Area Agreement.

Islington Council has also responded to the recession with a number of initiatives to support local residents, including a Freephone helpline and additional funding for information, advice and guidance services.

A child poverty pilot has attracted two years government funding for a casework service, targeting parents of younger children for interventions that will improve their employability through confidence building, basic skills training, providing access to affordable child care, and vocational training.

OPPORTUNITIES FOR DEVELOPMENT

Benefits, tax credits and employment support services are provided by a range of statutory providers including the Department for Work and Pensions, HM Revenues and Customs and the local council. Additionally, there are a range of ancillary services including information advice and guidance, child care services, training and skills and social care support.

Residents can contact these services for further information on how to make more effective use of existing benefits and employment support provision. While there are undoubtedly gaps in service provision, most glaringly is the availability of affordable child care. In addition one of the most serious barriers facing local residents is the complexity arising from the lack of integrated working across the agencies responsible for current service provision.

RECOMMENDATIONS

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

TO ACHIEVE THIS VISION, IT IS RECOMMENDED THAT:

1. Implementation of the recommendations from the 2008 JSNA be further developed.
2. The Islington Strategic Partnership seeks to realise improved effectiveness and efficiencies by co-ordinating the strategies, commissioning and action planning of services which focus on income maximisation, reducing NEETs, worklessness, child poverty, debt and fuel poverty through a co-ordinated anti-poverty programme.
3. Service interventions related to poverty should be linked with relevant local strategies and policies of partner organisations, for example the Islington Health Inequalities Strategy.
4. The anti-poverty programme should form the focus for integrating actions to mitigate the impact of the recession, with the new duties anticipated from the Child Poverty Bill and the duty to carry out a local economic assessment.
5. The anti-poverty programme should support the objectives of the SCS by:
   - Mitigating the impact of the recession on young adults.
   - Preventing the newly unemployed from becoming long-term unemployed.
   - Continuing to prioritise child poverty.
   - Mitigating the poverty experienced by older people and those unable to enter the labour market through targeted income maximisation.

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11 Housing and homelessness

INTRODUCTION

Decent affordable housing is a cornerstone of good health and a major determinant of health inequalities. Badly designed and poorly built houses with inadequate heating, damp, lack of space, poor lighting and shared amenities are a major contributor to poor health. Poor housing and homelessness are not just a housing problem. They have profound implications for the health and social wellbeing of the people affected, and for society as a whole [1] [2].

Housing within Islington is a market of extremes. At one end, the borough contains properties at the high end of London prices occupied by high income households, whilst at the other end many residents live on low incomes in social housing.

[1] 'Bedroom Standard' is used as an indicator of occupation density. A standard number of bedrooms is allocated to each household according to the age, sex and marital status of household members and their relationship to each other.

THE ISLINGTON PICTURE

HOMELESSNESS

Homelessness leads to poor physical and mental health [3]. Compared to neighbouring boroughs the number of rough sleepers in Islington has been low. The London-wide street count, carried out during one night in November 2009, reported four bedded street homeless people in Islington.

Levels of statutory homelessness in Islington have reduced overall since 2001/02 by about 78%. At the end of March 2009, Islington had 875 households placed in some form of temporary accommodation, including 329 households in hostel or annexe accommodation.

OVERCROWDING

Overcrowding is associated with increased physical and mental health problems and poor educational achievement. Islington has an overcrowding rate of 6.9% (defined using the Bedroom Standard[1]), equating to 6,100 overcrowded households, mostly concentrated in the social-rented sector. The majority of overcrowded households live in flats, and two thirds of overcrowded households contain children.

AFFORDABLE HOUSING AND HOUSEHOLDS IN NEED

The Islington Housing Needs Assessment 2008 [4] estimates 18% of Islington households (approximately 15,500 households) are living in unsuitable accommodation. Households in the rented sectors (particularly the social-rented sector) accounted for more than 90% of this need.

Table 11.1 Percentage of council homes in Islington at a decent standard

	Year						
	Performance					Target	
	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Percentage of homes of a decent standard	45	51	55	63	75	95	100

POOR QUALITY OF EXISTING HOUSING STOCK

Damp housing is associated with cold indoor temperatures and is caused by substandard construction and materials, inadequate heating systems and lack of ventilation. At the end of March 2009, 75% of council homes had met the Decent Homes Standard, which are homes defined as being warm, weatherproof and having reasonably modern facilities (**Table 11.1**).

Some groups are at particular risk from the lack of appropriate secure housing or poor quality housing. Groups including older people, the disabled and people suffering from long term physical and mental health conditions are disproportionately more likely to occupy poor housing stock. The Islington Housing Needs Survey 2008 showed:

- Children and young people were significantly over-represented among households in unsuitable housing in Islington.
- Older people, particularly single older people, were more likely to live in unsuitable housing, have problems maintaining their home, live in fuel poverty and in non-decent homes.
- People with special needs accounted for over 17,000 households (almost 20%) in Islington. These were predominantly people with physical disabilities and frail older people.

THE NATIONAL CONTEXT

There is no ideal model for providing housing services and each borough adopts a different approach. Government and opposition parties are encouraging councils to use their own innovative solutions to housing problems.

The lack of affordable social rented housing in Islington means increasing use is made of the private rented sector for vulnerable and low income households, especially as there is a Government target to reduce the use of temporary accommodation by 50% by March 2010. There are a range of initiatives in place to assist households to maintain their tenancy.

The Council's housing strategy team have also established a Homelessness Forum to bring statutory and voluntary and community sector agencies together to improve the way that services respond to the needs of people who are homeless or at risk of homelessness.

OPPORTUNITIES FOR DEVELOPMENT

The Council recently took part in a pilot survey to understand the experiences and needs of rough sleepers in Islington and their access to services. One of the findings was the need for effective advice to be available for those sleeping rough at times when they find themselves homeless or vulnerably housed.

During the development of the Council's housing strategy, feedback included concerns about improving the quality of advice offered by frontline agencies and the council's own housing advice services. A package of training sessions for community groups in Islington is aimed at developing advice skills and improving access to specialist advice services.

All of Islington council's affordable housing is gained via Section 106 agreements.[2] The recent downturn in the housing market is likely to result in fewer new homes being developed and fewer Section 106 agreements. This is impacting on the supply of new affordable housing and meeting the need for larger family-sized homes to reduce overcrowding.

[2] Section 106 of the Town & Country Planning Act 1990 allows a Local Planning Authority (LPA) to enter into a legally binding agreement (planning obligation) with a land developer over a related issue. S106 Agreements can act as a main instrument for placing restrictions on the developers, often requiring them to minimise the impact on the local community and to carry out tasks which will provide community benefits.

RECOMMENDATIONS

1. **Reduce homelessness and improve access to accommodation** including a strong emphasis on prevention of homelessness.
2. **Tackling overcrowding** by developing more, larger sized homes, promoting more efficient use of existing homes through under occupation schemes and family support strategies for the severely overcrowded.
3. **Increase affordable housing** and address the needs of vulnerable groups, by encouraging developers to build to the Lifetime Homes Standards and increasing floating support.
4. **Improving the quality of existing stock** by achieving the Decent Homes Standard by 2011, improving poor quality private sector homes and promoting energy efficiency schemes for vulnerable households.
5. **Neighbourhood renewal** – Contribute to achievement of sustainable communities, including tackling worklessness.
6. **Regeneration and planning** – Encourage developers to undertake health and social impact assessments and engage with residents prior to regeneration schemes.

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12 Educational attainment and learning

INTRODUCTION

There is a positive link between educational attainment and health [1], with the longer people spend in education and the higher their educational attainment, the better their overall health and healthy lifestyle behaviour [2].

Education builds skills, confidence and learning; helps to promote and sustain healthy lifestyles and choices; supports and nurtures human development and human relationships; and supports the development of personal, family and community wellbeing [2][3][4].

Table 12.1 Percentage of pupils attaining Level 4+ at Key Stage 2 in English, Maths and Science, 2004 and 2009

Source: DCSF Key Stage 2 results 2008/2009

	Percentage								
	English			Maths			Science		
	2004	2009	change	2004	2009	change	2004	2009	change
Islington	71	78	7	68	78	10	79	87	8
Statistical Neighbours [1]	75.5	78	2.5	70.5	78	7.5	82	86	4
National	78	80	2	74	79	5	86	88	2

1. Figures are median value of Islington's statistical neighbours

Table 12.2 Percentage of pupils attaining 5+ A* to C grades at Key Stage 4 (GCSE & equivalent) 2004 and 2009 (provisional)

Source: DCSF GCSE and equivalent results in England, 2008/09

	5+ A* to C GCSEs or equivalent qualifications including a C or higher in both English and Maths			5+ A* to C GCSEs or equivalent qualifications		
	2004 [2]	2009	change	2004 [2]	2009	change
Islington	28.9	45	16.1	46	65.3	19.3
Statistical Neighbours [1]	45.8	50.7	5.1	45.8	68.7	22.9
National	42.7	49.7	7	53.7	70	16.3

1. Figures are the median value of Islington's statistical neighbours
2. 2004 figures use the number of 15 year olds as the denominator, the 2009 use the number of year 11 pupils.

THE ISLINGTON PICTURE

In Islington, 44% of children and young people (0-19 years) are from BME groups, 43% do not have English as their first language, 43% live in households claiming benefits, and approximately 40% live in overcrowded conditions. Islington has an average of 140 children at any one time in need of child protection. There is an average of 320 children looked after in care at any one time, predominantly for reasons associated with abuse or neglect. Children in care tend to have poorer educational and health outcomes compared to children who are not looked after and one in five are likely to have a mental health problem.

Outcomes for children in Islington at the end of the Foundation Stage (approaching age 5) are lower than those for children nationally. The gap between the 20% lowest performing children and all children in 2009 was 38.2% in Islington – higher than the national gap of 33.9% [5].

The proportion of pupils achieving level 4 or above (benchmark score

RECOMMENDATIONS

Islington has high aspirations for its children and young people, and aims to ensure that every child gets an equally rich start in life and becomes equipped with the skills and knowledge to make the very best of her or himself, regardless of background or home situation. In particular:

- To provide the best start in life for young children and support their learning, development and achievement through an outstanding range of early years settings with associated excellent children's services building on the Children's Centre model and best practice nationally and internationally.
- To raise standards of achievement and attainment; to narrow the gap in attainment between different groups in the borough and meet or exceed the best performance nationally. To achieve this through effective partnership between schools, children's services, pupils, parents and the wider community.
- To positively change the life chances of the most disadvantaged members of the community with a specific emphasis on improving the pathways into education, employment and training for young people.
- To build on the strength of our schools and educational settings and support and challenge them to move from good to great so that we have outstanding provision across all phases of education.
- To support community capacity, social cohesion and wellbeing through schools and children's centres that are 'fit for purpose' and provide centres of learning for their communities

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for comparisons) for key stage 2 (age 11) in 2009 was 70%, similar to 2008. Performance at key stage 2 in Islington has improved much faster than nationally in recent years and children are now attaining close to the national average overall (see **Table 12.1**).

The percentage of children achieving 5 or more A* to G GCSEs and 5 or more A* to C GCSEs or equivalent grades has increased in the past five years (see **Table 12.2**), but remains below the national average. The proportion of students achieving 5 or more A* to C grades including English and Maths has risen to 44.9% from a low base of 28.9% in 2004.

There are a number of inequalities associated with these educational outcomes, for example in those eligible for free school meals (although the gap here is smaller than for England); and for particular ages, gender, ethnic and vulnerable groups.

The percentage of young people attaining a Level 3 qualification (A levels and equivalent) remains below national and London averages. However, Islington students from low income families are doing relatively better at this age than similar students both nationally and in London. The attainment gap between those who had been eligible for free school meals and those not, is just 1% for Islington compared to 25% nationally.

13 Smoking

INTRODUCTION

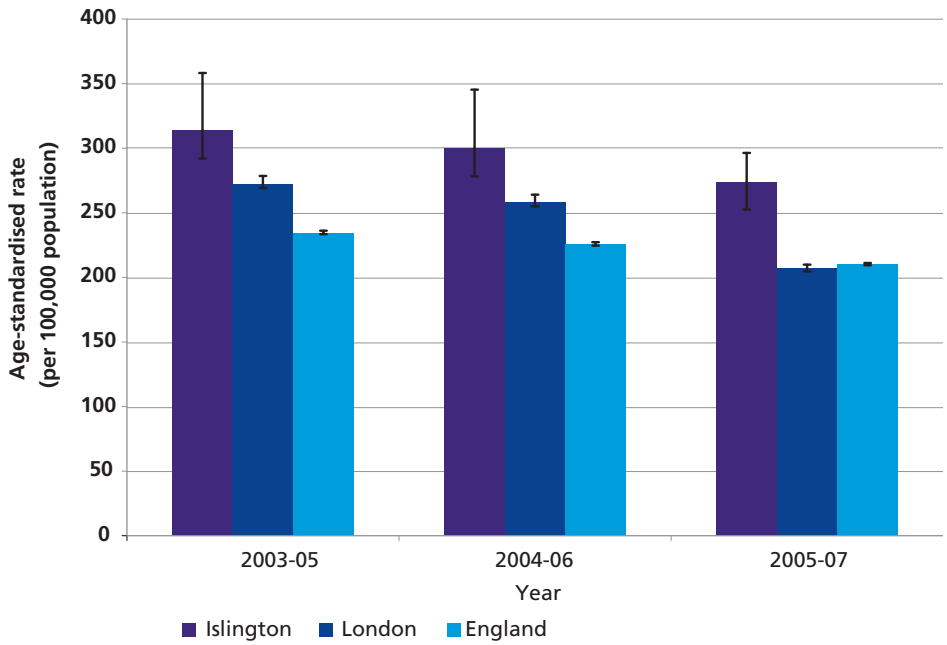
Smoking remains the single most important preventable cause of early death and ill health and is a major contributor to health inequalities both nationally and locally. Smoking contributes to a number of health problems including circulatory disease, diabetes and cancer. Nicotine is highly addictive and harms almost every organ of the body. Inhaling second hand smoke is also harmful and contributes to lung cancer, heart disease, asthma and strokes. Exposure to secondhand smoke among children is associated with sudden infant death, respiratory and ear problems. Unborn children exposed to maternal smoking are at risk of low birth weight, foetal death and preterm delivery.

THE ISLINGTON PICTURE

Smoking accounts for a major burden of ill health in Islington. Mortality attributable to smoking in those aged over 35 years in the borough is significantly higher than for London and England (**Figure 13.1**).

Figure 13.1 Directly standardised death rate attributable to smoking for those aged 35 years and over, per 100,000 population, Islington, London and England, 2003-05, 2004-2006, 2005-07

Source: London Health Observatory, APHO Health Profiles



Smoking deaths were due mainly to chronic obstructive pulmonary disease (COPD), cardiovascular diseases (CVD) (heart disease and stroke being the major causes of death) and smoking related cancers (lung, pancreas, bladder, kidney, larynx, mouth, pharynx, oesophagus, stomach, cervix and acute myeloid leukaemia). Lung cancer is by far the most important type of malignant disease affecting the population: Islington has the highest incidence and third highest mortality from lung cancer of all the London boroughs (**Figure 13.2**).

Mortality from lung cancer remains the single most important cause of Islington's continuing higher rate of premature cancer mortality and is the only type of cancer which has a significantly higher rate of mortality compared to London and England.

Figure 13.2 Directly age-standardised incidence rates of trachea, bronchus and lung cancer per 100,000 population by area of residence, PCTs in London SHA: 2005-07 (pooled)

Source: Thames Cancer Registry

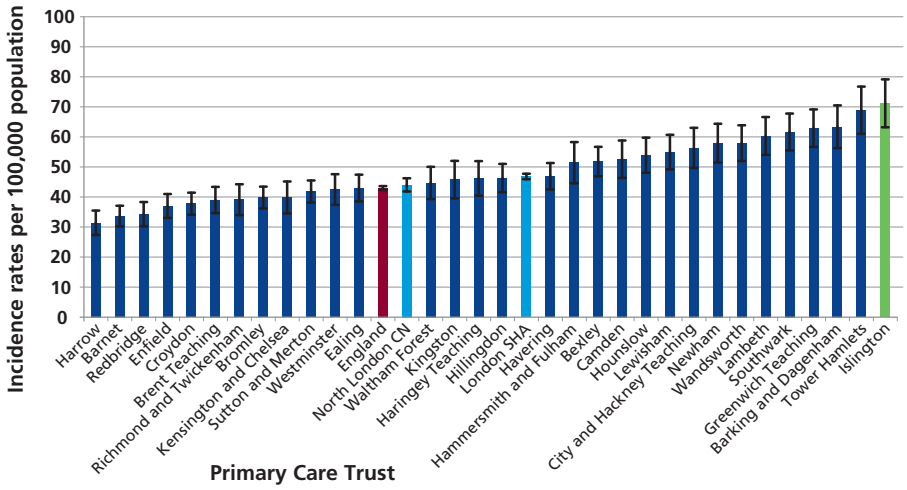


Figure 13.3 Estimated smoking prevalence in residents aged 16+ years, London PCTs, 2003-05

Source: Health Survey for England, 2003-05

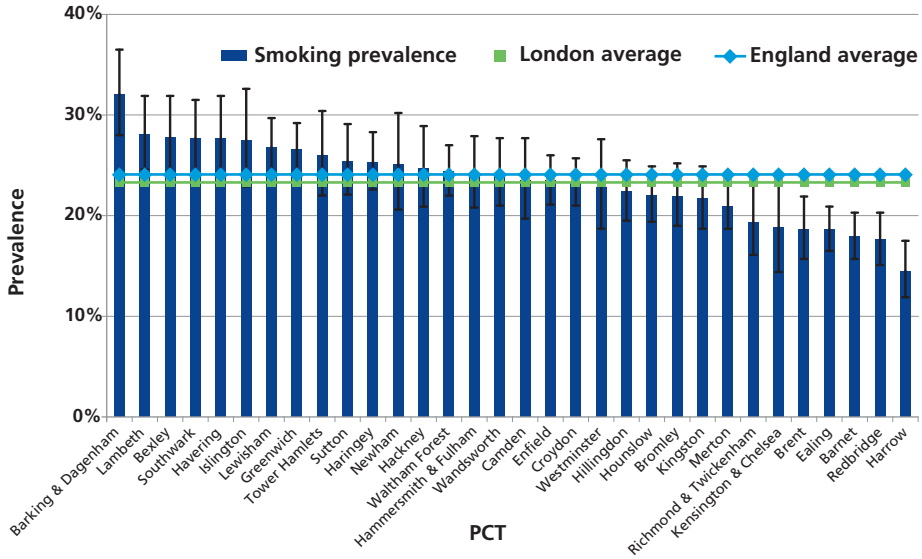
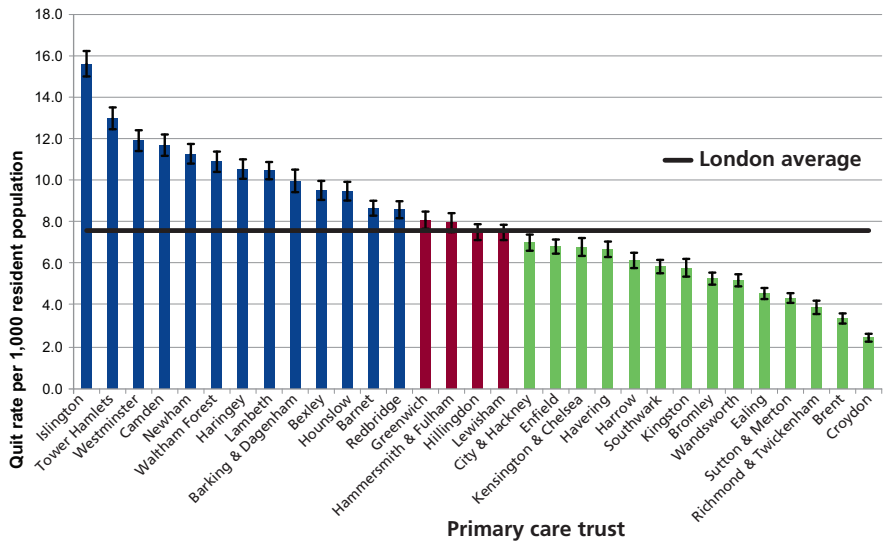


Figure 13.4 Smoking quit rate per 1000 population, London PCTs, 2008/09

Source: Islington Stop Smoking Service, 2009



Although work to promote symptom awareness, early presentation, prompt diagnosis and effective treatment continues to be significant in Islington, reducing the level of smoking in the Islington population is the most important intervention for reducing both premature and all age mortality from cancer.

The modelled estimate of adult smoking prevalence in Islington's resident population is 27.5%, which is higher than the rate for England at 24.1%. It should be noted that the confidence intervals around these estimates are wide, meaning Islington is not statistically different to most other London boroughs, or to the London and England averages. Based on the modelled estimates Islington ranks sixth highest out of all London boroughs and this equates to approximately 44,500 adult smokers in 2009 (**Figure 13.3**).

Smoking prevalence varies by ethnicity and socio-economic status and is more common in areas of deprivation. Key target groups for reducing smoking rates and preventing the uptake of smoking are:

- Routine and manual occupations.
- Bangladeshi, Irish, Somali and Pakistani men.
- Mental health service users, particularly those in inpatient settings.
- Prisoners.
- Pregnant women.
- Children and young people.

Between April 2008 and March 2009 4,454 smokers accessed NHS stop smoking support in Islington. The service achieved a four-week quit rate of 56%, which means that just over half of the smokers accessing stop smoking support were able to quit. Islington exceeded its four-week quit target of 2,468

to achieve 2,480 quitters, which was the highest achievement in the London region in terms of both the absolute number of quits, and the quit rate per 1,000 population aged 16 years and over (**Figure 13.4**).

NATIONAL DRIVERS FOR SERVICE PROVISION

The ideal model for the provision of cessation support is set out by Department of Health [1] guidance, which incorporates the evidence base for effective interventions and treatment supported by NICE. Current service provision in Islington adheres to the recommended delivery model, with cessation support commissioned from general practice, community pharmacies and the acute and voluntary and community sectors. All providers operate under service level agreements and either have annual quit targets or a payment by results incentive scheme. All providers are performance managed by Public Health.

Islington's Stop Smoking Service provision focuses on target populations, working with particular target groups or in certain target settings, including: young people, BME communities, mental health, social housing, and prisons, as well as having a remit to provide support to trained advisers from any setting.

REFERENCE LIST

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RECOMMENDATIONS

- Develop and implement a comprehensive communications and marketing plan in Islington to challenge the culture in which smoking is the norm and to create an environment and culture that is tough on illegal and counterfeit sales, and drives smokers to stop smoking.
- Continue to plan, coordinate and monitor delivery of activities that demonstrate effective joint agency working to reduce smoking prevalence, supported by the Local Area Agreement and via the Smokefree Alliance.
- Conduct an independent "peer review" to assess Islington's current approach to tobacco control and reducing smoking prevalence.
- Monitor compliance with Smokefree policies across all council and health departments and organisations in Islington and ensure action is taken where enforcement is inadequate and/or policies are being breached.
- Ensure that a range of accessible and appropriate communication channels are used to prevent young people from starting smoking and to educate those communities most affected by the health inequalities caused by smoking.
- Apply social marketing techniques and population segmentation to further understand the culture of smoking and smokers in Islington, to increase access to cessation support services in appropriate settings and to develop targeted marketing and educational interventions.
- Develop and promote the business case for local employers to reduce smoking prevalence amongst their employees and enforce Smokefree legislation that applies to company vehicles.
- Embed smoking cessation advice or referral in pre-operative, post-operative and antenatal care pathways.
- Build staff capacity to deliver effective cessation support in mental health settings, and in both HMP Holloway and Pentonville prisons.

14 Healthy eating

INTRODUCTION

A well-balanced diet is important for good health and involves consuming a wide range of foods, including fruit and vegetables, starchy whole grains, dairy products and lean protein. Government recommendations suggest at least five portions of fruit and vegetables per person per day [1].

A poor diet can have significant impacts on health and the development of a range of illnesses. However, food choices are influenced by many factors, such as individual responsibility, social class and community culture and environment. A combination of interventions (like education, promotion of healthy options and creation of supportive environments) are required to sustain healthy eating across the population.

THE ISLINGTON PICTURE

FRUIT AND VEGETABLE CONSUMPTION

Fruit and vegetable consumption in Islington is similar to levels for England and London. Within Islington more women are likely to eat five or more portions of fruit and vegetables every day. Older adults (55 years +) are less likely to consume the recommended amount of fruit and vegetables compared to those aged 16-34 years and 35-54 years. In general, higher socio-economic groups tend to consume more fruit and vegetables than the routine and manual groups.

OBESITY

The prevalence of obesity in Year 6 children in Islington is higher than levels of obesity in England but comparable to those in London (**Figure 14.2**). Rates of obesity in reception children are higher than those in London and England (**Figure 14.1**).

The prevalence of obesity in adults living in Islington is estimated to be 10% (confidence interval 5.1% to 14.9%) which is lower than the London level of 16.5%. The prevalence of overweight in adults is estimated to be 32.8% which compares to 34.3% for London [2].

Table 14.1 Prevalence of overweight and obesity amongst year reception children, Islington, London and England, 2008/09

Source: National Childhood Measurement Programme results 2008/09

	Percentage	
	Overweight	Obese
Islington	11.9	12.6
London	12.4	11.2
England	13.2	9.6

Table 14.2 Prevalence of overweight and obesity amongst Year 6 children, Islington, London and England, 2008/09

Source: National Childhood Measurement Programme results 2008/09

	Percentage	
	Overweight	Obese
Islington	15.7	21.4
London	14.7	21.3
England	14.3	18.3

NATIONAL DRIVERS FOR SERVICE PROVISION

National Institute for Health and Clinical Excellence (NICE) guidance on obesity [3] identified some key factors that influence a person's ability to maintain a healthy weight, which should be taken into account when planning and delivering interventions. These include:

- Individual readiness to make changes.
- Barriers to lifestyle change, including knowledge, socio-economic factors, environmental factors, personal tastes, views of family and community members, low levels of fitness and disabilities, low self-esteem and lack of assertiveness.

The Government's main strategy relating to healthy eating, 'Healthy Weight: Healthy Lives' [4] outlines five key themes to prevent and manage overweight and obesity. The five themes are:

- Children: healthy growth and healthy weight.
- Promoting healthier food choices.
- Building physical activity into our lives.
- Creating incentives for better health.
- Personalised advice and support.

NICE [5] also provides recommendations for service provision with respect to maternal and child nutrition, covering breastfeeding policy and programmes, promotion of the Healthy Start Scheme and continuing professional developments.

Healthy eating interventions need to be tailored to the different BME groups addressing cultural acceptability and recognition of different health behaviours.

RECOMMENDATIONS

Achieving healthy eating across Islington requires collaboration and coordination across all agencies. Interventions should be at the universal or population level as well as being targeted at particular groups. Given what we know about healthy eating and obesity in Islington, coupled with our knowledge of best practice, key recommendations include:

UNIVERSAL INTERVENTIONS

- Promote the Healthy Start scheme.
- Support the implementation of UNICEF baby-friendly initiative within the community and local hospitals.
- Provide training for Early Year's staff on effective healthy eating interventions
- Support Children's Centres with the implementation of the Healthy Children's Centre Programme.
- Implement and monitor the Islington Food Strategy and accompanying action plan.
- Develop local schemes to encourage businesses to promote healthy eating via increasing availability of healthier choices.
- Develop incentives to encourage fast food outlets to increase provision of healthy alternatives.
- Use social marketing techniques to understand more about the factors that influence local people's diet, in particular vulnerable groups.
- Integrate oral health messages into healthy eating promotion ensuring consistency of messages across services.
- Support community-based healthy eating projects ensuring tailored advice for vulnerable groups.
- Ensure obesity care pathways are in place for all age groups and are implemented and evaluated accordingly.
- Develop a commissioning framework for weight management interventions for all ages.
- Increase the uptake of school meals.

TARGETED INTERVENTION

- Target breastfeeding initiatives to groups and local communities with lower levels of breastfeeding.
- Target schools and local communities using local data such as childhood obesity and segmentation data and provide training and support regarding healthy eating.
- Ensure healthy start maternal vitamin supplements are available for healthy start recipients and those able to purchase them.
- Disseminate and utilise the findings from the young people's social marketing scoping exercise.
- Develop social marketing for low income, BME, mental health and vulnerable groups.
- Implement peer education initiatives within BME communities
- Support those in low income, vulnerable and BME groups to increase consumption of fruit and vegetables.
- Ensure that services reflect the local population profile in areas of high deprivation and include disabled people.

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15 Physical activity

INTRODUCTION

Physical activity is a broad term to describe force exerted by muscles in the body that results in energy expenditure above resting level. It can be as simple as everyday walking, cycling or gardening or take the form of organised, competitive sport.

Increasing physical activity levels can improve individual quality of life and reduce the risk of premature mortality or morbidity from diseases associated with inactivity. People who are physically active reduce their risk of developing coronary heart disease, type two diabetes [1], colon and breast cancers [2] [3], obesity [4], depression [5] and osteoporosis [6].

The average annual cost of physical inactivity to PCTs in London is estimated to be at least £105 million [7].

THE ISLINGTON PICTURE

Sport England's Active People Survey results showed that the proportion of adults (aged 16 years and over) undertaking 30 minutes of moderate physical activity on at least three days per week increased in 2008. Adult physical activity levels in Islington were higher compared to levels in London and England (**Figure 15.1**).

Islington specific demographic data for the 2008 Active People Survey is not yet available. Therefore data from 2006 and 2007 are outlined.

National data shows a sharp decline in physical activity among older age groups. A similar pattern is seen amongst adults in Islington, with levels of physical activity decreasing with increasing age (**Figure 15.2**).

In line with national trends, lower levels of physical activity are also observed in people with a limiting disability and in lower socio-economic groups.

Table 15.1 Proportion of adults (aged 16 years +) undertaking 30 minutes of moderate physical activity on at least three days per week, 2008

Source: Sport England: Active People Survey, 2008/9.

	Percentage		
	Active People Survey 1 (2006)	Active People Survey 2 (2007)	Active People Survey 3 (2008)
	Persons	Persons	Persons
Islington	24.0	20.9	24.2
London	21.3	20.2	21.2
England	21.0	21.3	21.6

Table 15.2 Proportion of adults (aged 16 years +) undertaking 30 minutes of moderate physical activity on at least three days per week, by age group

Source: Sport England: Active People Survey 2, 2007

		Percentage		
	Age group	England	London	Islington
Active People Survey 1, 2006	16-34	25.5	27.9	31.0
	35-54	15.4	21.4	21.5
	55+	6.7	11.1	10.8
Active People Survey 2, 2007	16-34	26.9	25.9	29.1
	35-54	16.0	20.3	17.1
	55+	7.8	11.5	8.6

NATIONAL DRIVERS FOR SERVICE PROVISION

There are two key national targets around physical activity:

- To reduce the proportion of overweight and obese children to 2000 levels by 2020.
- In addition to sustaining the target of 85% of schoolchildren doing two hours high-quality PE each week, to offer every child and young person (aged 5-19 years) an extra three hours per week of sporting activities provided through schools, colleges, clubs and community providers, by 2011 [10].

The National Institute for Health and Clinical Excellence (NICE) leads the evaluation of public health evidence for physical activity interventions. NICE recommend effective interventions at the whole population and at targeted levels. Guidance centres around four areas:

1. Promotion of a supportive built environment to encourage physical activity through facilitating active travel such as cycling and walking, use of parks and green spaces and opportunities for active and unstructured play [8].
2. Promotion of workplace physical activity through appropriate workplace policies, wider strategies and engagement from trade unions [9].
3. The promotion of physical activity, active play and sport for children and young people [10].
4. Commonly used methods to increase physical activity in primary care including brief interventions (opportunistic advice, negotiation or encouragement), exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling [11].

RECOMMENDATIONS

The Pro-Active Partnership, involving a range of stakeholders across the borough, has developed a five-year strategy and action plan. In parallel to this, an action plan has been developed to maximise the opportunities presented by the London Olympics and Paralympics.

WHOLE POPULATION INTERVENTIONS

- Partners should continue to support the Pro-Active Partnership, strategy and action plan
- Performance indicators and a performance management framework should be developed to evaluate physical activity interventions
- Partners should continue to support local initiatives and mass participation events promoting physical activity
- Active travel opportunities should be promoted and accessible to all sections of the local population
- Pro-Active partners should work with and provide training to a range of professionals such as town planners, travel planners and social workers to increase their awareness of the importance of physical activity
- The delivery of the Islington Olympic Board 2012 Action Plan should be supported

TARGETED INTERVENTIONS

- Partners should continue to develop activity-friendly environments with a particular focus on the most deprived areas
- Social marketing techniques should be used to better understand our population segments and to target the most inactive groups within local communities
- The 'Ever Active' programme (classes and magazines aimed at increasing participation in physical activity in older people) should be expanded by creating more opportunities for participation and volunteering
- A single-point-of-contact should be established to better communicate and promote existing activities
- Programmes should be developed which provide support for parents and carers to be physically active with their young (0-5 year old) children.
- Links with the health check programme should be optimised to target sedentary adults at risk of chronic disease due to inactive lifestyles

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(7) Department of Health. *Be Active, Be Healthy.* 2009.

(8) National Institute for Health and Clinical Excellence. *PH8 Promoting and creating built or natural environments that encourage and support physical activity.* 2008.

(9) National Institute for Health and Clinical Excellence. *P13 Promoting physical activity in the workplace.* 2008.

(10) National Institute for Health and Clinical Excellence. *P17 Promoting physical activity, active play and sport for pre-school and school-age children and young people in family, pre-school, school and community settings.* 2009.

(11) National Institute for Health and Clinical Excellence. *PH 2 Four commonly used methods to increase physical activity.* 2006.

16 Childhood immunisation

INTRODUCTION

Immunisation is one of the most effective, safe and cost-effective health interventions. Vaccination policy aims to protect individuals and communities from the risks of infectious diseases. Immunisation rates in Islington and London have been consistently lower than the national average, and well below 'herd immunity' levels.

'Herd immunity' refers to levels of vaccination coverage (usually around 95%) sufficiently high to prevent any sustained transmission of infection, protecting everyone in the population whether they have been vaccinated or not. National and local policy aims to achieve these levels of immunisation coverage. Since immunisation rates have been significantly below these levels in Islington and London, there is greater risk of outbreaks of diseases such as measles, mumps or rubella.

THE ISLINGTON PICTURE

In recent years, childhood immunisation rates have tended to be lower in Islington than the national average (as **Figures 16.1** and **16.2** show) and below the recommended level of 95% necessary to prevent outbreaks. Measles Mumps Rubella (MMR) vaccination has been particularly affected, following public concerns over safety. Factors linked to lower immunisation coverage in Islington include high population mobility and greater deprivation.

Islington's immunisation rates have shown increases since 2006/07, with significant improvements in the past year. Rates are now above the London average, and the gap with England has been significantly narrowed. There are still inequalities in immunisation uptake within Islington, particularly affecting disadvantaged families and children. Targeted work with Looked after Children ensured that 89% were fully up to date with their immunisations in 2008.

Recent action to increase uptake of immunisations are part of Islington's Childhood Immunisation Strategy and Action Plan (2009), which has invested and targeted resources to:

- The establishment of an immunising team, headed by an immunisation specialist and to include a nurse co-ordinator and administration post
- The further development of immunisation clinics within Children's Centres and improved access
- Better data quality and accuracy, leading to improved targeting and follow up of unimmunised children

Figure 16.1 Coverage of Diphtheria/Tetanus/Whooping Cough/Polio/Hib meningitis vaccination measured at age one year, Islington, London and England, 2006/07 – Quarter 1 2009/10

Source: HPA COVER quarterly vaccine coverage tables

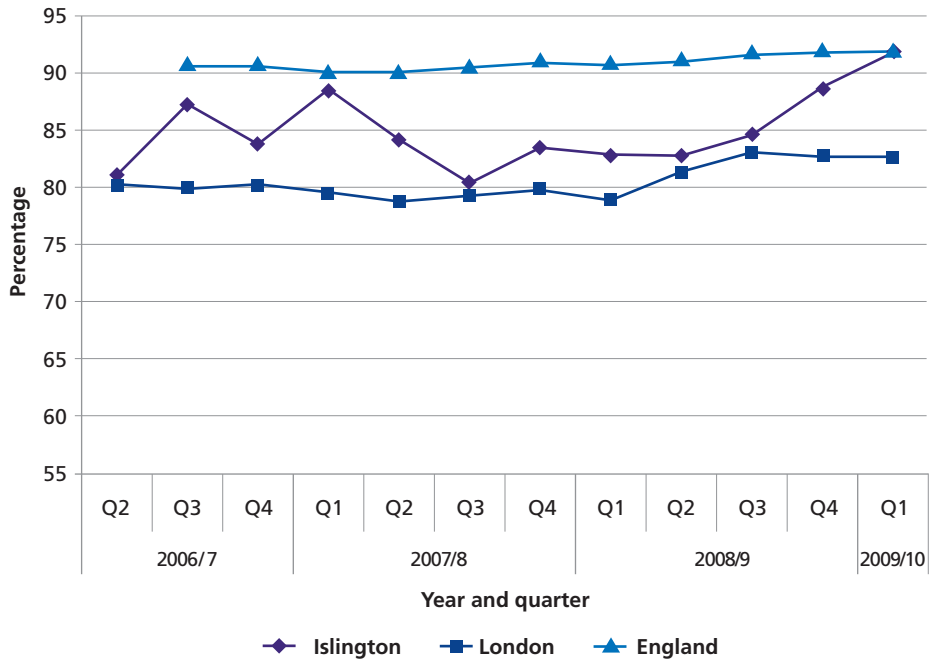
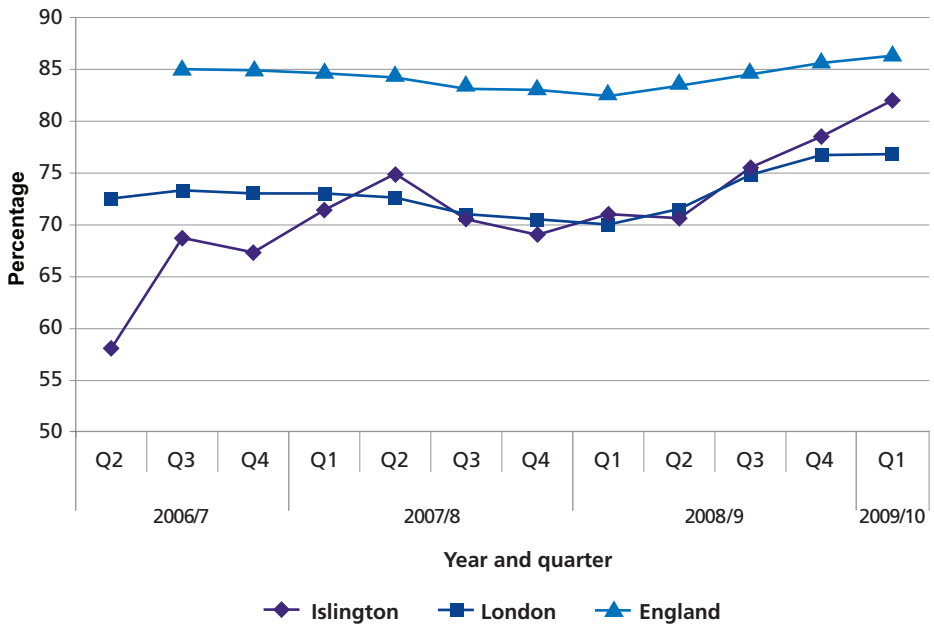


Figure 16.2 Coverage of MMR, measured at age two years, Islington, London and England, 2006/07 – Quarter 1, 2009/10

Source: HPA COVER quarterly vaccine coverage tables



NATIONAL DRIVERS FOR SERVICE PROVISION

The national immunisation programme covers courses of primary immunisations, together with booster doses to maintain ongoing immunity, for a range of diseases such as Measles Mumps Rubella, Hib meningitis, diphtheria, tetanus, polio, whooping cough and meningitis C. As well as the universal national immunisations, neonatal hepatitis B vaccination is given to babies born to mothers who are hepatitis B positive, to reduce the risk of mother-to-child transmission, and neonatal BCG vaccination for Tuberculosis (TB) is given to babies in areas where there is a high level of TB.

The majority of primary childhood immunisations are carried out by GP practices, with others carried out by universal child health services. In Islington, 31 out of 38 practices provide immunisations and immunisations are also carried out in clinics at health centres and Children's Centres. There are school-based programmes, including the new HPV vaccination programme for girls designed to protect young women from the most common types of HPV that cause cervical cancer. In 2008/9, the school-based HPV programme vaccinated 66% of Year 8 schoolgirls in Islington.

Islington's immunisation strategy has been based on models of effective practice, including Heart of Birmingham and Luton. Both areas have driven up immunisation rates through:

- Coordinated programmes informed by improved data flow, accuracy and quality.
- Targeting of areas and groups with lower immunisation rates with improved access to clinics and opening hours.
- Follow-up of unimmunised children.

National evidence shows that patient reminder and recall systems in primary care settings are effective in improving immunisation rates. NICE guidance (2009) makes six recommendations to address inequalities and increase immunisation uptake among children and young people, including ensuring staff are trained to a high level, ensuring relevant and appropriate information is available to parents, and ensuring immunisation of babies at risk of hepatitis B.

RECOMMENDATIONS

- To improve the data flow, collection and analysis of immunised and unimmunised children, bringing together data from primary care, universal children's services and other relevant sources.
- To review the use of patient reminder and recall systems in order to improve immunisation rates.
- To improve the offer and availability of immunisation services, working through primary care, community health and children's settings as indicated.
- To ensure the delivery of immunisation at home (domiciliary visits) for harder to engage families.
- To promote and raise awareness of the facts about immunisation across children's workforce and settings.
- To implement the immunisation strategy and action plan in partnership with all stakeholders including primary care.

17 Community safety

INTRODUCTION

Community safety is an important concern for Islington. Instances of crime and disorder, intimidating behaviour and community perceptions of crime have significant detrimental effects on the quality of life for individuals and communities. Over the last four years Islington has seen a continual decline in crime figures, with notable reductions in violent crime, sexual offences and racist crime. Although overall levels of crime have dropped, the rate of decline has been slower than other boroughs across London[1].

THE ISLINGTON PICTURE

There are two main categories to consider in relation to community safety – types of crime and types of anti-social behaviour (ASB).

TYPES OF CRIME IN ISLINGTON ARE IDENTIFIED AS:

- **Violence against the person:** This has decreased within Islington over the last four years.
- **Personal robbery:** Following increases in 2005/06 and 2006/07, Islington saw a 19% decline during 2007/08, similar to London.
- **Life threatening and gun crime:** There has been a decline in life threatening and gun crimes within Islington, with overall offences down by 35% in the 12 months ending March 2008 and a 46% decline on 2005/06 levels.
- **Residential burglary:** Burglary offences are split into two categories; residential and commercial. In 2006/07 there was a slight increase in burglary offences in Islington, attributed to a rise in the number of residential offences. However, 2007/08 saw a decline of 10.3%, the lowest levels in four years and largely attributed to a fall in residential offences.

TYPES OF ANTI-SOCIAL BEHAVIOUR AND DISORDER

Disorder cannot be measured in the same way as crime, as perceptions of disorder vary depending on who has reported it. However analysis of qualitative and quantitative data can provide an overview of the types of disorder in the borough which include youth disorder, alcohol and substance misuse disorder, and disorder associated with the street population such as beggars, street drinkers and rough sleepers.

Despite a decline in crime figures the Home Office considers Islington a high crime area. The Community Safety Partnership analysis (2006)[2] highlighted a number of issues, including demographic and economic

factors that have contributed to the higher crime levels in Islington.

POPULATION DENSITY

Crime rates are linked to residential population density [2]. Islington is a high-density borough with 118.3 people per hectare, compared to the London average of 45.6 people per hectare [3].

Islington has a large transient population, with workers, students and hospitality related visits to the borough. Increased transient numbers are linked to higher levels of offences, particularly where transience is related to the night-time economy.

TRANSPORT ROUTES

Areas with major transport routes show more crime clusters. Islington has a number of roads which may be considered arterial routes such as the A1 providing connections to Hackney, Haringey, and Camden boroughs.

DEPRIVATION

Crime and poverty are associated. Islington is the eighth most deprived borough in London [4] and has pockets of extreme wealth and poverty side-by-side.

ALCOHOL AND CRIME

Islington has a thriving night-time economy, being the fourth most densely populated borough in London for licensed premises. Alcohol-related crime and disorder is high in Islington, with 60% of suspects and victims involved in alcohol-related crime (2008/09) having an Islington address [2].

A full year strategic assessment into crime and ASB within the borough is currently in development.

SERVICES CURRENTLY PROVIDED IN ISLINGTON

In Islington the models of service provision aimed at tackling crime and disorder and community safety are based around the multi-agency Partnership Plan 2008-2011. The borough is required to produce an annual Crime and Disorder Strategic Assessment to establish an accurate picture of the current and emerging trends. For 2009/10 six areas were identified to be a focus of business: Public Confidence, Serious Violent Crime, Young People, Serious Acquisitive Crime, Drugs and Substance Misuse and Hate Crime. Models of services are based around the key themes identified within these areas.

Key themes:

1. **Priority Crimes** – including personal robbery, serious violence, life threatening and gun crime and residential burglary.
2. **Young People** – including serious youth violence, gangs and criminal damage.
3. **Substance Misuse** – including reducing harm to children, support with treatment and tackling youth drug and alcohol misuse.
4. **Domestic Violence & Hate Crimes** – including support to victims of violence, improving support and reporting opportunities and holding perpetrators to account.
5. **Community and Anti-Social Behaviour** – including reducing environmental damage, reducing numbers within the street population and using evidence-based communication to reassure the community.

OPPORTUNITIES FOR DEVELOPMENT

Currently it is unclear what provision is available for victims of domestic violence with complex needs such as alcohol and substance misuse. It is important to determine the extent of these issues and put in place appropriate services to assist those in need.

A gap has been identified in the provision of services for vulnerable women offenders and their families. Often these women suffer from social exclusion as a result of substance misuse, with catastrophic affects on family units. Plans are in place for a consortium to provide a holistic, co-ordinated response to the complex needs of women offenders and their families.

According to research approximately three quarters of assaults which result in hospital treatment do not appear in police records [5], indicating there may be a significant gap in local information relating to victims of violence. Currently, the Whittington Hospital's Emergency and Maternity departments are working with the Safer Islington Partnership to address this. The aim is to reduce levels of street and alcohol-related violence and help identify individuals who are victims of domestic abuse.

RECOMMENDATIONS

In light of the opportunities for development and the borough's 2008 Crime and Disorder Strategic Assessment, priority areas include:

1. PUBLIC CONFIDENCE

Research suggests that confidence in the criminal justice system may be linked to the public's willingness to engage. Local survey results may suggest a level of resident disengagement and dissatisfaction. Therefore priorities include:

- Partners developing a greater understanding of the socio-demographic population in Islington to aid community engagement.
- Development of an action plan outlining the community engagement strategy.

2. SERIOUS VIOLENT CRIME

Analysis identifies common themes associated with serious violent offences, including the night-time economy, violence associated with school closing times and knife-related robberies. Priority areas of focus therefore include:

- Youth violence.
- Alcohol related crime.
- Knife related crime.

3. YOUNG PEOPLE

Working with young people is necessary to reduce offending behaviour, curb gang-related activity and provide support and diversionary activities. Under the theme of Youth Crime, a number of strategies are being employed in relation to gangs, youth violence and provision of youth services and the following areas have been set as priorities:

- Reducing the carrying and use of weapons.
- Reducing violence among young people.
- Reducing substance misuse among young people.
- Tackling gangs and gang-related behaviour.

4. SERIOUS ACQUISITIVE CRIME

Over the last few months serious acquisitive crime has increased. In light of this the following priorities are:

- Reducing the incidence of robbery.
- Reducing the incidence of burglary.
- Reducing the incidence of motor vehicle crime.

5. DRUGS AND SUBSTANCE MISUSE

Recommended areas of focus include offending and re-offending, treatment and rehabilitation, street populations and the supply of drugs.

6. HATE CRIME

Islington has seen increases in incidents of hate crime over the last year. Although these may be linked to victims feeling more at ease in reporting such crimes, it is likely that many continue to go unreported. Due to the hidden nature of hate crime the following have been recommended as areas for targeted focus:

- Tackling domestic violence.
- Tackling racial, homophobic and faith hate crime.

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18 Alcohol

INTRODUCTION

Alcohol plays an important role in our society and in the economy. It is widely associated with socialising, relaxing and pleasure. It is estimated that over 90% of the adult population drink alcohol, with the majority drinking within safe limits. However, alcohol misuse is becoming an increasing problem. Three harmful consumption patterns are:

1. **Binge-drinking** – large amounts of alcohol consumed with the specific objective of getting drunk.
2. **Hazardous and harmful drinking** – alcohol is consumed regularly beyond the recommended maximum amounts.
3. **Dependent drinking** – chronic excessive drinking associated with levels of physical and mental-health related harm.

Although most young people do not drink, average alcohol consumption has increased significantly among those that do. Young people are more likely to binge drink than other groups, making them more likely to engage in risk-taking behaviours. Alcohol misuse is also associated with crime and disorder (including anti-social behaviour and domestic violence), and other economic and social problems (including worklessness, teenage pregnancy and school exclusions).

THE ISLINGTON PICTURE

PATTERNS OF DRINKING BEHAVIOUR [1]

- 21% of Islington adults were estimated to engage in hazardous drinking, similar to London (19%) and England (20%).
- Prevalence of binge-drinking was 15%, similar to London and England averages.

ALCOHOL-RELATED ILLNESS AND MORTALITY

- The directly standardised rate of hospital admissions for alcohol-related harm (2007/8) was 1,843 per 100,000 population; significantly higher than London and England.
- Alcohol-attributable mortality (2005-7) accounted for a reduction in life expectancy of 12.3 months (London: 8.7 months, England: 9.2 months) for Islington men and 3.9 months for Islington women (London: 3.6 months, England: 4.3 months).
- Islington has the highest rate (85.5 per 100,000) in London for alcohol-related admissions to hospital among people under 18.

ALCOHOL RELATED-CRIME AND DISORDER

- 3,009 alcohol-attributable crimes were recorded in 2008/09 which equates to 16 per 1,000 residents. This was the sixth highest rate among the London boroughs, and twelfth highest in the country
- Alcohol-related violent crime, including sexual violence, was significantly higher in Islington in 2008/9 (11.4 per 1,000 persons) compared with London (8.6 per 1,000) and England (6.1 per 1,000).

ALCOHOL AND THE ECONOMY

- 330 people in Islington (239 per 100,000 working age persons) were on incapacity benefits due to alcohol dependence, significantly higher than London and England.
- Islington was the fourth most densely saturated borough in London for alcohol licences in 2007/8[2].

NATIONAL DRIVERS FOR SERVICE PROVISION

The Models of Care for Alcohol Misusers (MoCAM) sets out good practice guidance for commissioners of alcohol treatment service pathways[3]. This model recommends a tiered service. The tiers refer to the level or intensity of the interventions provided.

NICE recommends specific actions in schools to identify, prevent and reduce alcohol use among young people[4]. New guidance for adults and young people will be released in 2010, covering prevention and early intervention, management of acute alcohol disease and management of alcohol dependence and psychological interventions[5].

'Safe Sensible Social: Next steps in the national alcohol strategy'[6] addresses alcohol-related interventions in the criminal justice system, enforcement of underage sales including pricing, promotion, labelling and industry standards on social responsibility. It aims to improve information and support public information campaigns to promote a 'sensible drinking' culture.

The Home Office provides recommendations and guidance for the police and local councils on management of alcohol-related anti-social behaviour, and best practice guidance for alcohol retailers. More recently, the Home Office has launched their consultation on a new code of practice for alcohol retailers[7]. The Home Office has also provided funding for local sensible drinking marketing activities and advertisement.

OPPORTUNITIES FOR DEVELOPMENT

Addressing sensible drinking and alcohol harm was identified as a priority policy in Islington's Health Inequalities Strategy (2009). A local multi-agency harm reduction strategy provides an opportunity to enhance coordination across all partners.

An alcohol treatment services needs assessment is currently underway to explore service robustness and ensure that treatment services are based fully on the national treatment pathway model. This includes the opportunity to continue to develop the offer for screening and brief interventions for hazardous and harmful drinking.

Islington's licensing services have a strong track record of working with local businesses to promote socially responsible drinking, reduce harm and tackle under-age and counterfeit sales. However, the increasing saturation of outlets across a significant part of the borough and increasing levels of alcohol consumption present a sustained and growing challenge for all emergency and enforcement bodies locally. The Sustainable Communities Act may offer opportunities to implement local alcohol saturation policies, using local evidence of alcohol related harm and disorder.

Improved local data links between A&E and police intelligence will assist in better ascertaining the true levels of alcohol-related harm in the borough, including victims of alcohol-related violence.

Promoting sensible drinking through the development of a communication plan that employs a social marketing approach across all partners is required to effectively address the differing needs and perspectives of the various target audiences.

RECOMMENDATIONS

- Priority should be given to an integrated alcohol harm reduction strategy setting out Islington's vision for reducing harm from alcohol and promoting sensible drinking, supported by coordinated action across all agencies.
- Given the high saturation of alcohol outlets in the borough, and its links to increased alcohol consumption and alcohol-related crime, priority should be given to developing the business case for a local saturation and enforcement policy under Sustainable Communities Act freedoms.
- Implement the pan-London data sharing project aimed to link alcohol-related injury and crime with accident and emergency data, to identify unreported cases and link the crime location.
- Implement a social marketing initiative to address binge drinking and hazardous drinking, based on the findings of the pilot work done to date.
- Consider steps to improve coverage of screening and brief interventions for hazardous and harmful drinking in key settings and groups.
- Work towards implementation of the MoCAM treatment model and explore mechanisms to improve treatment coverage.

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19 Substance misuse

INTRODUCTION

Substance misuse causes significant harm to health and wellbeing for individuals, families and communities. Levels of mortality and morbidity among people who are problem drug users is high, including significantly higher risks of death through overdose, infection with blood-borne viruses such as hepatitis B and C and HIV, and serious mental ill health. As well as these health problems, there are also many important social and economic consequences of drug use, including strong links to crime, homelessness [1], worklessness, poverty and harm within families.

National policy aims to reduce the harm caused by drugs, this includes:

- Increasing the number of drug users in effective treatment
- Moving on into rehabilitation and reintegration into the community.
- Reducing the use of illicit drugs, alcohol or volatile substances among young people
- Reducing the rate of drug-related offending.

Table 19.1 Number and prevalence rate of problem drug users per 1,000 population aged 15-64 years, by London Spearhead PCT, 2006/07

Source: Hay, G. et al, 2008 (2)

Spearhead PCT	Number of problem drug users	Rate per 1,000 population	Lower 95% CI	Upper 95% CI
Barking and Dagenham	1,077	10.04	8.62	11.99
City of London	63	10.33	7.21	13.41
Greenwich	2,305	15.09	12.09	18.28
Hammersmith and Fulham	3,093	24.26	20.89	27.38
Haringey	2,822	17.27	13.74	20.66
Islington	3,575	25.54	22.29	28.77
Lambeth	4,740	23.45	20.07	26.69
Lewisham	3,164	17.34	13.93	20.68
Newham	3,222	18.66	15.01	21.81
Southwark	4,373	22.15	19.75	25.08
Tower Hamlets	3,826	24.84	21.42	27.97
London	**74,822**	**14.2**	**13.80**	**14.78**

THE ISLINGTON PICTURE

Estimates suggest that Islington had 3,575 problem drug users in 2006/07, a rate of 25.54 per 1,000 adults aged 16-64 in the borough. This was highest among the London Spearhead areas, almost twice the London rate and almost three times the national rate. However, the estimates have wide confidence limits, and so should be treated with some caution (**Table 19.1**).

The figures in **Table 19.1** do not include prisons, where studies show high rates of problem drug use. In a study looking at psychiatric morbidity in prisons, 41% of female and 43% of male sentenced prisoners and 54% of female and 51% of male remand prisoners reported a measure of dependence on drugs in the year before prison [3].

ADULT SERVICES IN ISLINGTON

Islington's strategy for drug treatment is to ensure an integrated treatment system that promotes easy access to

and retention in structured treatment. During 2008/09, 814 new clients started treatment, of whom 83% remained engaged in effective treatment for at least 12 weeks. Overall, the number of clients in effective treatment was 1,484 in 2008/9, which was equivalent to 41.5% of the total estimated population of problem drug users in Islington. The majority of the discharges from drug services were unplanned – 63% (367/584) in Islington in 2008/9, compared with an average 58% unplanned across the London Spearheads.

CHILDREN AND YOUNG PEOPLE'S SUBSTANCE MISUSE SERVICES IN ISLINGTON

The Islington Young People's Drug and Alcohol Service (IYPDAS) provides an integrated service for young people under the age of 19, covering all levels of need with a multidisciplinary team working across universal, targeted and specialist Children's Services. During 2008 there were 113 young people in treatment, 80 of whom were new presentations. The majority of the service users were male 69%, and 44% were referred into the service via the criminal justice system. The main drug of choice was cannabis, followed by alcohol.

NATIONAL DRIVERS FOR SERVICE PROVISION

The National Treatment Agency (NTA) is responsible for the delivery of national targets on drug treatment. National and international evidence consistently shows that good quality drug treatment is highly effective in reducing illegal drug misuse, improving the health of drug misusers, reducing drug-related offending, reducing the risk of death due to overdose, reducing the risk of death due to infections (including blood-borne virus infections) and improving social functioning. Key references for the effectiveness of drug treatment include the Department of Health's Taskforce Review [4], the National Treatment Outcome Research Study, 1995–2000 [5] and the NTA report Treating Drug Misuse Problems: Evidence of Effectiveness [6].

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RECOMMENDATIONS

FOR ADULTS

- Promote harm reduction measures to reduce the risk of drug-related deaths and other harms to health.
- Embed the new drug treatment system, ensuring pathways of care run smoothly through the system, including key worker and reporting arrangements.
- Improve responsiveness of services to key groups under-represented in drug services including younger adults, clients with complex needs (including people with dual diagnoses), those in the criminal justice system and some BME groups.

FOR CHILDREN

- Ensure all children and young people receive drugs prevention advice and education in a variety of settings and formats, including through schools and youth services.
- Improve access to retention and aftercare services so that more young people receive treatment and leave treatment in a planned way.
- Improve the transitional arrangements to adult treatment services.

20 Environmental quality

INTRODUCTION

Our health is directly linked to the environment. For people to achieve optimal health, the physical environment around us must both enhance health directly and provide opportunities for people to live a healthy life. Dissatisfaction with the environment not only impacts on quality of life but can lead to low levels of physical activity and low levels of mental wellbeing (1).

The environment impacts on health through the amount and quality of green and open space; cleanliness; encouraging and facilitating physical activity; access to areas suitable for growing food; and air and noise pollution.

THE ISLINGTON PICTURE

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

The amount of open space has increased in recent years but this stands at just 86.2 hectares of registered green space in Islington, among the smallest amount per person of all London councils (2). The area is made up of over 127 open spaces, mostly small and well distributed across the borough.

In 2009 Islington was awarded the top award in the London in Bloom competition, judged on the quality of the borough's parks, streets and gardens.

Since 2005/06, Islington has reduced its levels of litter, detritus[1], graffiti and flyposting[2], as measured by local environmental quality scores (LEQs).

NATIONAL DRIVERS FOR SERVICE PROVISION

National guidance on the improvement of parks and open spaces has been produced by Greenspace, and CABE Space – a specialist unit within the Commission for Built Environment (CABE) that aims to bring excellence to the design and management of parks and public space in our towns and cities.

Local environmental quality is monitored and standards are set across a number of criteria. The local environmental scores (LEQs) are in place to monitor the cleansing of the local environment.

Keep Britain Tidy, BTCV and GreenSpace run the Green Flag award scheme – a benchmark national standard for parks and green spaces. A subset of this scheme is the Green Pennant

[1] Detritus comprises dust, mud, soil, grit, gravel, stones, rotted leaf and vegetable residues, and fragments of twigs, glass, plastic and other finely divided materials.

[2] Flyposting is defined as any printed material and associated remains informally or illegally fixed to any structure.

Award – a national award that recognises high quality green spaces in England and Wales that are managed by voluntary and community groups. Islington has a total of nine Green Flags and Pennants.

OPPORTUNITIES FOR DEVELOPMENT

The very high turnover of people in some of our key areas e.g. Upper Street and Old Street means that the environmental quality of these areas tends to deteriorate very quickly. In addition Islington has problems with flyposting, particularly on railway land. An agreement with Network Rail is in the process of being developed in order to address this.

The quality of housing land (e.g. levels of litter and general cleansing) does not always match maintenance levels in the wider public realm. Whilst grounds maintenance has been increased to match that of parks and open spaces, litter and cleansing are not necessarily of the same standard. In areas with higher deprivation levels the infrastructure and possible lack of civic pride can also mean that they deteriorate quite quickly.

RECOMMENDATIONS

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

- Increasing the quantity of open space and play areas by identifying sites which can be transferred and seeking additional spaces from new developments.
- Increasing the quality of open space and play areas by seeking investment into existing spaces and then working with residents so that spaces better serve their needs.
- Increasing the opportunity for residents to become involved in growing food in a sustainable way.
- Promoting urban greening and biodiversity particularly in areas of nature deprivation, by increasing the amount of land that is deemed to be of nature conservation value, developing the 'greening the grey' programme and promoting green roofs and other ecological measures in new developments.
- Improving access to play and leisure opportunities in a range of locations and areas, by ensuring provision of play space, unstructured space in new developments, and improving the quality of existing spaces.
- Improving environmental quality through ongoing work to tackle the cleanliness of Islington's public realm and by involving the community in the delivery of projects to improve the local environment.
- Developing a healthy environment that promotes physical activity particularly through use of the Local Development Framework to further develop walkable, mixed-use neighbourhoods designed around a public transport system which provides wide access to a range of services, facilities and open space.

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21 Climate change

INTRODUCTION

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

In order to tackle the impacts of climate change adaptations are required, to both adjust to the changing climate and mitigate further change by reducing emissions of greenhouse gases.

THE ISLINGTON PICTURE

In June 2009 new projections to ascertain the impacts of future climate on the UK (UK Climate Projections 09) were launched. The findings for London and the south east, along a medium emissions scenario, indicate (1):

- The average summer temperature is expected to rise by up to 4.2°C by the 2080s.
- The average winter temperature is expected to rise by between 2.1°C – 3.5°C by the 2080s.
- There will be a predicted increase in the number of days over 25°C over the next 70 years.
- Although there is no expected overall change in precipitation levels by 2020, by the 2080s precipitation in the South East could have fallen by around 30%.
- There is expected to be an increase in the number of severe or extreme weather events such as heatwaves, storms, sudden cold snaps and heavy downpours.
- Weather extremes will become harder to predict.
- The number of ten day dry spells and hot spells (where the daily maximum temperature is above 25°C) is set to increase, coupled with an overall fall in the number of frost days.

In Islington the changes in climate will be exacerbated by some of the borough's features, for example:

- A limited amount of green space combined with the extensive urban fabric will exacerbate the Urban Heat Island Effect (UHIE)[1].
- A large amount of surface run-off, due to non-porous hard surfaces, is likely to lead to increased incidence of flooding.

[1] This is the increased temperature of a built-up area compared to its rural surroundings. Temperatures in London can already be as much as 6°C higher than those in immediately surrounding areas

- A predicted increase in population in an already densely populated area will put further pressure on water resources.
- A high number of transport hubs, vital to the local economy, are at risk of disruption.

WHAT ARE THE KEY ISSUES?

Climate change has both direct and indirect effects on health and wellbeing. Increased summer temperatures may cause an increase in symptoms such as cramps, rash, oedema, syncope, heat exhaustion and heatstroke[2]. Other effects include dehydration and general discomfort due to hot weather, an increase in flies and diarrhoeal diseases and in stinging and biting insects which may cause serious allergic reactions.

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

Islington has one of the most comprehensive climate and sustainability programmes in England and Wales. We have an approach that encompasses both mitigation and adaptation, and assists residents, businesses, the voluntary and community sector and partners to install low carbon technology, reduce their energy consumption or adapt to climate change.

RECOMMENDATIONS

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

1. **Reducing per capita carbon dioxide emissions within Islington** through a range of targeted CO2 reduction programmes, including Islington's Climate Change Partnership, the Climate Change Fund, Green Living Centre and wider education and advice programmes.
2. **Reducing carbon dioxide emissions from the Council's own estate** through delivery of the Council's Carbon Management Plan, Environmental Management Systems and staff behaviour change campaigns.
3. **Development of a long-term strategy for Islington as a low carbon borough** through the range of policies included within the borough's Local Development Framework and development of plans to deliver local heat networks.
4. **Promotion of sustainable transport** through ongoing redesign of public realm and provision of appropriate facilities to promote walking and cycling, support to public transport improvements and car club development.
5. **Implementation of the Islington Climate Change Adaptation Strategy** which promotes the adaptation of parts of the borough and of council processes and policies to increased temperatures, higher flood risk and reduced availability of water and increases awareness of adaptation amongst local organisations and residents.

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Produced by:

NHS Islington
338-346 Goswell Road
London
EC1V 7LQ

Tel: **020 7527 1000**
Web: **www.islington.nhs.uk**

Islington Council
222 Upper Street
London
N1 1XR

Tel: **020 7527 2000**
Web: **www.islington.gov.uk**

NHS Islington is the operating name of Islington Primary Care Trust.

Design: www.watermarkcreative.co.uk

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