ISLINGTON Joint Strategic Needs Assessment 2013/14 – Executive Summary

1.0 What is the Joint Strategic Needs Assessment and what is its purpose?

Joint strategic needs assessment (JSNA) is a process by which the, Council, local NHS and other partners including voluntary organisations jointly describe the current and future health and wellbeing needs of the local population. The intelligence gathered should support identification of priorities and help determine what actions need to be taken to buy the right services for the local population to improve health and wellbeing and reduce inequalities. The production of a JSNA is a statutory requirement for Health and Wellbeing Boards.

2.0 Background and purpose of this document

In Islington a web- based "Evidence Hub" has been developed for the borough to house evidence, data, strategies, intelligence and policies. The Evidence Hub is designed to help share information across and within organisations and to inform the development of evidence-based and needs-based commissioning plans and priorities. In essence, the Evidence Hub is Islington's JSNA. A specific section of the Evidence Hub is denoted as the JSNA, for ease of navigation. All current JSNA chapters can be found here, written in a consistent JSNA factsheet format. Islington's Evidence Hub can be accessed at http://evidencehub.islington.gov.uk.

The Evidence Hub is now live for public access and was formally launched the week commencing 3rd of June 2013 with a series of lunchtime and evening drop in sessions for Council staff and Councillors. These events showcased the JSNA factsheets and gave live demonstrations of the website. Within the CCG, the Evidence Hub has been discussed at the Primary Care Development meeting and taken to GP locality forums and the CCG open day. It has also been promoted to the voluntary and community sector and to Health watch at a specific voluntary and community sector event focussing on public health and Islington's Health and Wellbeing priorities held in early June 2013.

The aim of this summary document is to present a digestible outline of the refreshed JSNA in 2013/14, with commentary on existing and future needs and the potential implications of changing needs. While this summary document is intended to support strategic discussion, changes in delivery or commissioning of services should be based on the detail contained in the individual factsheets of the full JSNA documents.

3.0 Islington's population

The population of Islington is living longer, growing and constantly changing. Women in Islington in line with national picture live longer than men. Life expectancy at birth for men in Islington is now 77.2 years, an increase of 3.7 years from 10 years ago (2009-11). However life expectancy for men in Islington remains lower than England

(78.6) and is one of the lowest amongst all London boroughs. For women in Islington life expectancy is 82.6 years and is similar to England.

According to the latest estimates from the Greater London Authority there are an estimated 212,400 people living in the borough of Islington in 2013. The population has increased by 30,000 (17%) since the 2001 census and is predicted to rise to around 239,800 persons by 2023. The number of people moving in and out of the borough is high. For the year ending June 2012, 19,900 people moved into the borough and 21,500 moved out. Movement is particularly high in those aged 16-24 years old. Constant churn of a population impacts on the type of services that are provided and the way services are provided e.g. cervical screening, educational attainment if children and young families enter the borough and start school mid-way through an academic year.

Births in Islington have increased significantly since the middle of the last decade, and there are now just under 3,000 births a year. However over the next few years the birth rate is projected to increase more slowly, reaching 3,160 a year by 2020. The general fertility rate is similar to London (at 54 births per 1,000 women aged 15-44) but substantially less than the national average rate (72 per 100,000).

Islington has a relatively young population. In absolute numbers the largest age group are people aged between 20 and 40 years. This presents a significant opportunity for prevention of ill health as people under 40 are unlikely to have developed conditions that are most responsible for death and disability in Islington. Older people make up a relatively small proportion of Islington's population, however in the next 10 years there will be a 17% increase in those aged 80 years and older and an 10% increase in those aged 65 years and older. The percentage increase in numbers of children and young people in the borough is also predicted to increase with a significant increase in those aged 4-10 years old.

Table 1. Islington estimated population by age and projected numbers, 2013 - 2023

Age group	2013	2023	Change (2013 to 2023)	% Change (2013 to 2023)
0-3	10,700	11,800	1,100	10.3%
4-10	14,200	17,500	3,300	23.2%
11-15	8,900	10,300	1,400	15.7%
16-24	29,700	30,100	400	1.3%
25-44	90,400	103,600	13,200	14.6%
45-64	39,800	46,000	6,200	15.6%
65-79	13,800	14,900	1,100	8.0%
80+	4,800	5,600	800	16.7%
Total	**212,300**	**239,800**	**27,500**	**13.0%**

Source: © GLA 2012 Round Demographic Projections -SHLAA

Islington's population is becoming increasingly ethnically diverse. In 2001 57% of Islington residents described themselves as White British. In 2011 this had reduced

to 48% describing themselves as White British. There are particularly high proportions of Turkish, Irish and black African and black Caribbean populations resident in Islington. Ethnicity varies considerably by age. The younger population is more diverse in Islington compared to the older population. 45% of those aged between 0-24 years are from a black minority ethnic (BME) background compared to 20% of the population aged 65 years and over.

This changing demographic picture has important implications for local health services since there are higher rates of some long term conditions in some BME communities, for example of heart disease and stroke, or of diagnosis of serious mental illness. Additionally, some behavioural risks, such as smoking, are also more common in some BME groups. These factors are often linked to significant socio-economic disadvantage and social exclusion.

With the ageing of the local population, together with increasing levels of long term conditions contributing to a relatively high level of disability in Islington, it can be expected that the number of carers in the borough will also increase. In the 2011 census, there were 16,300 carers in Islington. Carers are themselves at significantly greater risk of both physical and mental ill health than the general population

What does this mean for Islington?

- The aging of the population in Islington over the next 10 years will lead to a growing number of people living with long-term conditions, indicating an increasing need for health and care services to identify and manage these long term conditions earlier and more effectively. It can also be expected that there will be an increase in the number of people living with multiple long term conditions.
- The increase in the older adult population will mean an increasing number of people with dementia, and with the increase in the over 80s, an increasing number of whom will also be physically frail.
- Work with local communities/specific population groups to improve understanding about how to improve the accessibility and reach of services.
- Raise awareness of the needs of carers and improve access to support and training for carers.
- Ensure that the commissioning and provision of services are culturally sensitive and provide equity of access responsive to a changing population with differing health needs.

4.0 What modifiable factors contribute to poor health in Islington?

Many factors combine to affect the health of individuals and communities. Whether people are healthy or not is determined by a mix of genetic factors, their circumstances and environment, their lifestyle choices and their access and use of health services and other services that influence health (e.g. lifestyle change services, social care services). In the long term it is our circumstances and environment which include factors such as how safe we feel in the environment in which we live, the physical condition of our housing as well as availability, job security, income and education levels that have the strongest impact on health outcomes.

4.1 Housing

The availability and quality of housing (e.g. accommodation that may be cold, damp or overcrowded), impacts on both physical and mental wellbeing. Homes in poor physical condition can put occupants' health and safety at risk, especially where they are children, older, ill or disabled people. In Islington, private rented homes are more likely to fall below the Decent Homes Standard and are less energy efficient than affordable homes. Living in overcrowded situations can also adversely affect health and wellbeing, particularly for children. As of January 2013 there were 3,869 households on Islington's register living in overcrowded housing. The uncertainty that goes with living in temporary accommodation can have a negative impact on health and wellbeing. In Islington high house prices and private rents mean securing affordable housing is a key challenge for many households. The numbers of statutory homeless households in Islington have increased significantly in the past two years from 200 to just over 400 in 2011/12. The number of households placed in temporary accommodation has also risen.

4.2 Education

A good education is strongly associated with better health outcomes including life expectancy and disability-free health. Overall educational attainment at key stages for children going to Islington schools is improving and achievement is currently just below or similar to the national average. Children not on free school meals achieve better than those eligible for free school meals (proxy for deprivation). Attendance at school improves the chances of educational attainment. Islington schools have seen an improvement in attendance since 2007/08, particularly in secondary schools where attendance is better than the national average. The proportion of 16-18 year olds in Islington who are mot in education, employment or training (NEET) has increased in recent years, alongside a national decrease. In 2012, 8.8% of 16-18 year olds were NEET compared to 5.8% in London and 6.1% in England.

4.3 Employment

Being in good and secure employment has a positive impact on wellbeing whilst low quality and insecure jobs have a negative impact on both physical and mental health. Overall unemployment levels in Islington are similar to London but consistently higher than England. The highest levels of worklessness are in young adults aged

16-24. Groups with particularly high levels of unemployment in Islington include Black Minority Ethnic communities, those with learning disabilities and lone parents. A large number of people claiming out of work benefits in Islington also do so because of long-term illness or other health conditions. Mental ill health accounts for the largest proportion of claims for incapacity benefits reflecting the high prevalence of mental ill health in the borough.

4.4 Poverty

Poverty is a key determinant of poor outcomes in health and wellbeing. Higher levels of deprivation are linked to numerous health problems (e.g. chronic illness, lower life expectancy) and unhealthy lifestyles (e.g. obesity, smoking, drugs misuse). These factors mean that needs for health, social care and lifestyle services are higher amongst populations living in more deprived areas. Islington is ranked the 5th most deprived borough in London (out of 33) and 14th most deprived in England (out of 354). The impact that poverty (in terms of unemployment or low income) has on families with young children is particularly important. Disadvantage experienced in childhood strongly ties with health throughout life. Child poverty rates are very high in Islington and more than double the national average. Islington ranks as the second most deprived district in England on the Income Deprivation Affecting Children index (IDACI) with just under half of all children aged 0-15 years living in income deprived households. In 2010 41% of children in Islington were living in poverty in real terms (this equates to over 15,500 children), compared to 21% nationally. The emotional health of children is correlated with poverty. Particular vulnerable children are those who are looked after, youth offenders and children of parents with mental health problems.

According to the older people's deprivation index (IDAOPI), over two fifths (41.4%) of older people aged 60 years and over in Islington are income deprived compared to 18.1% across England.

What does this mean for Islington?

- A large scale, systematic and co-ordinated approach to reducing health inequality is needed that involves all partners and focuses on the wider socio-economic and environmental determinants and on family and individuals.
- Poverty is one of the greatest threats to health and wellbeing in the borough. Getting people into work and particularly those population groups that face persistent barriers to moving into work, should be a focus.
- The impact of welfare reform on vulnerable groups should be monitored and services to provide advice and support to population groups affected made available. Housing and security of housing is a particularly area that will be affected by welfare reform.

4.5 Modifiable behavioural factors contribute to poor health in Islington

Regular exercise, maintaining a healthy weight, reducing harmful levels of alcohol consumption and stopping smoking can prevent illness or at least delay it for many years. Unlike other factors such as age, and genetics poor lifestyle behaviours can be altered and in the medium term improve population health outcomes.

4.5.1 Smoking

The number of people who smoke has declined in Islington. Overall smoking prevalence, based on survey data in Islington has reduced from 33.5% in 2005 to 21% in 2011 and current estimates are not significantly different to that estimated for London (19%) and England (20%). However smoking remains prevalent in key population groups including the Turkish and Irish populations and those living with long term conditions including mental health. People from these groups may find it harder to quit and need more intensive support. Greater effort is therefore required to support people from these groups to stop smoking.

After a long period of reductions, rates of smoking in pregnancy have increased in the last year and are currently above the London average.

4.5.2 Alcohol

Islington has the highest levels of alcohol-related hospital admissions in London, third highest alcohol specific deaths among men, seventh highest rate of alcohol related crime. Trends in alcohol related admissions for both men and women are rising.

4.5.3 Physical activity

90% of adults and 29% of children do not exercise regularly. Women, older people, persons from lower socio-economic groups and those with a disability or illness are particular at risk of not exercising.

4.5.4 Obesity and overweight

1 in 4 young children aged 4-5 years old and almost 2 in 5 young children 10-11 years old had excess weight in 2011/12. Changes in prevalence of excess weight for children aged 4-5 years in Islington schools have recently shown a decrease and currently similar to the prevalence in England and London. The percentage of pupils aged 10-11 years who are overweight or obese in Islington has remained stable over the previous years and consistently higher than England.

Just over 67,000 adults registered with an Islington GP are obese or overweight and approximately two thirds of adults with a chronic illness are overweight and obese. Obesity increases with deprivation, with those living in the fifth most deprived areas in Islington being 25% more likely to be obese compared to the Islington average.

What does this mean for Islington?

Supporting people to live healthier lives across the life course remains a priority. Programmes and services to support people to adopt healthier lifestyles should be delivered at sufficient scale and appropriately targeted in order to shift population health outcomes positively, and reduce health inequalities within the borough. Specific areas of focus include:-

Tobacco

- Reduce second hand exposure
- Regulate and enforce the laws on sale and display of tobacco products
- Educate and prevent young people from starting smoking
- Ensure smoking cessation services target high risk populations to quit.

Overweight and obesity

- To continue to commission weight management services for children and adults and evaluate their effectiveness.
- To continue to commission and evaluate interventions that promote physical activity both universal services and those targeted at population groups most in need e.g. people on low incomes, people with disability.

Alcohol

- Increasing awareness of alcohol locally through the provision of clear, sensible advice around what is low risk drinking and why this is important.
- Innovative approaches for the provision of identification (screening) and brief advice (IBA) and alcohol liaison models to be expanded and developed.
- Strengthening enforcement to manage alcohol availability locally.
- Building on work already occurring locally, to ensure there is a strong partnership approach to maximise alcohol harm reduction, including enforcement of licensing regulations, IBA and high quality treatment services.

4.6 What ill health are people most affected by?

Cardiovascular disease (CVD), cancer and respiratory disease remain the leading causes of premature deaths and all deaths in Islington, although death rates are declining across the population as a result of people living longer. Table 2 below shows the average number of deaths in under 75 year olds and across all ages by primary cause of death in Islington between 2008-10. Diabetes, high blood pressure and obesity are also prevalent conditions that, although frequently not recorded as the underlying cause of death, significantly contribute to early death; similarly, mental health conditions significantly increase the risk of early death in a number of conditions. The increasing number of deaths due to liver disease associated with excessive alcohol consumption is also of particular concern.

Table 2. Number of deaths by cause of death, under 75, over 75 and all ages, Islington residents, 2008-10 (three-year average)

Cause of death	Aged under 75	Aged 75+	All ages
All cardiovascular diseases	132	200	331
All cancers	172	158	330
All respiratory diseases	43	96	139
All digestive diseases	36	26	63
All external causes	45	13	58
All infectious and parasitic diseases	10	7	17
Neo-natal	8	0	8
Other	52	93	145
Unknown	3	0	3
Total*	**502**	**592**	**1094**

Promoting healthy lifestyle behaviours will help to prevent or delay many deaths caused by long term conditions. As well as prevention, earlier diagnosis of these conditions, facilitating lifestyle advice and behaviour change and earlier medical management help to reduce the longer term ill health and disability associated with these conditions, as well as preventable deaths. This represents the closing the gap challenge, increasing the proportion of long term conditions in the population that have been diagnosed to provide earlier and more effective help and care.

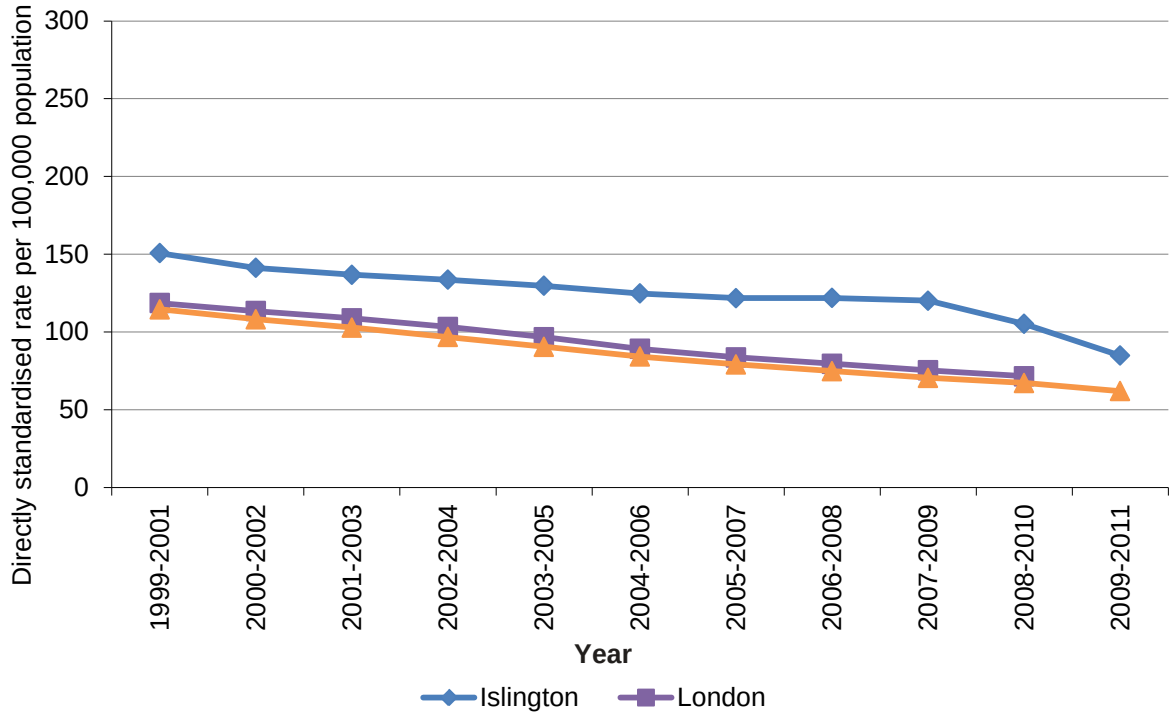
Table 3. The prevalence gap for six major long term conditions, Islington's registered population, aged 16+, September 2012

	Diagnosed prevalence (%)	Estimated prevalence (%)	Number diagnosed	Number not diagnosed
High blood pressure (interpret with caution)*	10.6%	20.4%	20,033	25,745
Diabetes	4.7%	6.8%	8,959	3,996
CHD	2.1%	4.2%	3,911	4,098
CKD**	1.8%	5.2%	3,388	6,255
COPD	1.7%	3.9%	3,281	3,977
Stroke/TIA	0.9%	2.0%	1,672	2,077

4.6.1 Cardiovascular disease

Early deaths (deaths before the age of 75) from cardiovascular conditions including coronary heart disease are declining, although cardiovascular diseases remain the leading cause of deaths across all ages in the borough. During the last six years the rate of early deaths from heart disease has been falling at a faster rate than in England and London. This means that, although still higher than the England average, the inequalities gap in early CVD mortality between Islington and England has significantly narrowed and Islington is making significant progress in reducing early death from CVD. However the rate of early deaths remains significantly higher for both men and women compared to London and England.

Figure 1. Directly standardised rate of under 75 mortality rate from CVD (provisional), Islington, London, and England, 1999-2001 to 2009-11



Source: NCHOD, 2012; EMPHO, 2013 (for 2009-11 data).
Note: Data for 2009-11 are currently provisional, and have not yet been published for London.

4.6.2 Diabetes

The gap between the number of people with diagnosed diabetes and the number expected to have the disease in Islington suggests a significant number of undiagnosed cases (over 6,000 people) in Islington. Islington's prevalence gap for diabetes is significantly higher compared to the gap in London and England. High levels of excess weight amongst younger people is likely to result in more people developing diabetes in future, associated with increased risks of developing complications including heart disease, stroke, kidney failure, blindness and amputations. A new enhanced service has been developed with GP's in Islington to enhance the management of diabetes and those at risk of developing diabetes in primary care

4.6.3 Respiratory disease

Respiratory diseases are important causes of ill health in Islington and of emergency admissions to local hospitals, particularly among older people. The main impact associated with COPD in Islington is a significant reduction in the quality of life of people with COPD and their carers' and frequent hospital emergency admissions caused by exacerbations of the condition. The second highest rate of potentially preventable hospital admissions in Islington are as a result of COPD (second only to admissions for influenza and pneumonia). Many of these admissions could

potentially be avoided through earlier diagnosis and better medical and lifestyle management; stopping smoking would prevent the majority of cases of COPD occurring in the first place. The COPD local enhanced service introduced in primary care and closer working with secondary care has resulted in emergency admissions for COPD by 14%. There are an estimated 4,000 cases of undiagnosed COPD in Islington. Higher levels of pollution in inner city areas like Islington will also contribute to respiratory disease morbidity and earlier mortality.

4.6.4 Cancers

Cancers are the leading cause of premature deaths (under 75) in Islington. The rate of early death from all cancers has been falling in the borough but at a slower rate than England, increasing the inequalities gap in early cancer mortality between Islington and England. Lung cancer is the largest contributor to early death amongst all cancers. The number of people who are alive after a diagnosis of prostate, breast, lung and colorectal cancer at 1 year and 5 years are generally similar compared to England. There is scope to further improve survival by early detection and treatment.

4.6.5 Liver disease

Most liver disease is preventable and much is influenced by alcohol consumption and obesity prevalence, which are both amenable to public health interventions. Islington currently has significantly higher mortality from liver disease compared to England and similar boroughs. The death rate from liver disease in Islington has slowly increased compared to previous years. Liver mortality rates are higher for men in Islington.

The long term conditions described above disproportionately affect those people living in deprived communities. Older people and those living with more than one long term condition are at significantly higher risk of poor quality of life. Nearly a third of all people with long-term physical conditions also suffer from depression or anxiety. This association is particularly strong for cardio-vascular disease, diabetes and chronic obstructive pulmonary disease (COPD).

4.6.6 HIV

With advances in treatment HIV can now also be considered a long term condition. In 2011 Islington's diagnosed HIV prevalence per 1000 population (aged 15-59) was 8.55. This is the 7th highest prevalence rate in London. The majority of diagnosed HIV infections in the borough are in gay and bisexual men. Improved survival and continuing new cases of infection occurring across all age groups has led to a shift in the age distribution of HIV diagnosed persons receiving care, with adults aged 50 and over living with HIV increasing in both number and proportion. Despite improving survival and treatment, the impacts of poverty and of stigma and discrimination continue to be important issues associated with HIV. As with other long term conditions, there are also higher rates of mental health conditions among people living with HIV.

4.6.7 Mental health

Mental health needs vary according to gender, ethnicity and age, and are influenced by family, social and environmental determinants. It has been estimated that mental health conditions are the single largest cause of ill health and disability in the population aged under 65, and they continue to be an important cause among people aged 65 and over. Mental health conditions can intensify the effects of a physical illness and considerably raise the cost of physical health care. Rates of hospitalisation and death due to physical health conditions for those with mental health problems are up to three times higher than for others

Islington has the highest prevalence of recorded serious mental illness on primary care registers (schizophrenia, bipolar disorder and other psychoses) in London and England. There are significant numbers of people suffering from depression (over 22,000 people) the highest rate in London. Increasing financial and other pressures caused by long term austerity and the impact of welfare reforms may particularly affect mental health needs in the borough.

There were 861 people with a diagnosis of dementia registered with Islington GPs in 2011/12. In the same year, Islington had the highest percentage of dementia diagnosed compared to estimated prevalence, as part of efforts to improve access to earlier diagnosis and support. Dementia is strongly correlated with age: the predicted ageing of Islington's population over the next few years, particularly significant in people aged 80 and over, can be expected to increase demand on dementia services.

Deaths due to suicide and undetermined injuries have reduced in recent years. Islington's rate is amongst the highest in London, but it is now similar to the London average. However, there continue to be significant risks for suicide in the general population of Islington.

What does this mean for Islington?

- There are a significant number of people living with a long term condition but who have not yet been diagnosed. Islington's closing the gap local enhanced service, which aims to find undiagnosed long term conditions should continue and be evaluated.
- Programmes raising awareness of signs and symptoms of long term conditions including cancers and COPD should be targeted at deprived communities to encourage early presentation.
- Implementing strategies and programmes that encourage people with long term conditions to self-manage and stay independent
- Improved lifestyle and medical management of long term conditions to improve quality of life.
- The strong link between physical health and mental health underlines the importance of the movement towards models of care that address both mental and physical health together.
- All those with a physical long term condition should be offered screening for depression.

5.0 The best start in life – children and young people and their families

There is now clear evidence of the importance of giving children the best start in life, and that there are a range of early interventions (starting not only in pregnancy, but pre-pregnancy) that are effective in achieving better long term outcomes and reducing inequalities. Although the majority of children and young people in Islington live healthy lives there are high levels of vulnerability and disadvantage. Groups particularly at risk of poorer outcomes, in childhood or later on in adulthood, include children living in poverty, young carers, children with disabilities, looked after children, youth offenders, children with mental health conditions and children of parents with long term mental health problems including personality disorder, or problem alcohol and substance misuse.

Interventions that address inequalities early on tend to demonstrate the best and most cost effective impacts on narrowing the gaps between groups. This is the underpinning basis for Islington's First 21 Months priority.

Key indicators of health and wellbeing include:

- Early access to maternity services (booking by 12 weeks plus 6 days) to ensure women and their partners receive timely care and support through pregnancy, including early identification of health or social problems that may require extra support. Islington had made good progress towards this target, achieving in excess of 90% in 2011/12, but has subsequently seen a reduction to below 80%. Earlier and more effective referral systems are needed, as well as promotion of the early access message into the community.
- Immunisation rates have significantly improved, including MMR and pre-school boosters. At 12 months, Islington now ranks 5th in London, with a rate in excess of 95%.
- Exclusive breastfeeding provides a significant level of protection against the future risk of childhood obesity. Initiation rates of breastfeeding in Islington are higher (90%) than London (87%) and England (74%). The rate falls at 6-8 weeks to (75%), but still remains higher than London and England.
- Islington's teenage conceptions had fallen to a rate of 34.3 conceptions per 1,000 15-17 year olds in 2011, from a rate of 62 conceptions per 1,000 in 2000-02. The Family Nurse Partnership is demonstrating early improved outcomes for teenage parents and their babies.
- Although there are significant risk factors in the population, rates of infant mortality and low birth weight babies are similar to national rates.
- Childhood obesity rates remain high in both Reception and Year 6 children in Islington, increasing the risk of long term health problems for these children. The most recent annual survey data (2011/12) found that 10% of children in Reception were obese (a reduction of 2.8% on the previous year, and similar to the rates for London and England) and 22% in Year 6, which was higher than the London and England averages but not dissimilar to other deprived boroughs.
- Mental health conditions in children and young people are estimated to be 36% higher than the national average, with more than 3,700 children and young

people aged 5-17 experiencing a mental health condition during any one week. Mental health conditions in childhood, particularly if untreated, are an important risk factor for mental health problems in adulthood. Schools and Children's Centres are increasingly important sources of referrals to CAMHS services.

- Admissions for asthma and some other long term conditions have been much higher for Islington children and young people compared to their national counterparts, being addressed through steps to improve medical management and self-care in community and primary care settings.

What does this mean for Islington?

- A strong preventive and early intervention offer in pregnancy and the early years is important to reduce long term inequalities.
- Promoting healthy eating, physical activity and access to weight management support to children and their families continues to be important to reduce high levels of obesity and excess weight.
- Access to effective services for conditions such as asthma or mental health problems in community and primary care settings will help to improve outcomes.

5.1 Sexual and reproductive health

Sexual and reproductive health is critical to population wellbeing, particularly in a borough such as Islington with its young adult population, high levels of mobility, deprivation and key groups at increased risk of sexual ill health including gay and bisexual men and people from some BME groups. Poor sexual health is associated with increased rates of unintended pregnancies, sexually transmitted infections (STIs), some cancers and infertility.

The rate of abortions and of repeat abortions in Islington is very similar to the London averages but higher than the national rates, which points to the need to improve access to choice and control over contraceptive methods as well as the continuing importance of high quality sex and relationship education and information.

In terms of sexually transmitted infections (STIs), Islington has higher rates of diagnosed acute STIs than the average for London and England, although rates are not dissimilar to other nearby deprived boroughs. Like England and London, the most commonly diagnosed STI is Chlamydia. The prevalence of chlamydia infections is highest in young sexually active adults (15-24 years). Young black people, particularly of black Caribbean origin, have a higher rate of chlamydia positivity than other groups. There have been recent marked increases in some STIs, including syphilis and gonorrhoea and new cases of HIV, among gay and bisexual men.

What does this mean for Islington?

- Ensuring high quality sex and relationships education, sexual health promotion and HIV prevention, and access to effective contraception methods and sexual health services to improve choice and control over fertility and reduce the risk of HIV and STIs. .

- Providing high quality, accessible and integrated sexual health promotion, testing and treatment services that are responsive to changes in population trends and needs.

6.0 People with learning disabilities

The events at Winterborne and the recent report by the Confidential Inquiry into premature deaths of people with learning disabilities have highlighted the responsibilities that public services have to ensure that people with learning disabilities receive equitable and accessible care and support. National data shows that people with learning disabilities are three more times likely to die early compared to others, and as a result their life expectancy is up to 20 years less than the general population. Some of the difference may be accounted for by higher rates of specific health issues including coronary heart disease, respiratory disease and epilepsy, however many of these deaths are potentially preventable through a mix of earlier diagnosis and better and more responsive management of health conditions.

In spite of these stark inequalities, life expectancy for people with learning disabilities is increasing, this is in part due to rising numbers of young people with complex needs surviving into adulthood as well as longer life expectancies amongst adults with learning disabilities. In Islington the actual numbers of adults with learning disabilities is expected to increase by 8% (50 people) in the next year.

There has been an increase in the number of people with learning disabilities who have received health checks, but improving the delivery of preventative interventions and earlier identification and management of physical health issues in people with learning disabilities remain important.

What does this mean for Islington?

- Ensuring prevention and treatment services are accessible and able to meet the needs of people with learning disabilities in order to improve outcomes and reduce inequalities.

6.0 Next steps

Through the development of the Health and Wellbeing board stakeholder engagement plan timetable opportunities to explore communities', service users and patient's views on findings from the JSNA and their local health and wellbeing issues to inform the on-going development of the JSNA.

Appendix 1

Table 1: List of JSNA factsheets/chapters and schedule for refresh, June 2013

Completed and published on Evidence	JSNA Factsheet title	Date of current fact sheet	Date of next update
	MATERNAL AND CHILD HEALTH		
✓	Infant mortality	March 2013	March 2014
✓	Teenage pregnancy	May 2013	May 2013
✓	Early access to maternity services	June 2013	June 2014
✓	Childhood Immunisations	October 2012	October 2013
	CHRONIC ILLNESS (including Cancer and cancer screening)		
✓	Cardiovascular disease	October 2012	October 2013
✓	Respiratory disease	November 2012	November 2013
✓	Cancer – overall summary	October 2012	October 2013
✓	Cervical cancer	January 2013	January 2014
✓	Breast cancer	November 2012	November 2013
✓	Bowel cancer	November 2012	November 2013
✓	Lung cancer	November 2012	November 2013
✓	Prostate cancer	April 2013	April 2014
✓	Diabetes	November 2012	November 2013
	MENTAL HEALTH		
✓	Mental Health	June 2013	June 2014
✓	Psychotic disorders	June 2013	June 2014
✓	Dementia	March 2013	June 2014
	Depression and anxiety	Expected October 2013	October 2014
	Suicide and undetermined injury	Expected October 2013	October 2014
	INFECTIOUS DISEASES		
✓	Infectious disease	March 2013	March 2014
	HIV	Autumn 2013	TBC
	CLINICAL RISK FACTORS		
✓	Adult overweight and obesity	October 2012	October 2013
✓	Childhood obesity	March 2013	March 2014

✓	High blood pressure	November 2012	November 2013
✓	Season Health (excess winter deaths)	October 2012	October 2013
	LIFESTYLES		
✓	Smoking	November 2012	November 2013
✓	Oral health (adult & children)	October 2012	October 2013
✓	Physical activity	October 2012	October 2013
✓	Alcohol	October 2012	October 2013
	Substance misuse	July 2013	TBC
	Sexual health	TBC	TBC
	VULNERABLE POPULATIONS		
	Older people	TBC	TBC
✓	Carers (Adults)	January 2013	TBC
	Children that are looked after	TBC	TBC
✓	People with a learning disability	January 2013	TBC
✓	People with physical disabilities and sensory impairment	January 2013	TBC
	WIDER DETERMINANTS OF HEALTH		
	Child Poverty	TBC	TBC
✓	Educational attainment and lifelong learning	April 2013	April 2014
✓	Housing and Homelessness	June 2013	TBC
	Employment and prosperity	TBC	TBC
✓	Unemployment and NEETs	May 2013	May 2014
	Community safety	TBC	TBC
	Environmental quality	TBC	TBC
✓	Air quality	October 2012	October 2013