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PUBLIC HEALTH INTELLIGENCE
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Public Health Outcomes Framework

Second Edition

September 2013

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About this profile

Purpose

The Department of Health published the Public Health Outcomes Framework in 2012, and released new data as well as new indicators in May 2013. The Outcomes Framework will be used to hold local areas to account for improving population health outcomes over the coming years. While areas will not have nationally imposed targets relating to these indicators, achievement against outcomes will form the basis of local "health premiums" (financial incentives), the details of which will be published in 2015/16.

The Public Health Outcomes Framework (PHOF) has two overarching outcomes for achievement:

- Increased healthy life expectancy
- Reduced differences in life expectancy and healthy life expectancy between communities.

The indicators are grouped into four domains, each covering a broad area of public health. This report does not include information on the full list of indicators proposed by the Department of Health as the publication of data is a continuing process, with new indicators and data being released on a quarterly basis. However, every effort has been taken to ensure that those indicators presented here include the latest available data at the time of publication. Data updates are published on the Public Health Outcomes Framework Data Tool (http://www.phoutcomes.info/).

The aim of this report is to allow those working to improve population health in Islington to look at achievement against the wide range of public health outcomes. Public Health England now produce local profiles, comparing local authorities to others within their region, therefore this profile compares Islington to other local authorities with a similar level of deprivation from across England. This is in line with Public Health England's Longer Lives report, which placed Islington in the most deprived socioeconomic decile. The aim is to show how Islington compares against local authorities with a similar level of need. The report also provides an in-depth look at each indicator, describing Islington's position and key steps being taken to improve outcomes for each indicator.

The audience for this report includes those who influence and are responsible for improving population health and wellbeing within Islington. This includes: the Health and Wellbeing Board, London Borough of Islington (Councillors and officers), Islington's Clinical Commissioning Group (CCG), Whittington Health, and other partners.

Further information and feedback

This profile was compiled by Mandy Guest, David Clifford, Harriet North, and colleagues from the Public Health Department and other London Borough of Islington Departments.

It was reviewed by Baljinder Heer and Jonathan O'Sullivan

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We would also very much welcome your comments on these profiles and how they could better suit your requirements, so please do contact us with your ideas.

Understanding the data

This report contains a wide variety of indicators, and a guide to interpreting the most commonly used ones is below.

For a full description of each indicator, please see the DH Technical Specification 2013 or the Public Health Outcomes Framework Data Tool (http://www.phoutcomes.info/)

95% confidence intervals (95% CI)

- Percentages and standardised ratios are reported with 95% confidence intervals. These intervals show the level of certainty in the estimate.
- The level of certainty is influenced by the random occurrences that are inherent in life, and is influenced by the size of the population being studied (i.e. one can be more certain about a percentage calculated from the whole borough's population than one calculated based on the number of people with a rare disease).
- Comparing these confidence intervals around percentages, rates, and other figures, we can say with confidence that there is a real difference between two numbers; that the difference is unlikely to be a chance outcome. This 'real' difference is called statistical significance, a phrase that is used throughout the report.

Crude rates

Why is it used?

- To show the number of events that occur in a population of a specified size (typically 1,000 or 100,000 people).

Interpreting the values

- Crude rates do not include an adjustment according to the population's characteristics (e.g. age or sex), so rates are not completely comparable between boroughs with a different population structures.

Standardised rates

Why is it used?

- Standardised rates allow for a more detailed comparison between areas of different population structures.

Interpreting the values

- Standardised rates show the number of events that could be expected, if the borough's population had the same age and sex structure as a comparison population (in this report, England is usually used as the comparison population). This adjustment allows for a full comparison between boroughs.

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Note: London comparators not currently available
Green: better compared to August 2012
Red: worse compared to August 2012
Black: no difference compared to August 2012
Italic: data not available in August 2012

Islington performance May 2013

Data not statistically tested against England average

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Better than England average	Similar to England average	Worse than England average
Ensuring every child has the best start in life		
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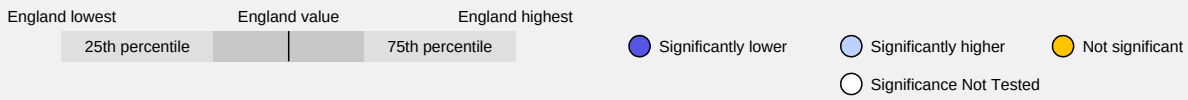
Islington

Spine Charts

Wider determinants of health		Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
1.01	Children in poverty	2010	40.9	21.1	7.4		45.9
1.03	Pupil absence	2010/11	5.98	5.79	4.84		7.12
1.04i	First time entrants to the youth justice system	2011	1,142	749	296		2,134
1.05	16-18 year olds not in education employment or training	2011	8.4	6.1	1.6		11.8
1.06i	Adults with a learning disability who live in stable and appropriate accommodation	2011/12	74.8	70.0	30.9		93.8
1.06ii	Adults in contact with secondary mental health services who live in stable and appropriate accommodation	2010/11	67.5	66.8	1.3		92.8
1.10	Killed and seriously injured casualties on England's roads	2009 - 11	44.3	42.2	18.1		82.4
1.12i	Violent crime (including sexual violence) - hospital admissions for violence	2009/10 - 11/12	88.7	67.7	9.9		213.5
1.12ii	Violent crime (including sexual violence) - violence offences	2011/12	26.2	13.6	4.9		32.7
1.13i	Re-offending levels - percentage of offenders who re-offend	2010	32.2	26.8	17.3		36.3
1.13ii	Re-offending levels - average number of re-offences per offender	2010	0.94	0.77	0.41		1.25
1.14i	The percentage of the population affected by noise - Number of complaints about noise	2010/11	17.7	7.8	1.3		66.7
1.15i	Statutory homelessness - homelessness acceptances	2011/12	4.8	2.3	0.2		9.7
1.15ii	Statutory homelessness - households in temporary accommodation	2011/12	10.9	2.3	0.0		32.4
1.16	Utilisation of outdoor space for exercise/health reasons	Mar 2009 - Feb 2012	4.1	14.0	2.2		29.1

1.01 - % of children living in households where income is less than 60% of median household income before housing costs **1.03** - % of half days missed by pupils due to overall absence (incl. authorised and unauthorised absence) **1.04i** - Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population **1.05** - % of 16-18 year olds not in education, employment or training (NEET) **1.06i** - % of adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family **1.06ii** - % of adults receiving SMHS living independently at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting **1.10** - Rare of people KSI on the roads, all ages, per 100,000 resident population **1.12i** - Age-standardised rate of emergency hospital admissions for violence per 100,000 population **1.12ii** - Crude rate of violence against the person offences per 100,000 population **1.13i** - % of offenders who re-offend from a rolling 12 month cohort **1.13ii** - Average no. of re-offences committed per offender from a rolling 12 month cohort **1.14i** - No. of complaints per year per LA about noise per 1,000 population **1.15i** - Homelessness acceptances per 1,000 households **1.15ii** - Households in temporary accommodation per 1,000 households **1.16** - % of people using outdoor space for exercise/health reasons

How to interpret the spine charts



These spine charts have been extracted from Public Health England's report on Islington, and summarise Islington's position by Domain.
They show Islington's performance along with the highest and lowest values nationally, as well as highlighting any significant differences between Islington and England. It is important to note that performing above the England average may be a positive outcome for some indicators, and a negative one for others.

Islington

	Health improvement	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
2.01	Low birth weight of term babies	2010	2.22	2.85	1.75		7.79
2.02i	Breastfeeding - Breastfeeding initiation	2011/12	89.9	74.0	41.8		94.3
2.02ii	Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	2011/12	75.0	47.2	19.7		82.8
2.03	Smoking status at time of delivery	2011/12	9.1	13.2	2.9		29.7
2.04	Under 18 conceptions	2011	34.4	30.7	9.4		58.1
2.06i	Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2011/12	23.6	22.6	16.1		30.0
2.06ii	Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2011/12	38.1	33.9	26.6		42.8
2.08	Emotional well-being of looked after children	2011/12	14.2	13.8	9.5		20.1
2.14	Smoking prevalence - adults (over 18s)	2011/12	21.8	20.0	13.2		29.3
2.15i	Successful completion of drug treatment - opiate users	2011	5.8	8.6	4.3		19.9
2.15ii	Successful completion of drug treatment - non-opiate users	2011	31.4	39.5	19.7		69.0
2.17	Recorded diabetes	2011/12	4.84	5.76	3.60		8.02
2.20i	Cancer screening coverage - breast cancer	2012	68.0	76.9	59.4		85.1
2.20ii	Cancer screening coverage - cervical cancer	2012	68.1	75.3	60.3		81.4
2.21vii	Access to non-cancer screening programmes - diabetic retinopathy	2011/12	69.2	80.9	66.7		95.0
2.22i	Take up of NHS Health Check Programme by those eligible - health check offered	2011/12	21.5	14.0	0.0		91.1
2.22ii	Take up of NHS Health Check programme by those eligible - health check take up	2011/12	69.1	51.2	8.6		100.0
2.23i	Self-reported well-being - people with a low satisfaction score	2011/12	27.6	24.3	14.6		30.5
2.23ii	Self-reported well-being - people with a low worthwhile score	2011/12	24.2	20.1	12.8		25.4
2.23iii	Self-reported well-being - people with a low happiness score	2011/12	31.3	29.0	19.2		36.6
2.23iv	Self-reported well-being - people with a high anxiety score	2011/12	46.0	40.1	34.4		48.3
2.24i	Injuries due to falls in people aged 65 and over (Persons)	2011/12	2,230	1,665	1,070		2,985
2.24i	Injuries due to falls in people aged 65 and over (males/females) - Male	2011/12	1,742	1,302	704		2,535
2.24i	Injuries due to falls in people aged 65 and over (males/females) - Female	2011/12	2,718	2,028	1,298		3,713
2.24ii	Injuries due to falls in people aged 65 and over - aged 65-79	2011/12	1,396	941	545		1,726
2.24iii	Injuries due to falls in people aged 65 and over - aged 80+	2011/12	5,981	4,924	2,892		8,965

2.01 - % of all live births at term with low birthweight **2.02i** - % of all mothers who breastfeed their babies in the first 48hrs after delivery **2.02ii** - % of all infants due a 6-8 week check that are totally or partially breastfed **2.03** - % of women who smoke at time of delivery **2.04** - Rate of conceptions per 1,000 females aged 15-17 **2.06i** - % of all children aged 4-5 classified as overweight or obese **2.06ii** - % of all children aged 10-11 classified as overweight or obese **2.08** - Average difficulties score for all children aged 4-16 who have been in care at least 12 months on 31st March **2.14** - Prevalence of smoking among people aged 18+ **2.15i** - % of opiate drug users that left drug treatment successfully who do not re-present to treatment within 6 months **2.15ii** - % of opiate drug users that left drug treatment successfully who do not re-present to treatment within 6 months **2.17** - % of QOF-recorded cases of diabetes registered with GP practices aged 18+ **2.20i** - % of eligible women screened adequately within the previous 3 years on 31st March **2.20ii** - % of eligible women screened adequately within the previous 3.5 or 5.5 years (according to age) on 31st March **2.21vii** - % of those offered diabetic eye screening who attend a digital screening event **2.22i** - % of eligible population aged 40-74 offered an NHS health check **2.22ii** - % of eligible population aged 40-74 offered an NHS health check who received an NHS health check **2.23i** - % of respondents scoring 0-6 on the question Overall, how satisfied are you with your life nowadays? **2.23ii** - % of respondents scoring 0-6 on the question Overall, to what extent do you feel the things you do in your life are worthwhile? **2.23iii** - % of respondents scoring 0-6 on the question Overall, how happy did you feel yesterday? **2.23iv** - % of respondents scoring 4-10 on the question Overall, how anxious did you feel yesterday? **2.24i** - Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons age 65+ per 100,000 population **2.24ii** - Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65-79 per 100,000 population **2.24iii** - Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons age 80+ per 100,000 population

How to interpret the spine charts

Islington

	Health protection	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
3.01	Fraction of mortality attributable to particulate air pollution	2010	7.90	5.60	3.60		8.30
3.02	Chlamydia diagnoses (15-24 year olds)	2011	2,557	2,125	783		5,995
3.03i	Population vaccination coverage - Hepatitis B (1 year old)	2011/12	66	-	-100		100
3.03i	Population vaccination coverage - Hepatitis B (2 years old)	2011/12	100.0	-	2.6		100.0
3.03iii	Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2011/12	95.6	94.7	84.9		98.8
3.03iii	Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2011/12	96.4	96.1	85.7		98.8
3.03iv	Population vaccination coverage - MenC	2011/12	94.6	93.9	81.4		98.6
3.03v	Population vaccination coverage - PCV	2011/12	95.2	94.2	83.8		98.6
3.03vi	Population vaccination coverage - Hib / MenC booster (2 years old)	2011/12	90.2	92.3	75.7		97.3
3.03vi	Population vaccination coverage - Hib / Men C booster (5 years)	2011/12	86.3	88.6	0.0		97.6
3.03vii	Population vaccination coverage - PCV booster	2011/12	88.4	91.5	74.7		97.0
3.03viii	Population vaccination coverage - MMR for one dose (2 years old)	2011/12	90.7	91.2	78.7		97.2
3.03ix	Population vaccination coverage - MMR for one dose (5 years old)	2011/12	93.1	92.9	79.8		98.0
3.03x	Population vaccination coverage - MMR for two doses (5 years old)	2011/12	83.0	86.0	69.7		95.3
3.03xii	Population vaccination coverage - HPV	2011/12	82.1	86.8	62.3		97.2
3.03xiii	Population vaccination coverage - PPV	2011/12	62.9	68.3	52.8		76.6
3.03xiv	Population vaccination coverage - Flu (aged 65+)	2011/12	73.8	74.0	64.8		81.5
3.03xv	Population vaccination coverage - Flu (at risk individuals)	2011/12	52.8	51.6	43.4		66.3
3.04	People presenting with HIV at a late stage of infection	2009 - 11	35.2	50.0	0.0		75.0
3.05i	Treatment completion for TB	2011	82.5	84.3	55.6		98.3
3.05ii	Treatment completion for TB - TB incidence	2009 - 11	40.5	15.4	1.1		137.0
3.06	Public sector organisations with a board approved sustainable development management plan	2011/12	86	84	20		100

3.01 - Fraction of all-cause adult mortality attributable to long-term exposure to current levels of anthropogenic particulate air pollution **3.02** - Crude rate of chlamydia diagnoses per 100,000 young adults aged 15-24 **3.03i** - % of eligible children who received 4 doses of Hepatitis B vaccine at any time by their 1st/2nd birthday **3.03iii** - % of eligible children who received 3 doses of DTaP/IPV/Hib vaccine at any time by their 1st/2nd birthday **3.03iv** - % of eligible children who have received the completed course of Men C vaccine by their 1st birthday **3.03v** - % of eligible children who have received the complete course of PCV vaccine by their 1st birthday **3.03vi** - % of eligible children who have received one booster dose of Hib/Men C vaccine by their 2nd/5th birthday **3.03vii** - % of eligible children who have received one booster dose of PCV vaccine by their 2nd birthday **3.03viii** - % of eligible children who have received one dose of MMR vaccine on or after their 1st birthday and at any time up to their second birthday **3.03ix** - % of eligible children who have received one dose of MMR vaccine on or after their 1st birthday and at any time up to their 5th birthday **3.03x** - % of eligible children who have received two doses of MMR vaccine on or after their 1st birthday and at any time up to their 5th birthday **3.03xii** - % of girls aged 12-13 who have received all 3 doses of the HPV vaccine **3.03xiii** - % of eligible adults aged 65+ who have received the PPV vaccine **3.03xiv** - % of eligible adults aged 65+ who have received the flu vaccine **3.03xv** - % of at risk individuals aged 6 months 65 years (excluding pregnant women) who have received the flu vaccination **3.04** - % of adults (aged 15+) newly diagnosed with HIV with a CD4 count <350 cells per mm3 **3.05i** - % of people completing treatment for TB within 12 months prior to 31st December **3.05ii** - Rate of reported new cases of TB per year per 100,000 population **3.06** - % of NHS organisations with a board approved sustainable development management plan

How to interpret the spine charts

Islington

	Healthcare and premature mortality	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
4.03	Mortality rate from causes considered preventable (provisional)	2009 - 11	177.6	146.1	100.7		264.2
4.04i	Under 75 mortality rate from all cardiovascular diseases (provisional)	2009 - 11	84.8	62.0	40.3		116.0
4.04ii	Under 75 mortality rate from cardiovascular diseases considered preventable (provisional)	2009 - 11	52.6	40.6	23.0		75.1
4.05i	Under 75 mortality rate from cancer (provisional)	2009 - 11	121.4	106.7	82.5		152.0
4.05ii	Under 75 mortality rate from cancer considered preventable (provisional)	2009 - 11	73.2	61.9	45.2		98.1
4.06i	Under 75 mortality rate from liver disease (provisional)	2009 - 11	22.0	14.4	8.7		39.3
4.06ii	Under 75 mortality rate from liver disease considered preventable (provisional)	2009 - 11	17.8	12.7	7.5		37.0
4.07i	Under 75 mortality rate from respiratory disease (provisional)	2009 - 11	24.6	23.4	13.7		62.0
4.07ii	Under 75 mortality rate from respiratory disease considered preventable (provisional)	2009 - 11	12.3	11.6	5.3		28.6
4.08	Mortality from communicable diseases (provisional)	2009 - 11	34.7	29.9	22.0		54.9
4.10	Suicide rate (provisional)	2009 - 11	9.8	7.9	4.3		13.9
4.11	Emergency readmissions within 30 days of discharge from hospital	2010/11	11.9	11.8	8.1		13.8
4.11	Emergency readmissions within 30 days of discharge from hospital - Male	2010/11	12.6	12.1	8.6		14.8
4.11	Emergency readmissions within 30 days of discharge from hospital - Female	2010/11	11.2	11.4	7.2		13.2
4.12i	Preventable sight loss - age related macular degeneration (AMD)	2010/11	90.6	109.4	10.0		224.4
4.12ii	Preventable sight loss - glaucoma	2010/11	10.4	11.8	0.0		36.9
4.12iii	Preventable sight loss - diabetic eye disease	2010/11	3.0	3.6	0.0		12.9
4.12iv	Preventable sight loss - sight loss certifications	2010/11	26.8	43.1	2.9		85.7
4.14i	Hip fractures in people aged 65 and over	2011/12	344.1	457.2	337.9		599.5
4.14ii	Hip fractures in people aged 65 and over - aged 65-79	2011/12	135.7	222.2	135.7		346.7
4.14iii	Hip fractures in people aged 65 and over - aged 80+	2011/12	1,282	1,515	993		2,021

4.03 - Age-standardised rate of mortality from causes considered preventable per 100,000 population **4.04i** - Age-standardised rate of mortality from all cardiovascular diseases (incl. heart disease and stroke) in those aged <75 per 100,000 population **4.04ii** - Age-standardised rate of mortality considered preventable from all cardiovascular diseases (incl. heart disease and stroke) in those aged < 75 per 100,000 population **4.05i** - Age-standardised rate of mortality from all cancers in those aged <75 per 100,000 population **4.05ii** - Age-standardised rate of mortality considered preventable from all cancers in those aged < 75 per 100,000 population **4.06i** - Age-standardised rate of mortality from liver disease in those aged < 75 per 100,000 population **4.06ii** - Age-standardised rate of mortality considered preventable from liver disease in those aged < 75 per 100,000 population **4.07i** - Age standardised rate of mortality from respiratory disease in those aged <75 per 100,000 population **4.07ii** - Age-standardised rate of mortality considered preventable from respiratory disease in those aged < 75 per 100,000 population **4.08** - Age-standardised rate of mortality from communicable diseases per 100,000 population **4.10** - Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population **4.11** - Indirectly standardised % of emergency admissions to any hospital within 30 days of the previous discharge from hospital **4.12i** - Crude rate of sight loss due to age related macular degeneration (AMD) in those aged 65+ per 100,000 population **4.12ii** - Crude rate of sight loss due to glaucoma in those aged 40+ per 100,000 population **4.12iii** - Crude rate of sight loss due to diabetic eye disease in those aged 12+ per 100,000 population **4.12iv** - Crude rate of sight loss per 100,000 population **4.14i** - Age-sex standardised rate of emergency admissions for fractured neck of femur in those aged 65+ per 100,000 population **4.14ii** - Age-sex standardised rate of emergency admissions for fractured neck of femur in those aged 65-79 per 100,000 population **4.14iii** - Age-sex standardised rate of emergency admissions for fractured neck of femur in those aged 80+ per 100,000 population

How to interpret the spine charts

Domain 1: Improving the wider determinants of health

Objective: Improvements against wider factors that affect health and wellbeing and health inequalities

Indicators (indicators which are still being finalised nationally are in italics)

1.01	Children in poverty
1.02	*School readiness*
1.03	Pupil absence
1.04	First-time entrants to the youth justice system
1.05	16-18 year olds NEETS
1.06	People with mental illness or disability in settled accommodation
1.07	*People in prison who have a mental illness or a significant mental illness*
1.08	*Employment of those with a long term health condition including those with a learning difficulty/disability or mental illness*
1.09	*Sickness absence rate*
1.10	Killed or seriously injured casualties on England's roads
1.11	*Domestic abuse*
1.12	Violent crime (including sexual violence)
1.13	Re-offending levels
1.14	The percentage of the population affected by noise
1.15	Statutory homelessness
1.16	Utilisation of green space for exercise/health reasons
1.17	*Fuel poverty*
1.18	*Social connectedness*
1.19	*Older people's perception of community safety*

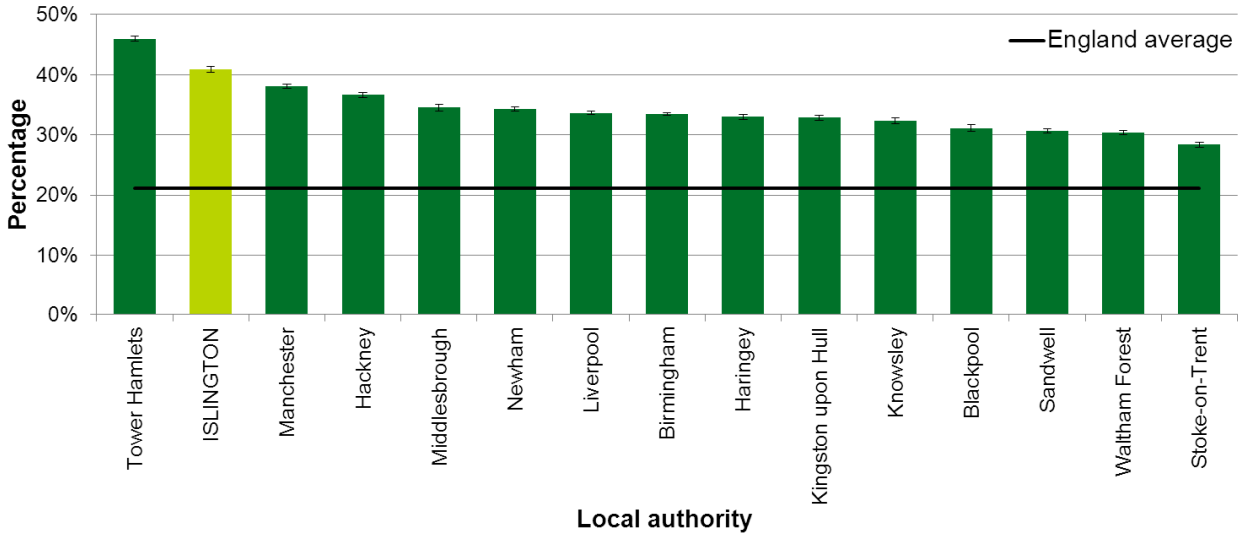
1.01 - Children in poverty

Rationale from DH Technical Specification, 2013

Child poverty is an important issue for public health. Inclusion of this indicator emphasises its importance. The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy.

The Islington picture

Percentage of children in poverty, Islington and similarly deprived boroughs compared against the England average, all persons, under 16 years, 2010



Source: HM Revenue and Customs (Personal Tax Credits: Related Statistics - Child Poverty Statistics)

Note: the local authorities on this chart are not the same group as Islington's Statistical Neighbours, as defined by the Department for Education.

Islington is ranked second in the country in terms of the proportion of children living in poverty, with 41% of children living in families whose household income was less than 60% of the national median. This equates to 13,610 children in Islington living in poverty.

There is variation across Islington with 29% of children living in poverty in Highbury East compared to 52% in Holloway (2009).

There are several other indicators used to track child poverty. Data on the number of Islington children living in families receiving out of work benefits is published quarterly. The figures indicate that the number of children living in these households has also steadily fallen; from 13,090 in 2010 to 12,140 in 2011, and to 11,070 in February 2013.

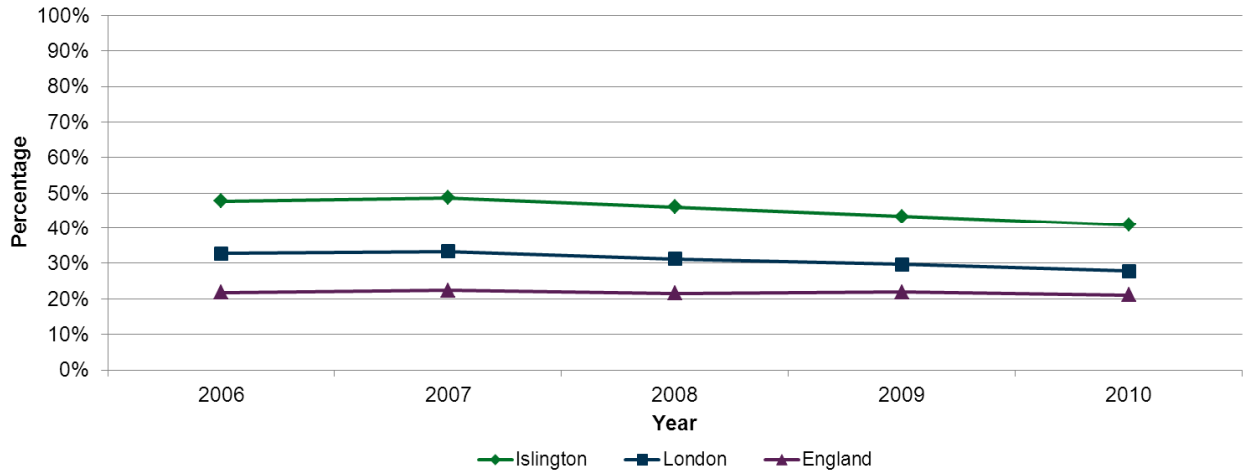
Census data from 2011 showed that in Islington, 12% of households with dependent children were living in statutory overcrowded conditions, which can impact a child's social and educational development.

Nearly 50% of pupils in Islington's primary schools and 61% of pupils in Islington's secondary schools were eligible for and claiming Free School Meals in January 2012 which are both higher than the inner London average (33% and 52% respectively).

1.01 - Children in poverty

Since 2007 there has been a steady fall in the proportion of Islington's children who are living in poverty, from 49% to 41%. The level of child poverty in Islington has fallen at a similar rate to London, and has fallen faster than the national average, narrowing the gap slightly.

Percentage of children living in poverty, aged under 16 years old, Islington, London and England, 2006 to 2010



Source: HMRC, 2012

Equalities and health inequalities

- Employment: the single greatest risk factor affecting child poverty is worklessness.
- Disability: children living in households with at least one disabled parent are significantly more likely to experience child poverty. A 2011 Needs Assessment for services for disabled children in Islington found that disabled children and young people in Islington are more likely to live in social housing, live in an overcrowded property, or live in a household in receipt of low income or workless benefits than the average 0-18 year old living in Islington.
- Family size: among households where at least one adult is working, there is an increased risk of child poverty in larger families. For example, the 2010 Child Poverty Needs Assessment found that 40% of children in families with one or two dependent children were living in workless or low income households, while over 70% of children in families with more than two children were living in workless or low income households.
- Age: the children of younger parents (aged under 25) are more likely to be in poverty. The children of teenage parents are particularly at risk.
- Ethnicity: nationally, although the majority of children in poverty are White British, some Black and Minority Ethnic groups, notably Pakistani, Bangladeshi and Black African communities, are significantly more likely to be affect by poverty. In Islington, data used for the Child Poverty Needs Assessment in 2010 found that there was variation in the proportion of children living in workless or low income households amongst different ethnic groups. Whilst only around a third of Chinese children lived in a workless or low income household, over 80% of Kurdish and Black African (excluding Somali) children lived in a workless or low income household.

1.01 - Children in poverty

Key programmes in Islington

Universal services

Islington residents can receive all the benefits that they are entitled to through help from Income Maximisation. The Benefits Team who administers housing and council tax benefit can also provide advice on making a claim and signpost residents to support in saving and money management. There is also advice and support available for parents to return to work and courses to increase employability through Islington's Parental Employment Partnership and Job Centre Plus. For those in receipt of benefits or low wages the Learning offer from Adult Community Learning and City and Islington College is available. Children's Centres and schools provide support for families through family learning, access to ESOL (English for Speakers of Other Languages) courses and other employability skills.

Targeted services

There are numerous poverty related targeted services available in Islington. Residents with housing difficulties can contact the Housing Services e.g. Housing Aid Centre. There are several services available for substance misuse including Primary Care Drug and Alcohol Service, CASA Family Service, Islington Drug and Alcohol Specialist Service and ISIS North. Services supporting people with mental health issues include iCope, Islington Mind and Families First. Parents with learning difficulties can seek help and advice from Adult Services, The Elfrida Society, and Centre 404 and there is also a unit specialising in domestic violence.

Targets

The national commitment remains to eradicate child poverty by 2020.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of children aged under 16 living in families in receipt of CTC whose reported income is less than 60% of the median income or in receipt of Income Support or (Income-Based) Job Seeker's Allowance.

Denominator: Number of children aged under 16 for whom Child Benefit was received in each local authority.

Further information

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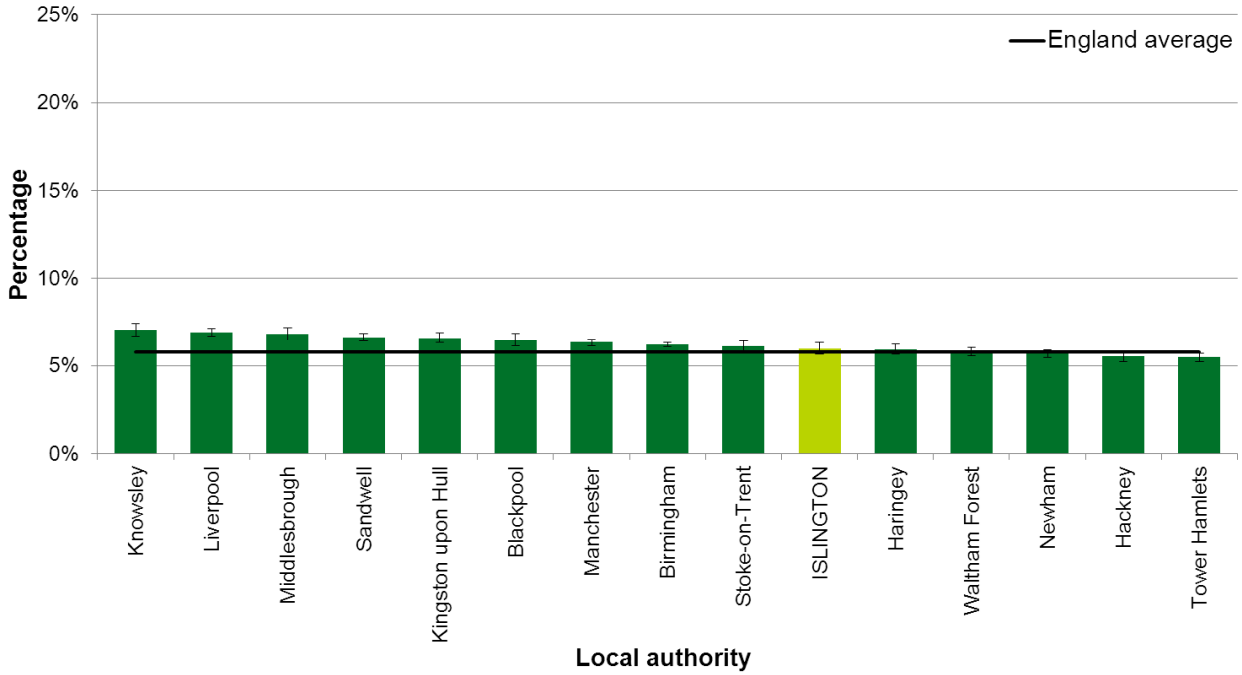
1.03 - Pupil absence

Rationale from DH Technical Specification, 2013

Parents of children of compulsory school age (aged 5 to 15 at the start of the school year) are required to ensure that they receive a suitable education by regular attendance at school or otherwise. Education attainment is influenced by both the quality of education they receive and their family socio-economic circumstances. Educational qualifications are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources. These are related to health and health inequalities.

The Islington picture

Percentage of half days lost through pupil absence, Islington and similarly deprived boroughs compared against the England average, all persons, 5-15 years old, 2011/12



Source: The School Census

Note: the local authorities on this chart are not the same group as Islington's Statistical Neighbours, as defined by the Department for Education.

Absence data for the academic year 2011/12 has been published, which shows absence levels for Islington school pupils fell to 5.2% (298,201 out of 5,769,066 half days), equal to the England average and similar to the average absence level of the comparator boroughs shown in the chart above. However, it is useful to report the absence levels for primary, secondary and special schools separately. In 2011/12, Islington primary school absence level was 4.7%, the secondary school absence level was 5.6% and the special school absence level was 9.4%. Special school absence levels across the country as a whole are higher than other types of school, usually due to higher levels of absence because of illness or medical appointments.

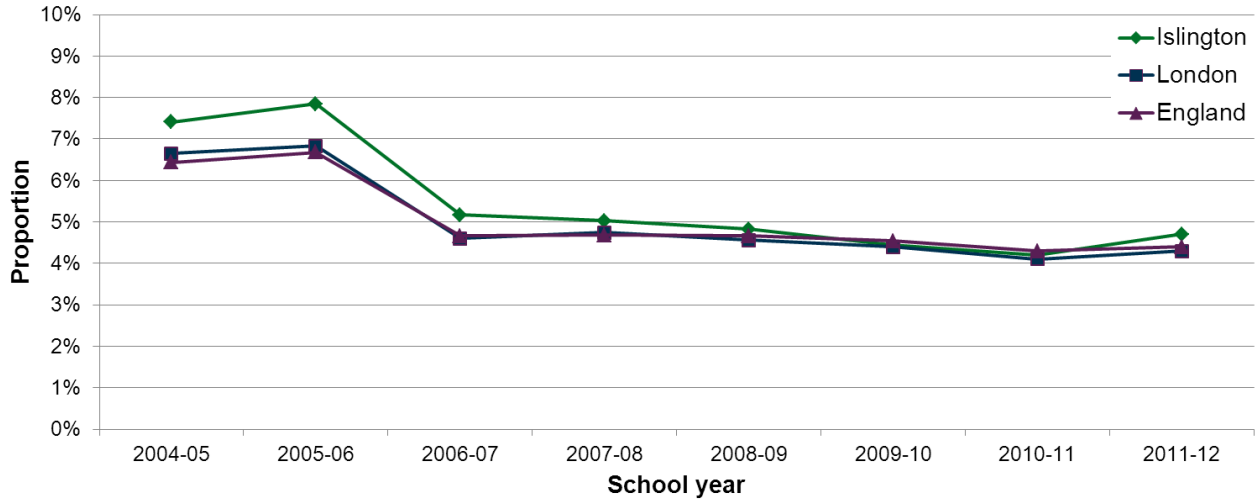
1.03 - Pupil absence

Islington has seen an improvement in attendance in recent years, with primary and secondary schools having reduced absence rates every year since 2007/08.

Persistent absenteeism relates to those children who have sustained periods of absence from school. In July 2011, the Department for Education (DfE) announced a change in the definition of persistent absence, lowering the threshold from pupils who have missed 20% of sessions to those who have missed 15% of sessions.

In Islington primary schools, persistent absence in 2011/12 was 4.1% (452 persistent absentees), higher than Inner London (3.4%) and national rates (3.1%). In the borough's secondary schools, persistent absence was 7.1% (567 persistent absentees) in 2011/12. This was lower than the national average (7.4%) but not as good as Inner London (6.3%).

Proportion of half-days of school lost to pupil absence, Islington, London and England, all pupils at state-funded primary or secondary schools, 2004-05 to 2011-12



Source: Department for Education

Equalities and health inequalities

- **Age**: Absence from school, at a national level, tends to be higher among younger children, and then decreases by each year of age during the Primary School phase. During the secondary school phase, however, absence levels tend to rise by each year of age, peaking in Year 11.
- **Ethnicity**: In 2011/12, the Secondary School absence levels for White British pupils in Islington schools was 8.1% (based on the first two terms), higher than the absence level of any other ethnic group.
- **Deprivation**: Islington pupils who are eligible for Free School Meals have higher levels of absence than those who are not eligible. DfE research has found that nationally, pupils who are eligible for Free School Meals are twice as likely to be a persistent absentee as similar pupils who are not eligible for them.
- **Gender**: The overall rate of absence is higher for boys in Islington primary schools, but is higher for girls in Islington secondary schools.

1.03 - Pupil absence

Key programmes in Islington

Education Welfare Service

The Education Welfare Service (EWS) promotes the importance of regular school attendance and investigates the causes of poor attendance. When a child or young person has a record of absences, or has stopped going to school altogether, Education Welfare Officers (EWOs) work with parents and carers, school staff and other agencies, including the courts, to improve attendance.

Islington promotes regular school attendance for all pupils in Islington schools, including those in the independent sector. Our EWOs work with schools to identify pupils whose attendance is of concern and seek to help families resolve problems through support and negotiation. Parents who fail to work with their EWOs may find a range of legal sanctions used to enforce their children's school attendance.

Targets

There are no local or national targets for this indicator

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: The number of sessions missed due to overall absence

Denominator: The total number of possible school sessions

Further information

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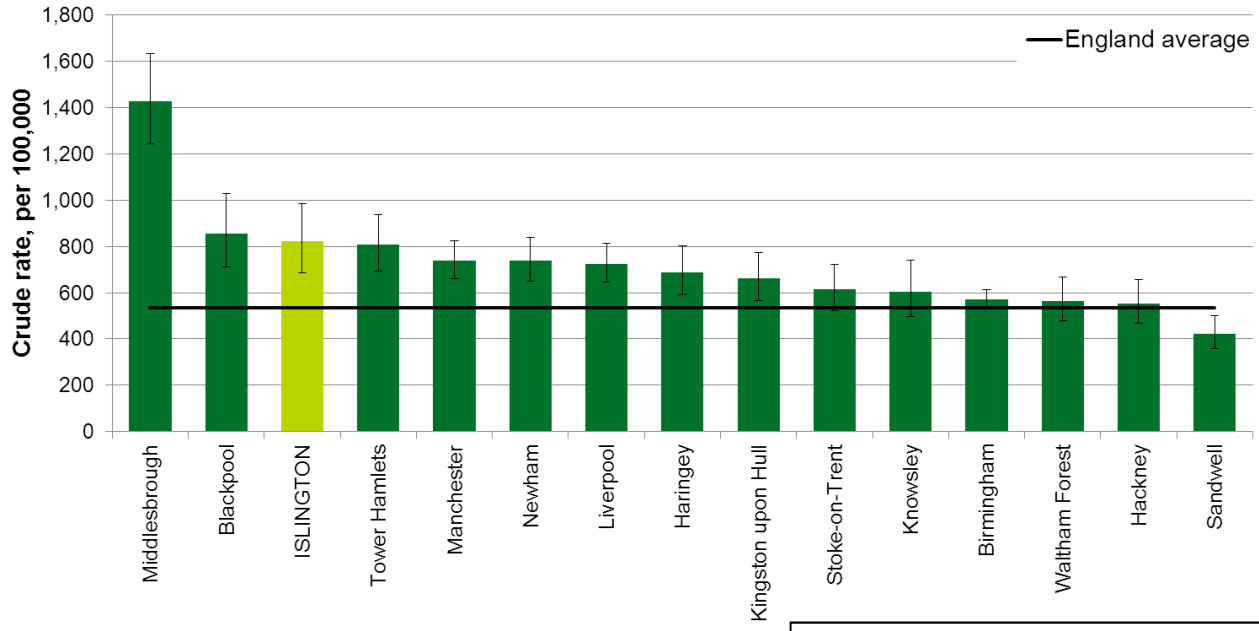
1.04i - First time entrants to the youth justice system

Rationale from DH Technical Specification, 2013

Children and young people at risk of offending or within the youth justice system often have more unmet health needs than other children.

The Islington picture

Crude rate of first time entrants to the youth justice system, Islington and similarly deprived boroughs compared against the England average, all persons, aged 10-17 years, 2012



Source: Ministry of Justice, 2012

Note: the local authorities shown in this chart are not the same group as the Youth Offending team 'Family', which Islington are usually compared with for this indicator.

In 2012, the Islington rate of 10-17 year olds receiving their first reprimand, warning or conviction fell to 824 first time entrants per 100,000 10-17 year olds in the resident population. This is comparable to most of the local authorities with similar levels of deprivation, as shown above. However, Islington is higher than the London (585 per 100,000) and England rates (537 per 100,000).

The Islington rate of first time entrants, when compared to the size of the population, was higher than the England and London averages in 2012. The Youth Justice Board define a set of comparator authorities, known as a Youth Offending Team (YOT) 'Family', that each authority should use for benchmarking (note that these are not the same authorities as those shown in the chart). The Islington 2012 rate is above the YOT Family average (720 per 100,000).

1.04i - First time entrants to the youth justice system

There has been a strong focus in Islington on reducing the risk of young residents entering the criminal justice system. As a result there has been a substantial decrease in the rate of first time entrants, in line with regional and national trends. The Islington rate has been falling each year since 2007, when it peaked at 2,375 first time entrants per 100,000 10-17 year old population.

The actual number of young Islington residents entering the youth justice system has also fallen in recent years. In 2007, 331 young people in Islington received their first reprimand, warning or conviction. In comparison, in 2012/13, only 109 young people in Islington entered the youth justice system for the first time.

Crude rate of first time entrants to the youth justice system per 100,000 population, aged 10-17 years old, Islington, London and England, 2002 to 2012

Source: Ministry of Justice, 2012

Equalities and health inequalities

- Risk factors for youth offending include inadequate parenting, child abuse/maltreatment, family disruption, poor parental supervision, parental or sibling criminality, having teenage parents, parental substance misuse, mental health problems, domestic violence, unstable living conditions, economic disadvantage, learning difficulties, and unidentified speech and language needs.
- There is a high prevalence of complex and persistent mental health and social care needs among children and young people in contact with the youth justice system. Significantly higher levels of unmet needs are found among young offenders in the community than among those in secure care, particularly with regard to education, peer and family relationships and risky behaviour.
- Across England, there is an overrepresentation of Black/Black British young people who offend, compared to the size of the population. In Islington, there is also an overrepresentation of young people from a mixed ethnic group who offend (based on all offenders aged 10 to 17, rather than just first time entrants to the youth justice system).

1.04i - First time entrants to the youth justice system

Key programmes in Islington

Teams involved in the prevention of offending include:

- The Targeted Youth Support Service ensures that young people and their families are identified and offered support at the earliest opportunity so they can be diverted from offending, avoid repeat offending and access support through our Stronger Families offer (if eligible). Borough intelligence and anti-social behaviour data is used to deploy detached youth workers and youth buses, in order to prevent escalation and to engage with young people and wider communities.
- Knife crime prevention programmes, group work, and positive activities are provided by Targeted Youth Support that lead to accredited outcomes. This is further strengthened by a restorative justice approach - giving victims a greater say in how the young person can make amends and reinforces the consequences of their action, with a view to prevent them entering the criminal justice system.
- The 18 – 24 Gangs Transitions Team launched in October 2012 and has 24 live cases (as of July 2013).
- The Stop and Search Monitoring Group became operational in April 2013. The group looks at disproportionality, including first time entrants into the criminal justice system.

During December 2012, the Safer Islington Partnership was subject to an Ending Gang and Youth Violence Peer Review. The Bronze Group (a multi-agency operation group that shares information and coordinates resources to prevent and reduce young people's involvement in gang activity) was identified as an overall example of good practice.

The Specialist Multiagency Outreach Support Service works with adolescents with complex needs in some of Islington's most hard to reach and socially excluded families, who, without the provision of services, are likely to present as a danger to themselves or others through serious anti social and/or offending behaviour.

Targets

There are no set targets for this indicator

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of 10-17 year olds receiving their first reprimand, warning or conviction.

Denominator: Mid-year populations (10 to 17 year olds)

Further information

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1.05 - 16-18 year olds not in education employment or training

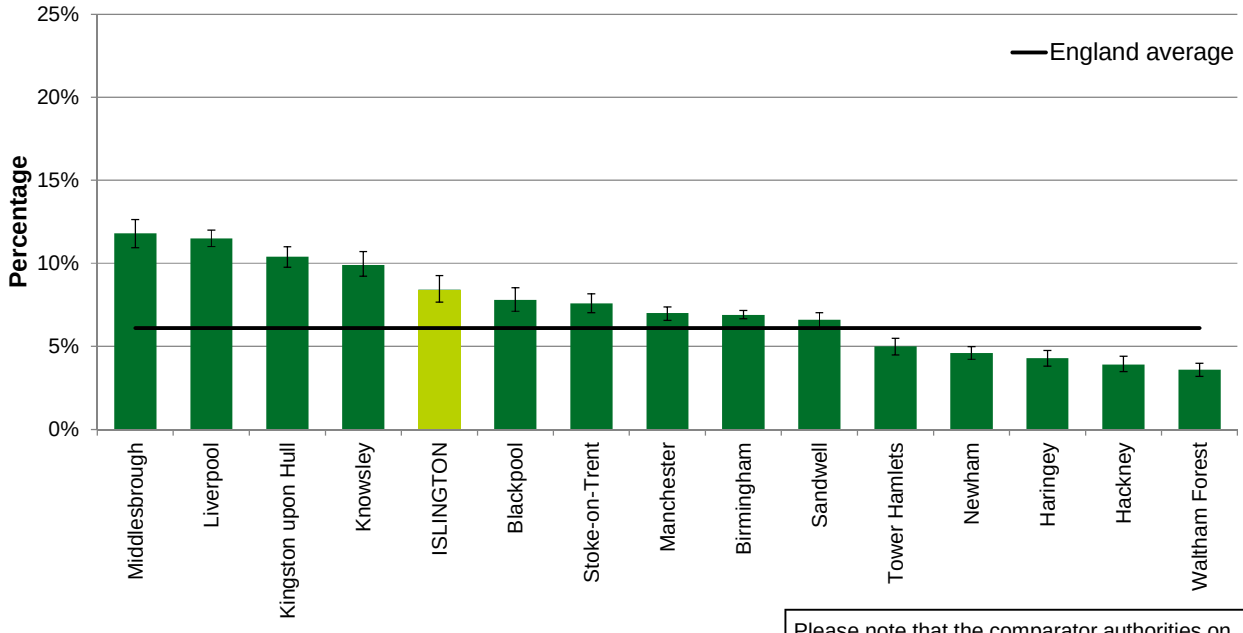
Rationale from DH Technical Specification, 2013

Young people who are not in education, employment or training (NEET) are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood. The indicator is included to encourage services to work together to support young people, particularly the most vulnerable, to engage in education, training and work.

The government is raising the age of participation in education and training. Young people completing their GCSEs in 2013 will remain in education or training for at least one further full academic year. Young people completing their GCSEs in 2014 will remain in education or training until at least their 18th birthday.

The Islington picture

Percentage of 16-18 year olds not in education employment or training, Islington and similarly deprived boroughs compared against the England average, all persons, aged 16-18 years, 2012



Source: Department for Education

Please note that the comparator authorities on this chart are not the same group as those Central London local authorities that Islington are usually compared with for this indicator.

The latest data on this measure shows that between November 2012 and January 2013, 8.8% of Islington's resident 16 to 18 year olds were not in education, employment or training. This is an adjusted figure, to take into account that the activity of some 16 to18 year olds is not known and relates to an estimated 470 young people. This is higher than the England average and the fifth highest in the comparator group shown above. This is slightly higher than the average for the comparator group of Central London local authorities across the same period, which stood at 7.9% (please note this is a different group than the local authorities shown in the chart above).

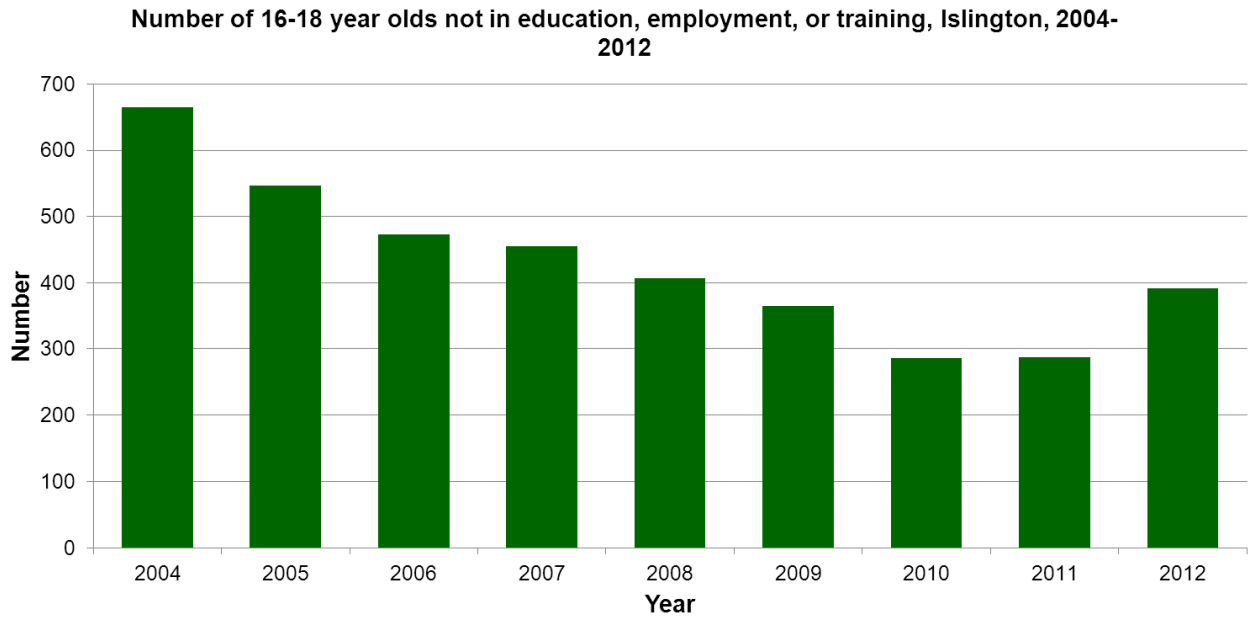
1.05 - 16-18 year olds not in education employment or training

The definition of NEETs has changed several times over the past decade, so it is difficult to meaningfully comment on trends in the proportion of NEETs over time. However, the proportion of 16-18 year-olds not in education, employment or training (NEET) in England has generally remained at around 10% for the past decade.

In Islington, there is a long-term downward trend in the number of young people altogether out of education, employment and training. This measure is a focus for the recently initiated Education and Pathways to Employment project.

The long-term Islington trend shows improvement. In 2004, 665 young residents were NEET. Between 2004 and 2008 the number of NEET young residents was consistently above 400. In contrast, between 2009 and 2012 the number of young residents known to be NEET has been consistently below 400.

Overall figures mask a changing picture, both locally and nationally. There has been a reduction in the proportion of 16 and 17 year-old altogether out of education, employment and training; and an increase in the proportion of 18 year olds NEETs.



Source: Central London Connexions

Equalities and health inequalities

- Young people with Learning Difficulties and Disabilities (LDD) are more likely to be altogether out of education, employment and training. Nationally, at the age of 16, young people with LDD are twice as likely to be NEET than those without.
- Teenage parents and pregnant young women are at particular risk of disengagement from education, employment and training. In England, nearly 70% of young mothers aged 16 to 19 are Not in Education, Employment or Training. In Islington, around half of teenage parents and pregnant young women known to the Youth Careers Team are NEET.

1.05 - 16-18 year olds not in education employment or training

Key programmes in Islington

The Education and Pathways to Employment project is Islington's approach to increasing employment, and securing pathways to employment, for young people. The project is divided into dedicated 'workstreams'. The seven operational workstreams are:

- Sustaining 60% of pupils 5 GCSEs at grades A*-C including English and mathematics
- Effective information, advice and guidance in place for all students
- High quality Alternative Provision, (including opportunities to achieve grade C and above in English and maths)
- Ensuring that the Raising of the Participation Age is well managed and leads to better outcomes
- Strategic partnerships with businesses, to provide the best opportunities for students to access education, employment or training at every level - including opportunities for work experience - pathways through apprenticeships are secured and vacancies are filled
- Engagement with schools and other stakeholders to support the project, to ensure that it is planned and targeted
- Engagement with young people to determine the objectives of the project and the evaluation of its impact

This is supported by a range of services, particularly the School Improvement Service; the Youth Careers Team; the Alternative Provision Team; and the Business and Employment Support Team.

Targets

No Islington-resident 16-18 year-old should be altogether out of Education, Employment or Training, by 2015.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: The estimated number of 16-18 year old residents not in education, employment or training

Denominator: The total number of 16-18 year old residents known to the local authority

Further information

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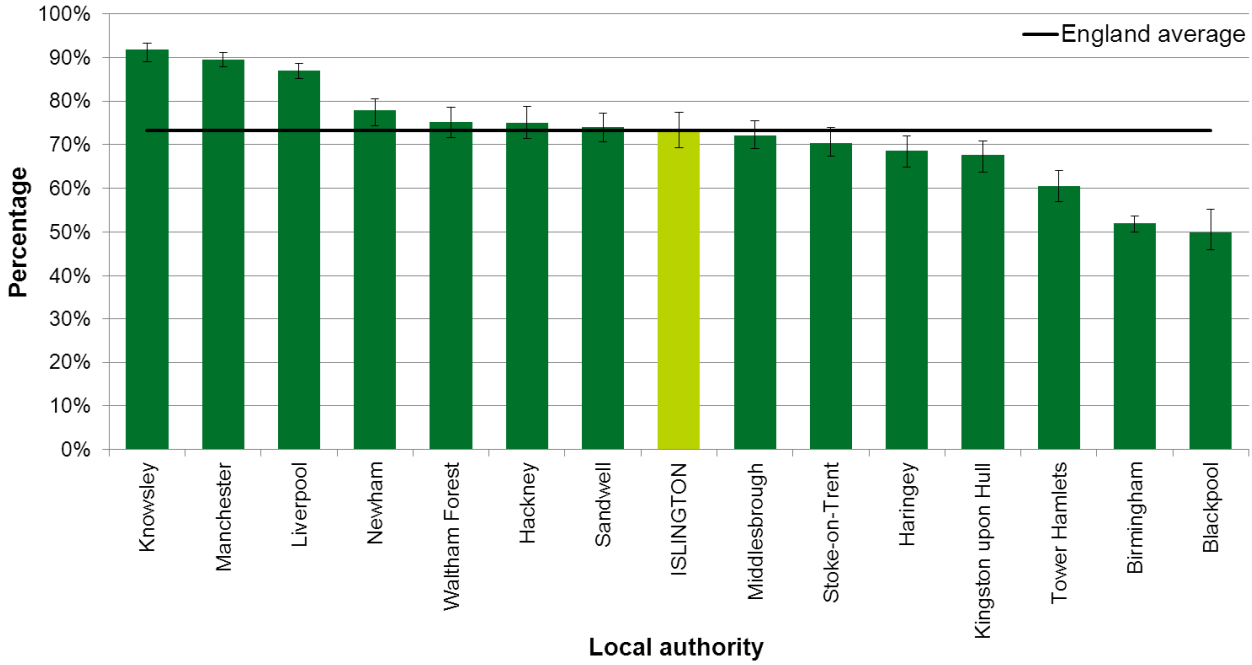
1.06i - Adults with a learning disability who live in stable and appropriate accommodation

Rationale from DH Technical Specification, 2013

The indicator is intended to improve outcomes for adults with a learning disability in settled accommodation by improving their safety and reducing their risk of social exclusion. Maintaining settled accommodation and providing social care in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital or more costly residential care and ensures a positive experience of social care.

The Islington picture

Percentage of adults with a learning disability who live in stable and appropriate accommodation, Islington and similarly deprived boroughs compared against the England average, all persons, 18-64 years, 2012/13



Source: Health and Social Care Information Centre.
Note: Data are provisional.

In 2012/13 330 people with global learning disabilities, aged 18-64 years, were living in stable and appropriate accommodation in the community in Islington, either with their family or in their own homes. This represents 75% of the local learning disabled population and is in line with the England average, and broadly comparable to the other similarly deprived boroughs.

In 2011/12, 723 adults were registered with their GP as having a global learning disability. National estimates indicate that the prevalence of people with autism who also have global learning disabilities is 52%, this equates to 376 people.

1.06i - Adults with a learning disability who live in stable and appropriate accommodation

It is estimated that 50 new people with global learning disabilities will require adult services in Islington each year. This is due to:

- Improvements in health care with many more people often with profound and multiple learning disabilities surviving into infancy, adulthood and older age.
- The growing number of older family carers who are struggling to cope with the demands of caring.

The extra costs to the NHS and local authority in Islington of providing services to the growing number of adults with learning disabilities is estimated at £2million each year. Compared to London and England, Islington supports a similar percentage of men to live in their own homes or with family (71%), but a significantly greater percentage of women (81%). The reason why Islington has more women living in their own home or with family than the national or London average is not fully understood.

Percentage of working age adults with a learning disability known to local authorities who live in their own home or with family, Islington, London and England, 2012/13

Source: Health and Social Care Information Centre
Note: 2012/13 data are provisional.

Equalities and health inequalities

- Adults with learning disabilities are amongst some of the most vulnerable and socially excluded people in society. Learning disabled people have the same rights as the general population to live healthy, productive and independent lives with appropriate and responsive treatment and support to develop to their maximum potential. However, nationally people with a learning disability experience worse health, social and economic outcomes.
- The average prevalence of learning disabilities is higher in men (0.5%) compared to women (0.3%) across all age groups, with a particularly marked gender difference in those aged less than 20 years.
- The prevalence of learning disabilities does not differ significantly by ethnic group in women, but is higher in Black men (0.7%) compared to all men in Islington (0.5%). However, the number of White men with learning disabilities is higher.

1.06i - Adults with a learning disability who live in stable and appropriate accommodation

Key programmes in Islington

Accommodation based support services

- Outreach housing support to people living in general needs housing.
- 'Move on' intensive transition support to develop independent living skills
- Extra Care Supported accommodation schemes providing one bedrooms flats or shared flats and houses for people with low, moderate, severe and profound learning disabilities

Respite services for family carers

- Residential care short breaks
- Shared lives short breaks (placements with foster carers)
- Personal budgets enabling people to buy their short break of choice

Social inclusion services

- Centred based activities commissioned from a variety of providers to meet bespoke needs
- Outreach community based social inclusion and leisure programme
- Further Education for 18–25 year olds
- Community Access Project providing training to younger adults on life skills

Targets

Provide local accommodation options, enabling adults with learning disabilities to live as independently as possible in the community and support family carers to care for relatives with learning disabilities at home.

Indicator definition: **for a full definition please refer to the DH Technical Specification, 2013**

Numerator: Number of working age (aged 18-64) learning disabled service users known to councils with adult social service responsibilities (CASSRs) who are living in their own home or with their family during the financial year.

Denominator: Number of working-age (aged 18-64) learning disabled clients known to CASSRs during the financial year.

Further information

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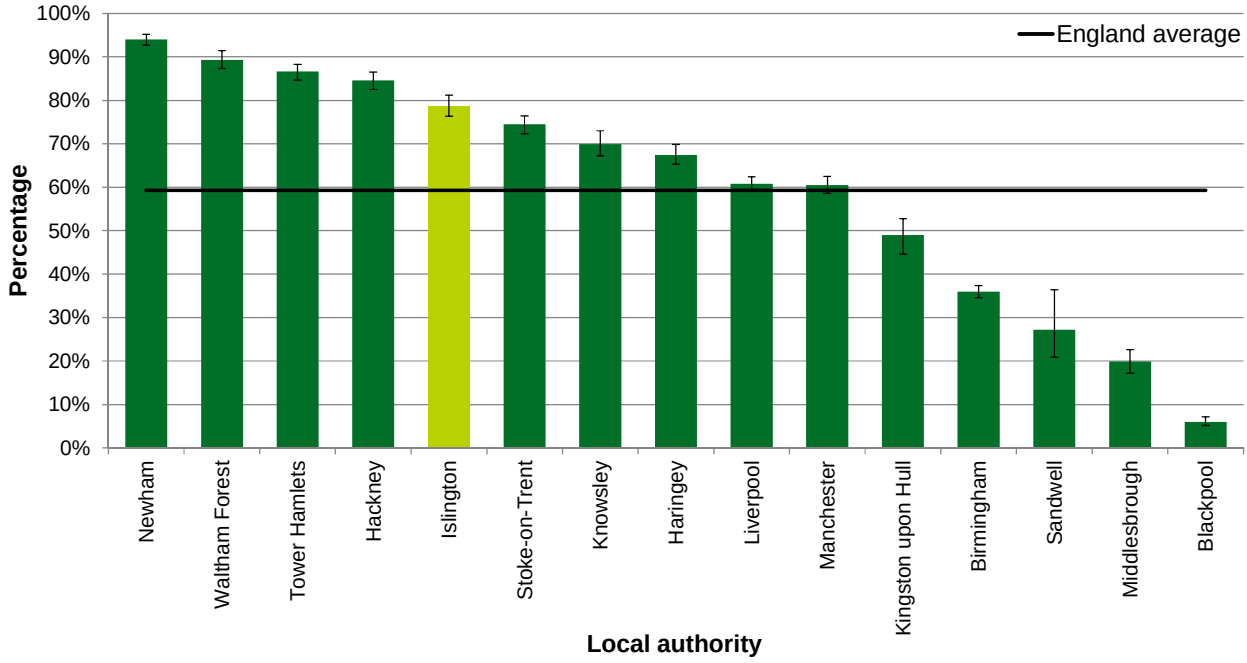
1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation

Rationale from DH Technical Specification, 2013

The indicator is intended to improve outcomes for adults with mental health problems in settled accommodation by improving their safety and reducing their risk of social exclusion. Maintaining settled accommodation and providing social care in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital or more costly residential care and ensures a positive experience of social care.

The Islington picture

Percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation, Islington and similarly deprived boroughs compared against the England average, all persons, 18-69 years, 2012/13



Source: Health and Social Care Information Centre.
Note: Data are provisional.

Provisional data for 2012/13 show that 79% of people accessing mental health services who were on the Care Programme Approach***** were known to be in settled accommodation in Islington. This equates to 840 people and is similar to 2011/2012 when the percentage stood at 78%.

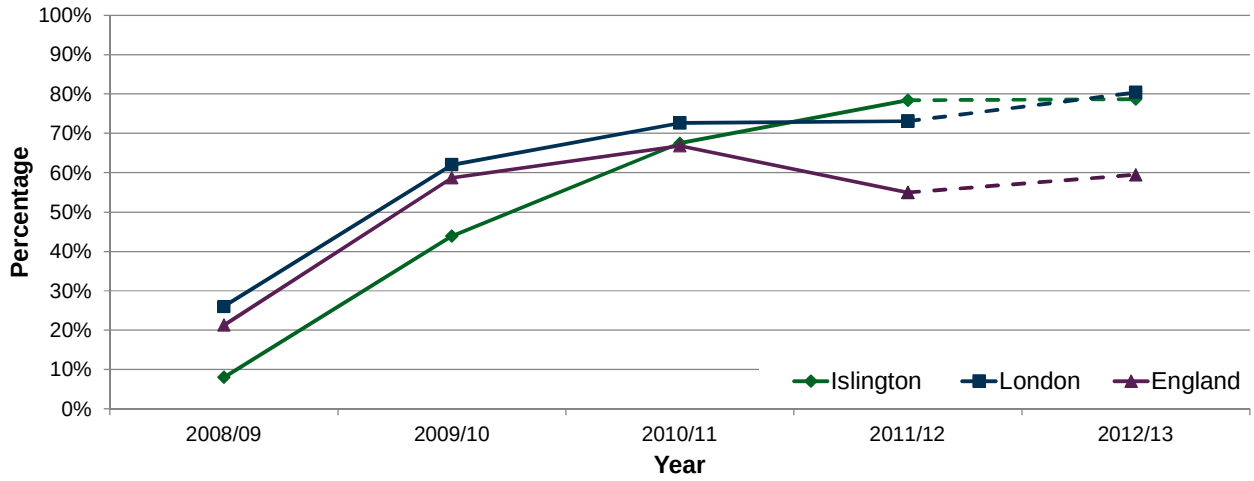
Islington's performance on this indicator is similar to the London average (80%) and significantly higher than the England average (59%). The borough has a lower percentage of service users in settled accommodation than four similarly deprived London local authorities. However, the provisional figures for Islington are lower than reported by Camden & Islington NHS Foundation Trust (CANDI) and are being queried with the NHS Health & Social Care Information Centre.

***** The Care Programme Approach is a nationally prescribed framework for the coordination of care for mental health service users with more complex needs. A small number of complex and high risk individuals may be receiving care in eating disorder or psychotherapy services where the care programme approach to managing care for service users may not be used.

1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation

The Department of Health (DH) started to collect data on the percentage of mental health service users in settled accommodation in 2008/09. Data quality was initially low, as is frequently the case for a new indicator, so it is difficult to meaningfully comment on time trends at either a national or local level. The chart shows an improvement in recording of information about mental health service users, rather than an increase in the percentage of service users in appropriate accommodation.

Percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation, Islington, London and England, all persons aged 18-69, 2008/09 to 2012/13



Source: Health and Social Care Information Centre
Note: 2012/13 data are provisional.

Equalities and health inequalities

- Mental health: people with mental health problems are more likely to live in social housing or rented accommodation than people with no reported mental health problems.
- Gender: women are more likely to experience mental health problems than men.
- Family size: single parenting is a significant risk factor for experiencing one or more neurotic disorder.
- Employment and income: people who are either economically inactive or earning a low income are more likely to experience mental health problems.
- Ethnicity: in Islington, rates of serious mental illness are significantly higher in a number of Black and Minority Ethnic groups, including Black Caribbean, White and Black Caribbean, and Black African.

1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation

Key programmes in Islington

Universal services

In order to enable more people with mental health problems to live within the community, several units of residential accommodation have been converted to supported housing schemes.

There are also extensive supported housing schemes delivered through the council's Supporting People Programme.

Targeted services

In Islington, Mental Health First Aid is available to all Housing staff. Additionally, there are a number of services to support those with mental health problems

Services

Islington Mental Health Housing Floating Support Service provides housing related support to people with mental health problems who are currently or about to be living in their own accommodation.

Targets

For 2013/14, the target is for 86% of people accessing mental health services to be living in settled accommodation.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of adults aged 18-69 who are receiving secondary mental health services on the Care Programme Approach recorded as living independently (with or without support).

Denominator: Number of adults aged 18-69 who have received secondary mental health services and who were on the Care Programme Approach at any point during the financial year.

Further information

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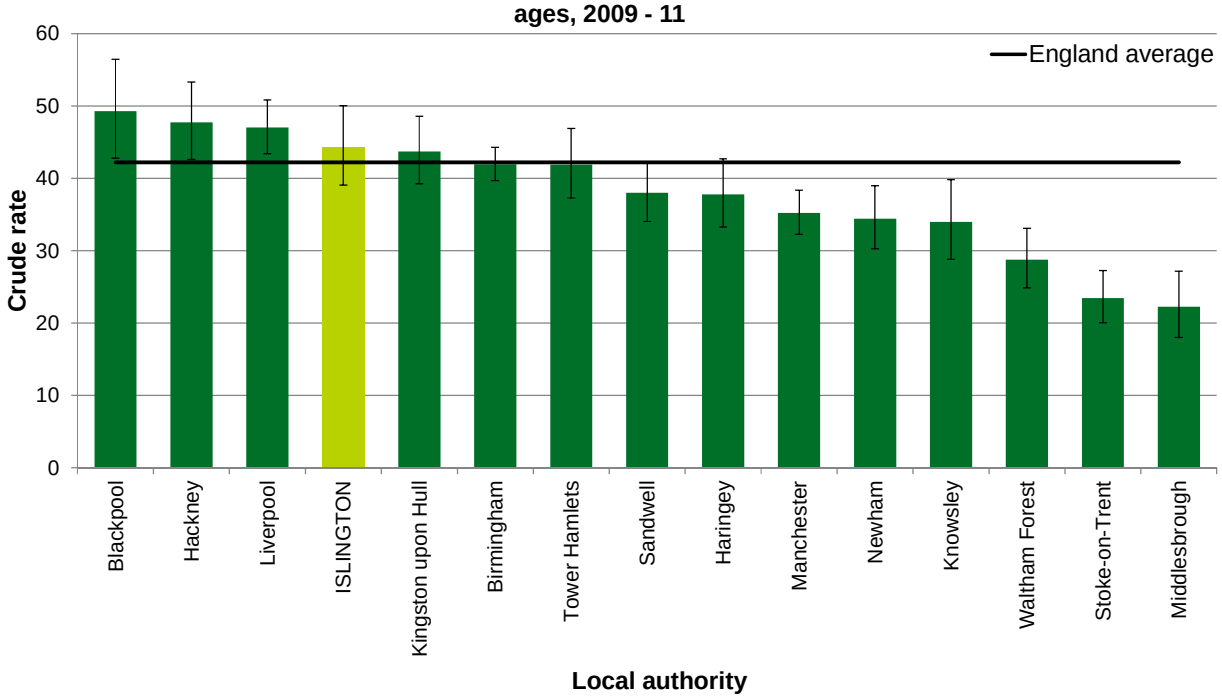
1.10 - Killed and seriously injured casualties on England's roads

Rationale from DH Technical Specification, 2013

Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity, particularly in younger age groups. The World Health Organisation (WHO) now recognises them as the main cause of acquired disability. For children and for men aged 20-64 years, mortality rates for motor vehicle traffic accidents are higher in lower socioeconomic groups. The vast majority of road traffic collisions are preventable and can be avoided through improved education, awareness, road infrastructure and vehicle safety.

The Islington picture

Crude rate of killed and seriously injured casulties on England's roads, Islington and similarly deprived boroughs compared against the England average, all persons, all ages, 2009 - 11



Source: Department for Transport

Between 2009-11, the number of Killed or Seriously Injured (KSI) casualties on all roads in Islington was 258, equivalent to a rate of 44 per 100,000 resident population. The rate of KSI casualties on Islington's roads was similar to the England average of 42 per 100,000.

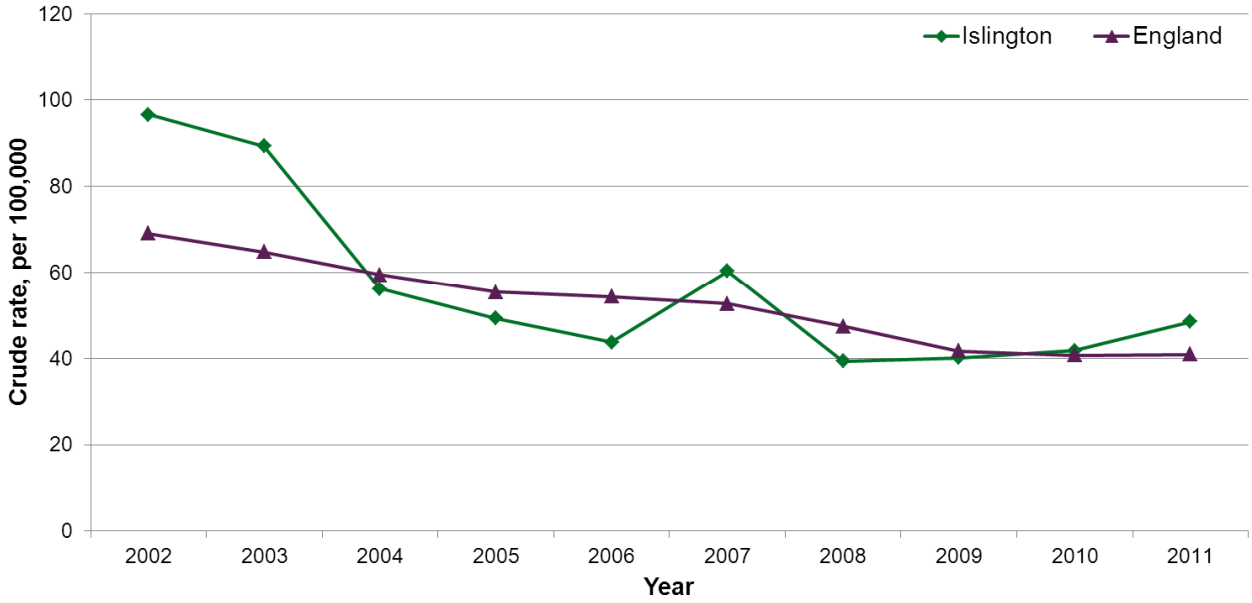
In 2011, 38% of KSI casualties were cyclists and 29% were pedestrians, with the remainder being all other road users combined. There were four fatally injured people (two cyclists and two pedestrians). Five children (<16 years) were seriously injured in 2011, an increase of two compared with 2010.

1.10 - Killed and seriously injured casualties on England's roads

The rate of deaths or serious injuries has been falling over time for both Islington and England. In 2002 the rate in Islington was 98 per 100,000 population and in 2011 it was 48 per 100,000; a decrease of 50%. Heavy snow falls experienced during the early months of 2010 but not in 2011 could be a significant factor in the KSI increase recorded in 2011.

Compared to 2010, national (Great Britain) statistics for 2011 show that the although the number of pedal cyclists and motorcyclists killed decreased by 4% and 10%, respectively, there were increases in the number seriously injured of 16% and 10% respectively. The number of pedestrians killed increased by 12%, and pedestrians seriously injured also increased by 5%.

Crude rate of people reported killed or seriously injured on the roads per 100,000 population, Islington and England, 2002-2011



Source: Department for Transport

Equalities and health inequalities

- Gender: boys and men are more likely to be killed or involved in a road traffic accident than girls and women.
- Age: peak ages for road traffic accidents are in childhood and early adulthood, with significantly higher rates in boys and men. Nationally, road collisions are the leading cause of death for young adults aged 15-24 and they account for over a quarter of deaths in the 15 -19 age group.
- Deprivation: pedestrians in the most deprived areas of London are 2.5 times more likely to be killed or seriously injured in a road traffic accident than their counterparts in the least deprived areas.

1.10 - Killed and seriously injured casualties on England's roads

Key programmes in Islington

Road environment design

Islington has an ongoing programme of measures designed to reduce the number and severity of accidents, based on extensive accident and conflict analyses. The programme uses a wide range of measures to improve safety for all road users and to encourage increased use of streets as places that meet the needs of pedestrians, cyclists and public transport users, and not just the movement of motor vehicles. These include improvements to road signs, markings and surfaces; junction re-design; traffic calming schemes; 20-mph limits and zones and improved walking and cycling facilities. Islington is the first London borough to bring in a 20mph speed limit on all its roads.

Education and training programmes

We deliver a comprehensive range of road safety initiatives for all road user groups with the aim of accident and casualty reduction. The Road Safety and Special Projects Team provide a comprehensive range of road safety initiatives for nursery, pre-school, primary, secondary school pupils and adults who live or work in the borough. Examples of these include cycle training programmes for adults and children through the Bikeability scheme; pedestrian training for children; School Travel Plans; and Safer Steps, a programme aimed at nursery age children. Additionally, the team delivers a number of special projects. Recent examples include a competition for school children to design a poster focussed on speed reduction and ScootAlive, an award-winning scooter safety programme for 12-16 year olds.

School crossing patrols

School crossing patrols are also employed in the borough, primarily to help children and other vulnerable members of the community across the road safely, on their way to and from school.

Targets

The Road Safety Action Plan for London 2020 sets a 2020 target of reducing the number of people killed or seriously injured by 40%, compared to the 2005-2009 average.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: The number of people of all ages reported killed or seriously injured on the roads, between 2009 and 2011.

Denominator: 2001 Census based mid-year resident population estimate for the year 2010 multiplied by three.

Further information

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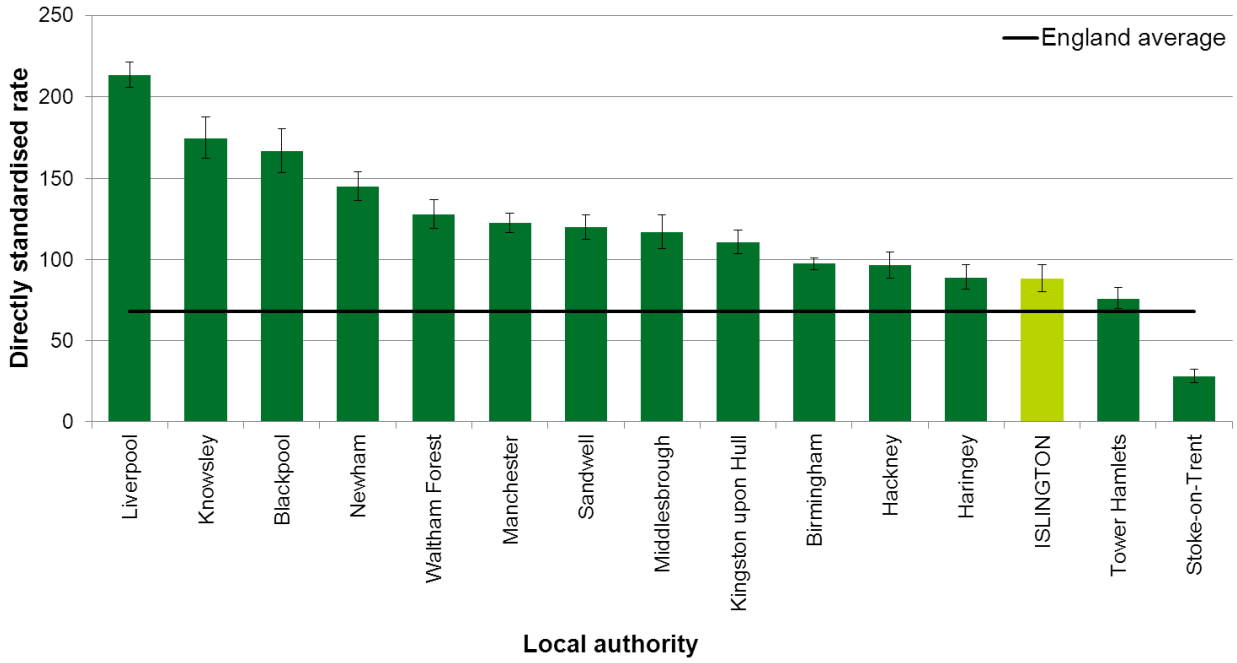
1.12i - Violent crime (including sexual violence) - hospital admissions for violence

Rationale from DH Technical Specification, 2013

Public health services have an important role to play in tackling violence. Directors of Public Health, located within local authorities, will be tasked with looking widely at issues including crime reduction, violence prevention, responses to violence and reducing levels of reoffending, which can also prevent health inequalities.

The Islington picture

Directly standardised rate of hospital admissions for violence, Islington and similarly deprived boroughs compared against the England average, all persons, all ages, 2009/10 - 11/12



Source: HES

Islington residents experience a greater rate of hospital admissions due to violent crime compared to England as a whole; this is important as hospital admissions for violence generally represent more serious forms of violence. The Islington rate of 89 per 100,000 population is equivalent to around 180 admissions per year. In comparison to 14 other similarly deprived boroughs, Islington has the third-lowest rate of hospital admissions, and has a significantly lower rate than nine of the 14.

Hospital admissions due to violence represent only one component of harm caused by violence, although admissions tend to reflect more serious injuries. Research by the North West Public Health Observatory (NWPHO) in 2012 estimated that for every hospital admission for violence, a further ten assault victims require treatment at emergency departments. A further study from the NWPHO suggested that only around one third of violent incidents requiring treatment in Accident & Emergency are reported to the police. Therefore, anonymised hospital data in conjunction with police records and other information can be a useful tool to identify violent crime hotspots, allowing targeted interventions.

1.12i - Violent crime (including sexual violence) - hospital admissions for violence

Many incidents of youth violence (and other types of violence) involve alcohol, with alcohol increasing risks of both perpetrating and being a victim of violence. Analyses of A&E data show that attendances following an assault peak on weekend nights, when a large proportion of assault patients are young men who have been drinking at bars and nightclubs. As previously mentioned, not all A&E attendances for violence result in an admission to hospital.

The NWPHO study also found that intimate partner violence in particular tends to be under-reported to the police, and some victims experience abuse repeatedly over a long period of time. It is therefore important that victims are identified when admitted to hospital and offered support.

Anonymised hospital data is an increasingly important source of intelligence on violence and violent hotspots, along with data from police, the London Ambulance Service and Islington's Anti-Social Behaviour Teams.

Equalities and health inequalities

- **Deprivation:** The experience of violence, both as a perpetrator and victim, shows a strong inequalities gradient, with emergency hospital admission rates for assault being around five times higher in the most deprived communities than in the most affluent. Similarly, attendance at A&E resulting from assaults increases as the level of deprivation increases. In the most deprived areas, emergency hospital admissions for men peaked at 18 years of age with a rate of 698/100,000, compared with 218/100,000 among 18-year old men in the most affluent areas. The peak for women was at age 15 in the most deprived areas (118/100,000) compared with age 20 in the most affluent areas (28/100,000).
- **Gender**: Men are more likely to be admitted to hospital as a result of violence compared with women. However, women are more likely to be victims of sexual violence. The 2011/12 Crime Survey for England and Wales estimated that around one in five women aged 16 and over (20%) had been a victim of sexual assault compared with 2.7% of men.
- **Age**: Rates of emergency hospital admissions for violence rise sharply between the ages of 10 and 18 years across both genders and all deprivation quintiles, before steadily falling as age increases beyond 18 years. However, the rate decreases from its peak more rapidly among men compared with women, and more rapidly in affluent areas compared with more deprived areas.

1.12i - Violent crime (including sexual violence) - hospital admissions for violence

Key programmes in Islington

The Violence Against Women and Girls (VAWG) Strategy 2011 – 2015 details the strategic aims for tackling domestic violence on the borough, including work surrounding the protection of survivors and their children from further violence through the Multi-Agency Risk Assessment Conference (MARAC). Other aims under this strategy include a new offender management programme focusing on the persistent perpetrators of domestic violence.

The Gang and Serious Youth Violence Strategy and action plan details targeted enforcement, prevention and engagement work undertaken against gangs operating in the borough. Under the new policing structure (Local Policing Model) there is a proactive gangs team, who are tasked with disrupting and apprehending those who are identified as gang members.

Tackling alcohol-related harm is a priority for Islington and this is closely linked to hospital admissions for violence. A new licensing policy was implemented in January 2013, which established six cumulative impact areas in Islington. Within these areas, there is a rebuttable presumption that new licences or extensions to hours will normally be refused unless the licensee can demonstrate that there will be no additional impact in the area.

The Safer Islington Partnership, public health, police, and Whittington Health NHS Trust are working together to develop and implement a process for collecting and sharing anonymised data about assaults seen in A&E in line with College of Emergency Medicine Guidance. From this it is hoped that a richer picture of where incidents of violence happen, particularly those which occur within licenced premises, so that appropriate action can be taken.

Targets

There is currently no national or local target.

Indicator definition: **for a full definition please refer to the DH Technical Specification, 2013**

Numerator: The number of emergency hospital admissions for persons resident in the area where the primary diagnosis or any of the secondary diagnoses are ICD-10 codes X85-Y09, for all ages, for the years 2009/10 to 2011/12.

Denominator: ONS mid-year population estimates for 2009 and 2010.

Further information

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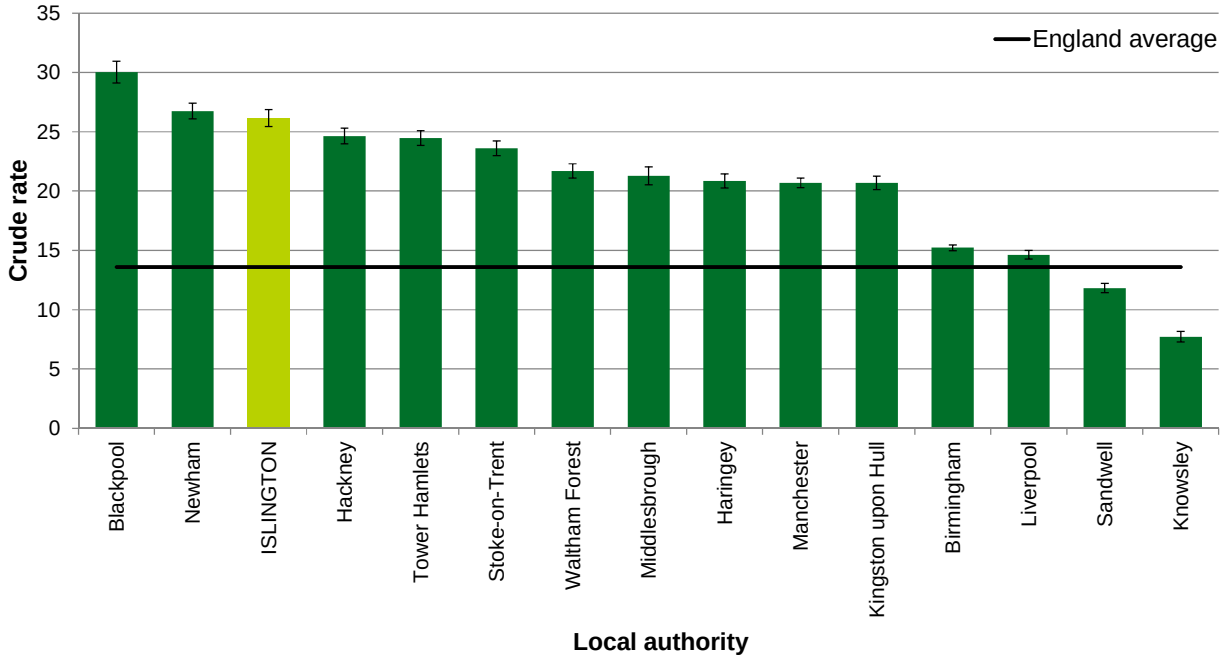
1.12ii - Violent crime (including sexual violence) - violence offences

Rationale from DH Technical Specification, 2013

Public health services have an important role to play in tackling violence. Directors of Public Health, located within local authorities, will be tasked with looking widely at issues including crime reduction, violence prevention, responses to violence and reducing levels of reoffending, which can also prevent health inequalities.

The Islington picture

Crude rate of violence offences, Islington and similarly deprived boroughs compared against the England average, all persons, all ages, 2011/12



Source: Home Office

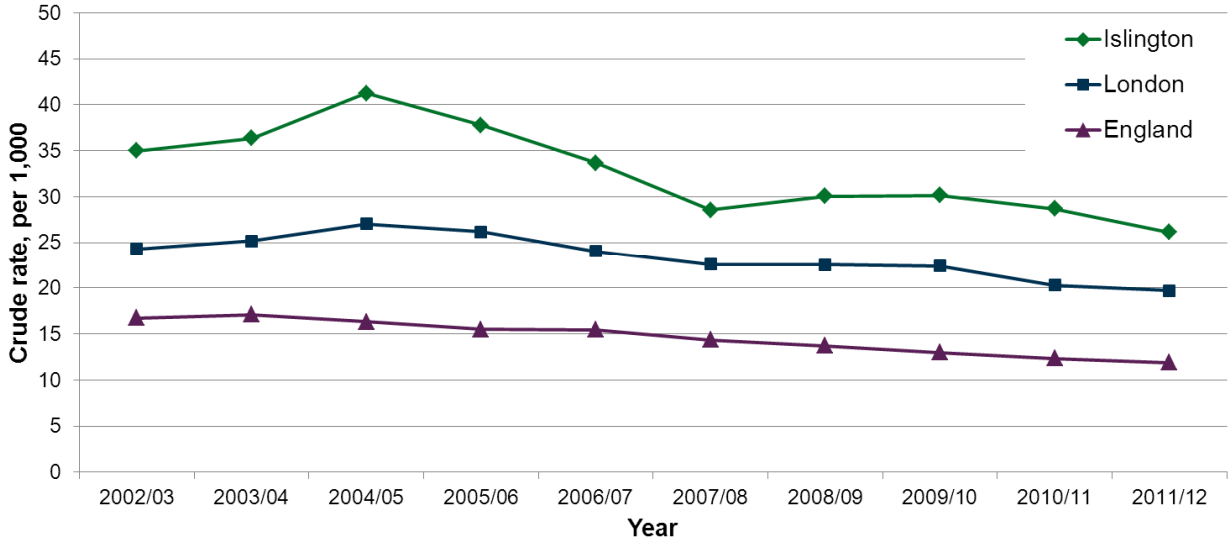
Home Office data for 2011/12 indicates that the crude rate for violent crime in Islington as 26 offences per 1,000 population (5,076 offences) and suggests that levels on the borough are well above that of the England Average of 14 per 1,000 population. When compared with other similar areas nationally, Islington has amongst highest rates of violent crime (only Blackpool has a significantly higher rate). However, caution should be applied when making comparisons between areas which have been identified as most similar socio-economically with regard to crime levels. The method of calculating figures per 1,000 population does not take into account the significantly inflated population levels that Islington experiences on a daily basis as people travel to commercial and entertainment areas of the borough.

Comparing Islington's 2012/13 violent crime levels with other London boroughs finds that Islington is above the London mean, with the eleventh highest figures of the 32 London boroughs.

1.12ii - Violent crime (including sexual violence) - violence offences

Over an extended period Islington has experienced year on year reductions in the levels of violent crime with figures for 2012/13 indicating a 22% reduction in offences compared to 2005/06. Although levels of violent crime have been declining over time, over the last fiscal year offence levels have increased in the borough by 3.8% (252 offences). This increase can largely be attributed to a rise in recorded domestic violence in Islington which itself increased by 23%. Other areas of violent crime nonetheless have seen significant reductions over the last year; in particular, Serious Youth Violence which fell by 42%, Knife Crime 38% and Gun Crime 22%. These reductions have largely been as a result of targeted enforcement, prevention and engagement work that has been undertaken against gangs operating on the borough.

Crude rate of violent crimes (including sexual violence) per 1,000 residents, Islington, London and England, 2002/03 - 2011/12



Source: Home Office, 2012; ONS population estimates, 2012

Equalities and health inequalities

The Crime Survey for England and Wales 2011/2012 highlighted that it is young men who are most likely to be victims of violence. However, it should be noted that the profile of victim of violence and sexual offences varies according to offence type, with approximately 65% of victims of murders during 2011/12 being male. Conversely, women are more likely to be victims of domestic violence.

The impact of violence not only affects victims through the physical injuries that they sustain but can also have a serious impact on a person's mental health. Both forms of injury can have long term detrimental effects on a person's health and wellbeing, potentially limiting someone's lifestyle in a way that is continually damaging.

1.12ii - Violent crime (including sexual violence) - violence offences

Key programmes in Islington

Perpetrators of violent offences are dealt with through the criminal justice system, however the borough also undertakes a significant amount of work to curb and deter violent behaviour whilst supporting the victims of such crimes.

The Violence Against Women and Girls (VAWG) Strategy 2011 – 2015 details the strategic aims for tackling Domestic Violence on the borough, including work surrounding the protection of survivors and their children from further violence through the Multi-Agency Risk Assessment Conference (MARAC). Other aims under this strategy include a new offender management programme focusing on the persistent perpetrators of domestic violence.

The Gang and Serious Youth Violence Strategy and action plan details targeted enforcement, prevention and engagement work undertaken against gangs operating on the borough. Under the new policing structure (Local Policing Model) there is a proactive gangs team, who are tasked with disrupting and apprehending those who are identified as gang members.

The Safer Islington Partnership (SIP) has taken a tighter stance on licensed premises under the licensing review panel. In addition, there is a pan borough Alcohol Dispersal Zone and a Community Alcohol Partnership currently running in Bunhill ward.

The SIP and Whittington Health NHS Trust are working together within the emergency department of the Whittington hospital to record the levels of victims of violence that attend. From this it is hoped that a richer picture of where incidents of violence happen, particularly those which occur within licenced premises, so that appropriate action can be taken.

Targets

Corporate target for 2013/2014 is 1,685 violence with injury offences.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Violence with injury offences

Denominator: Rounded mid-year populations, 2010

Further information

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1.13 - Re-offending levels

Rationale from DH Technical Specification, 2013

Tackling a person's offending behaviour is often intrinsically linked to their physical and mental health, and in particular any substance misuse issues. This outcome therefore cannot be addressed in isolation. Offenders often also experience significant health inequalities that will need to be identified, examined and addressed locally in partnership with organisations across the criminal justice system. Furthermore, a large proportion of families with multiple needs are managed through the criminal justice system, and their issues are inter-generational. Re-offending therefore has a wide impact on the health and well-being of individuals, their children and families, and the communities they live in.

The Islington picture

The most recent data indicates that Islington has the highest rate of re-offending in London, with 946 people re-offending between July 2010 – June 2011, 32% of the total offending population. This was higher than averages for England and Wales and represents a 1.3% increase in proven re-offending rates compared to the previous 12 months figures.

Over the year there were a total of 2752 re-offences meaning that there was an average re-offence rate of 2.9 amongst re-offenders in Islington. This is one of the highest averages of re-offences per offender in London and above England and Wales averages. Levels varied amongst adult and juvenile re-offenders with adults having an average re-offending rate of 2.9, where as juvenile re-offenders had a rate of 3.0 re-offences.

Re-offending levels of adult offenders who had been sentenced less than 12 months in Pentonville and Holloway prisons were notably higher than the Islington average of 2.91, with July 2010 – June 2011 data indicating a re-offending rate of 4.51 for Pentonville Prison and 5.44 for Holloway. It must be noted however that although both prisons are situated in the borough, they serve a wider population than Islington. Islington residents make up about 10% of Pentonville inmates and 5% of Holloway prison so the re-offending rates do not reflect offending rates of Islington residents but rather offending rates of the prison estate and these rates are in line with re-offending rates of the wider prison estate.

Equalities and health inequalities

Research into the health of offenders show extreme levels of poor physical and mental health and risk-taking behaviours, amongst the offender and ex-offender population.

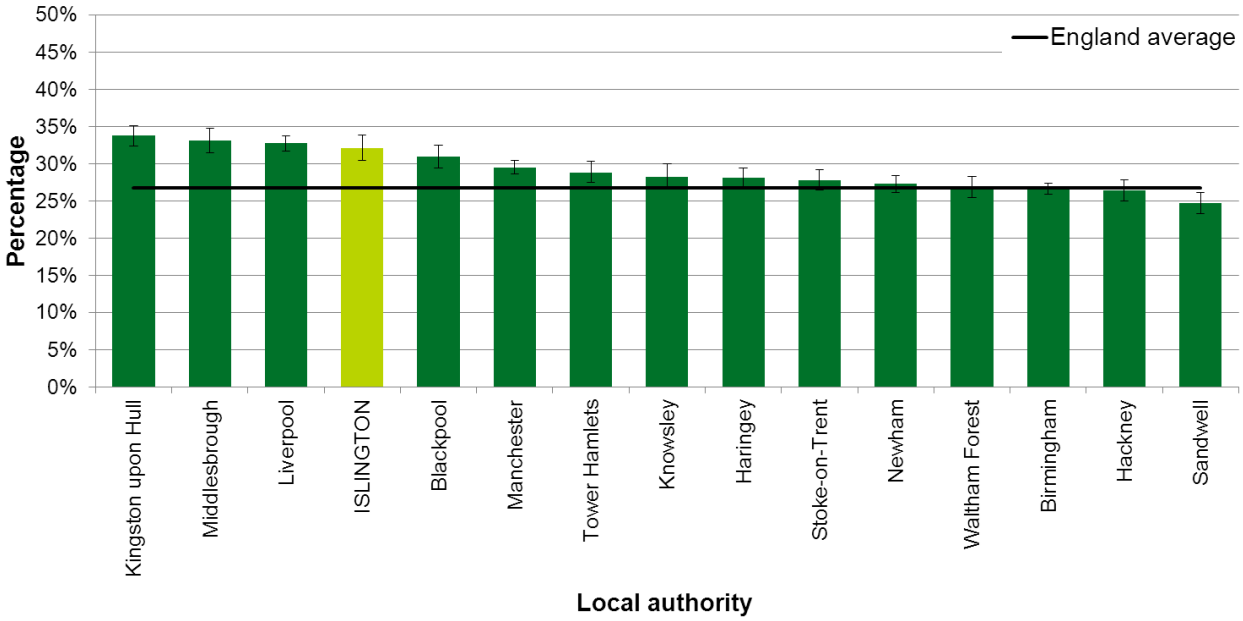
Amongst the offending population there is a higher prevalence of substances and alcohol misuse. Unaddressed substance and alcohol misuse increase the likelihood of drug related re-offending.

Offenders often find social integration difficult and high unemployment rates are underpinned by poor educational achievement, homelessness and worklessness. Offenders can often be identified as having multiple complex needs. The consequences of childhood deprivation, unstable living conditions, family disruption, child abuse, poor parental supervision, domestic violence and parental or sibling criminality all can be identified as aggravating factors

Clear health needs can be identified within prison populations in terms of poor mental health and although there are no agreed estimates for the prevalence of learning disabilities or difficulties, many offenders have learning barriers which inhibit their ability to cope within the criminal justice system.

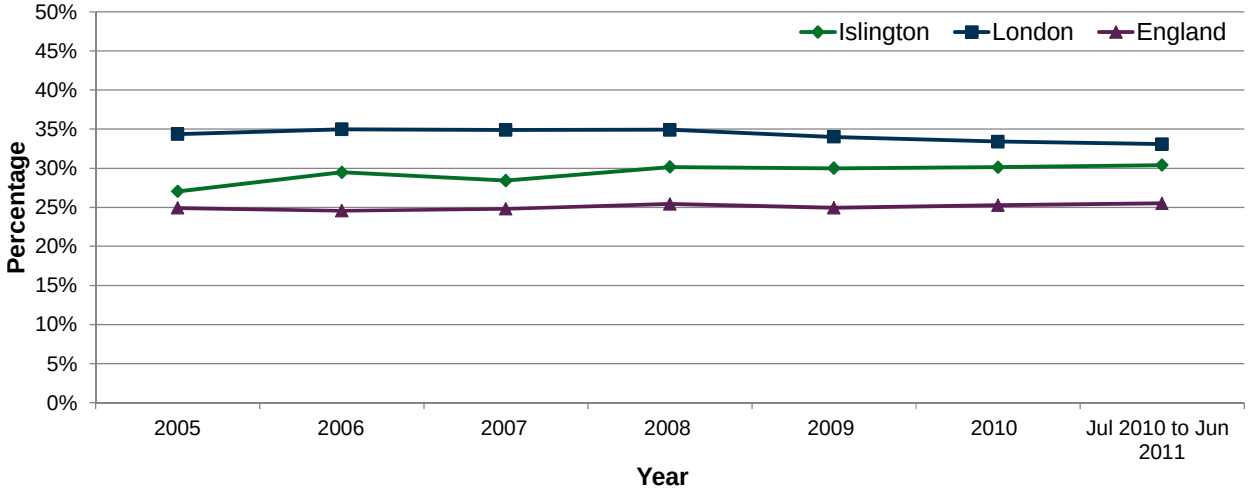
1.13i - Re-offending levels - percentage of offenders who re-offend

Percentage of offenders who re-offend, Islington and similarly deprived boroughs compared against the England average, all persons, all ages, 2010



Source: Ministry of Justice

Percentage of offenders who are proven reoffenders, Islington, London and England, aged 18 and over, 2005 to 2011



Source: Ministry of Justice, 2013

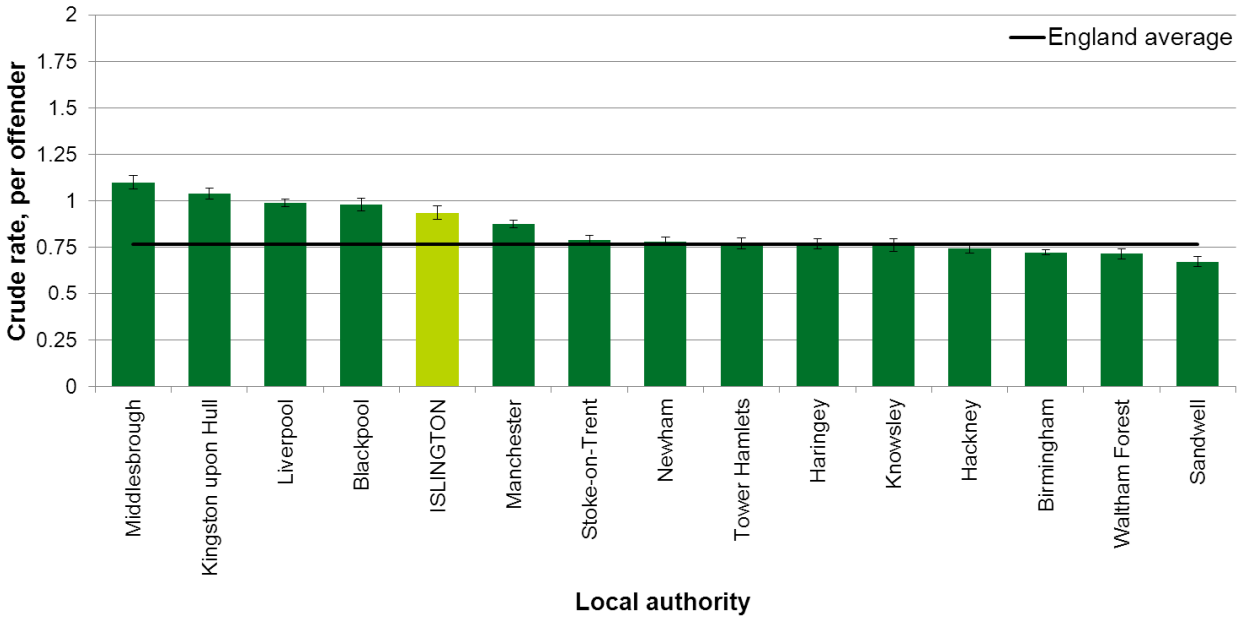
Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of offenders in the cohort who are re-offenders

Denominator: Number of offenders in the cohort

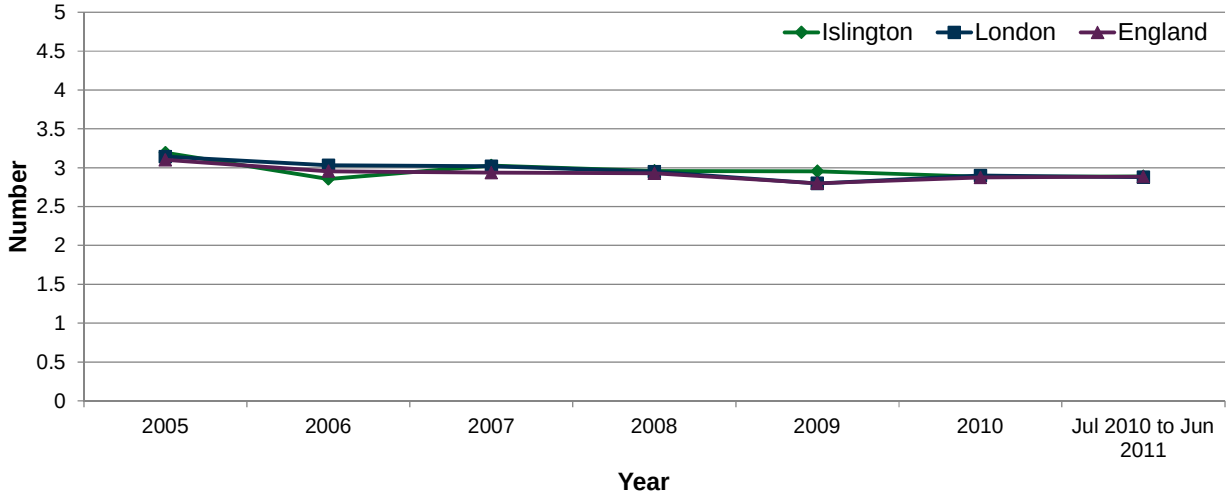
1.13ii - Re-offending levels - average number of re-offences per offender

Crude rate of re-offences per offender, Islington and similarly deprived boroughs compared against the England average, all persons, all ages, 2010



Source: Ministry of Justice

Average number of reoffences per re-offender, Islington, London and England, aged 18 and over, 2005 to 2011



Source: Ministry of Justice, 2013

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: The number of re-offences committed

Denominator: The number of offenders in the cohort

1.13 - Re-offending levels

Key programmes in Islington

Islington's programme approach is to provide specialist, targeted and universal provision to ensure effective offender management of Key Offending cohorts as well as a coherent multi-agency approach to managing offenders generally. Central to this approach is effective risk management and integrated working between the prison, community and statutory partners of Islington's Crime and Disorder Partnership, the Safer Islington Partnership.

Islington delivers a number of projects aimed at delivering interventions and managing risk of the right people who are targeted in line with strategic tasking priorities and the objectives outlined in SIP's MOPAC funded programmes. These include

- The FOCUS project targeting the top 300 adult offenders committing acquisitive and serious acquisitive crime-the main purpose of this programme is to reduce re-offending and improve employment outcomes.
- The Drug Intervention Programme focusing on identifying offenders committing drug related crimes for the purpose of improving engagement in structured treatment and reducing attrition from treatment services and re-offending rates.
- The Domestic Violence persistent perpetrator project which ensures effective risk management of DV perpetrators to reduce risk posed to the victim.
- A prison based offender programme targeting revolving door offenders.
- A complex needs women's project linking perpetuator and Domestic Violence victim referrals.

Targets

Reduce re-offending rates of target cohort from 2.85-1.8 over a five year period and general re-offending rates although there is no target for this.

Further information

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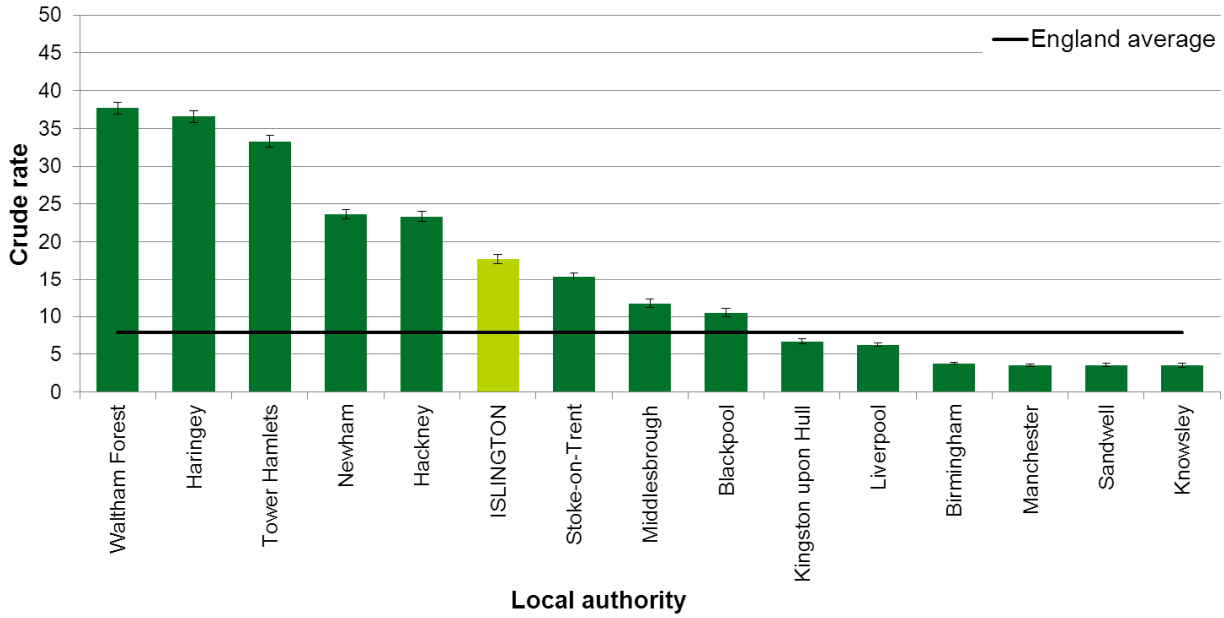
1.14i - The percentage of the population affected by noise - Number of complaints about noise

Rationale from DH Technical Specification, 2013

There are a number of direct and indirect links between exposure to noise and health and wellbeing outcomes. Complaints about noise are the largest single cause of complaint to most local authorities. Exposure to noise can cause disturbance and interfere with activities, leading to annoyance and increased stress. Furthermore, there is increasing evidence that exposure to high levels of noise can cause direct health effects such as heart attacks and other health issues.

The Islington picture

Crude rate of complaints about noise, Islington and similarly deprived boroughs compared against the England average, all persons, all ages, 2010/11



Source: Data collated by CIEH on number of noise complaints. Extrapolation determined by DEFRA in association with CIEH

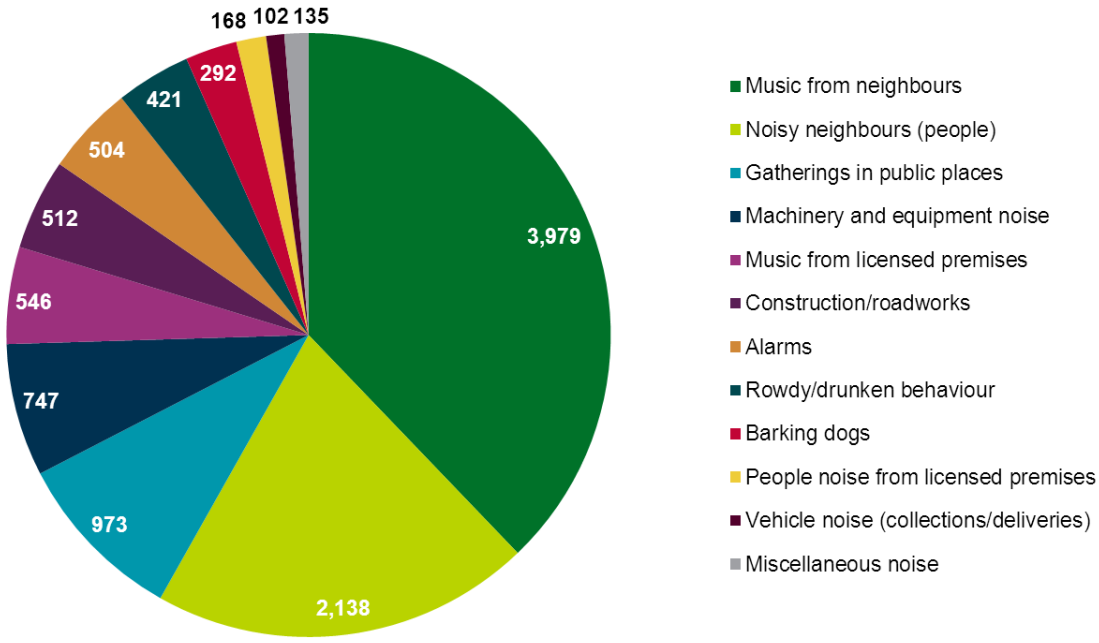
The Chartered Institute of Environmental Health (CIEH) annually surveys local authorities regarding the number of noise complaints they have received. In 2010/11 Islington had 18 complaints per 1,000 population (3,684 complaints). This was significantly above the England average of 8 per 1,000 but below the London average of 21 per 1,000.

When we compare Islington with other local authorities with similar levels of socioeconomic deprivation, the borough has the 6th highest levels of noise complaints of 15 similarly deprived boroughs. However, it has the lowest rate of complaints out of the similarly deprived London boroughs.

1.14i - The percentage of the population affected by noise - Number of complaints about noise

More recent data collected locally through the Anti-Social Behaviour (ASB) hotline indicates that during 2012/13 there were approximately 10,600 calls to the council that featured a noise complaint. A little over a third of calls related to music attributed to noisy neighbours, followed by noisy neighbours - people (20%). The ASB hotline is a 24-hour service which was launched in February 2012. This service led to a significant increase in the amount of noise complaints reported in Islington, hence the difference between the current number of noise complaints and the CIEH estimates from 2010/11.

Number of complaints about noise received by Islington Council, by source of noise, 2012/13



Source: Islington Council's Anti-Social Behaviour hotline, 2013

Equalities and health inequalities

- The WHO asserts that excessive noise can seriously damage health and interfere with people's daily activities. It can disrupt sleep, cause cardiovascular and psychophysiological effects, reduce performance, and generate annoyance responses and changes in social behaviour.
- In 2012, the WHO found that in European countries complaints about street noise and noise from neighbours is higher among people with lower income. However, the difference in reported noise between higher and lower income groups was small within the UK.

1.14i - The percentage of the population affected by noise - Number of complaints about noise

Key programmes in Islington

In Islington the public can report instances of noise nuisance to Public Protection's Noise service thorough the 24-hour ASB hotline or online, and can expect a response within 24 hours. To establish the extent of the noise nuisance people are encouraged to complete a noise diary. Before any formal action can be taken the Noise team have to independently establish the problem. This is done by the Noise team during the day or ASB out of hours team who patrol Islington estates during the weekday evenings, and up until 4am on a Friday and Saturday.

A number of powers can be used to resolve persistent noise issues including issuing a legal abatement notice to the individual or property responsible. Failure to adhere to this notice can lead to prosecution, seizure of the equipment making the noise or the council entering a property or vehicle to silence the noise. If it is the case that noise is emanating from a council housing property the Noise Service can provide evidence for the housing managers to take action against tenants for breach of the tenancy agreement, this can result in the tenant and their household being evicted. In the instance that the noise is identified as coming from a licensed premises, the Noise Service can object to any renewal in their license

In addition to the Noise service Islington has a dedicated ASB team tasked with reducing ASB in the borough. On occasions the ASB team assist the Noise Service when it is found that complaints regarding noise include other aspects as ASB.

Targets

There are no local or national targets for this indicator.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of complaints about noise.

Denominator: 2010 mid year population estimates

Further information

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1.15 - Statutory homelessness

Rationale from DH Technical Specification, 2013

Homelessness is associated with severe poverty and is a social determinant of health. Homelessness is associated with adverse health, education and social outcomes, particularly for children. To be deemed statutorily homeless a household must have become unintentionally homeless and must be considered to be in priority need. As such, statutorily homeless households contain some of the most vulnerable and needy members of our communities. Preventing and tackling homelessness requires sustained and joined-up interventions by central and local government, health and social care and the voluntary sector.

The Islington picture

While Islington's rate of statutory homelessness is broadly comparable to similar London boroughs, it is well above the national average for England.

However numbers of statutory homelessness in 2012/13 in Islington actually decreased very slightly, in contrast to the national figure which increased by 6% over the 2011/12 figures.

The decrease in homelessness acceptances in Islington, against the national trend, is due to the boroughs pro-active approach in dealing with the impact of welfare reform and its effect on homelessness. The 2012–2014 homelessness strategy focuses support for those most at risk of homelessness.

As of 30th June 2013 there were 1,016 homeless households living in temporary accommodation. Whilst this is an increase of 7.6% compared to the same date in 2012, it is below the national increase of 10%. Changes to the welfare benefits system are a particular challenge and homelessness is expected to increase further as the changes take effect.

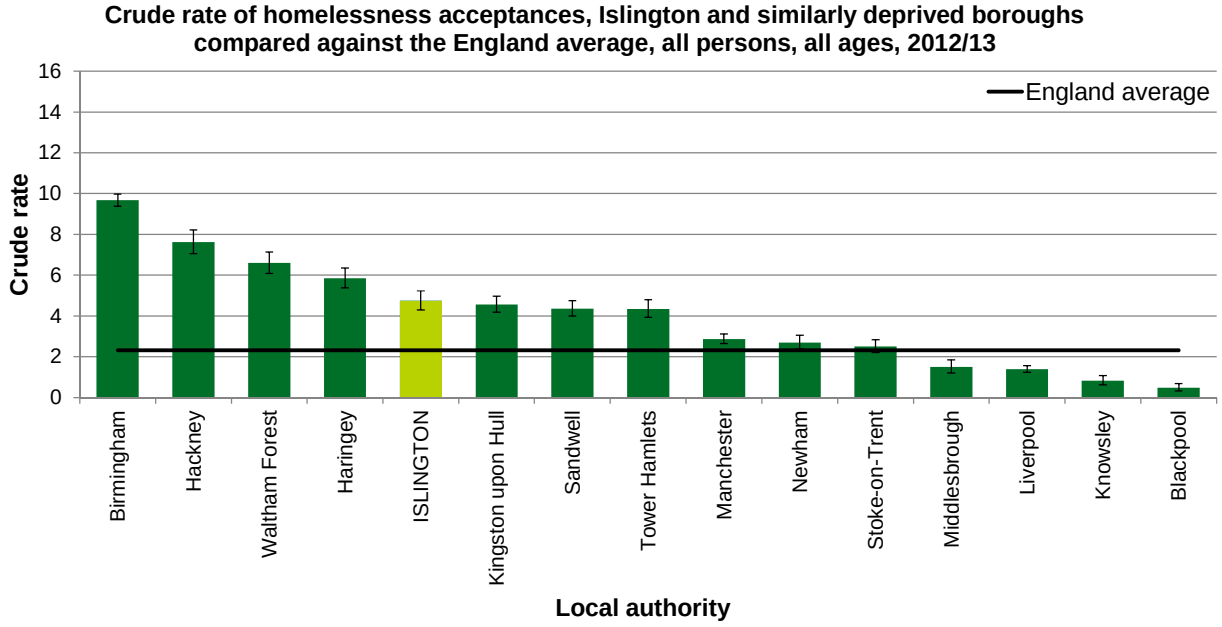
Around three quarters of the temporary accommodation population are households with children, with female lone parents making up the single largest group at 58%.

Equalities and health inequalities

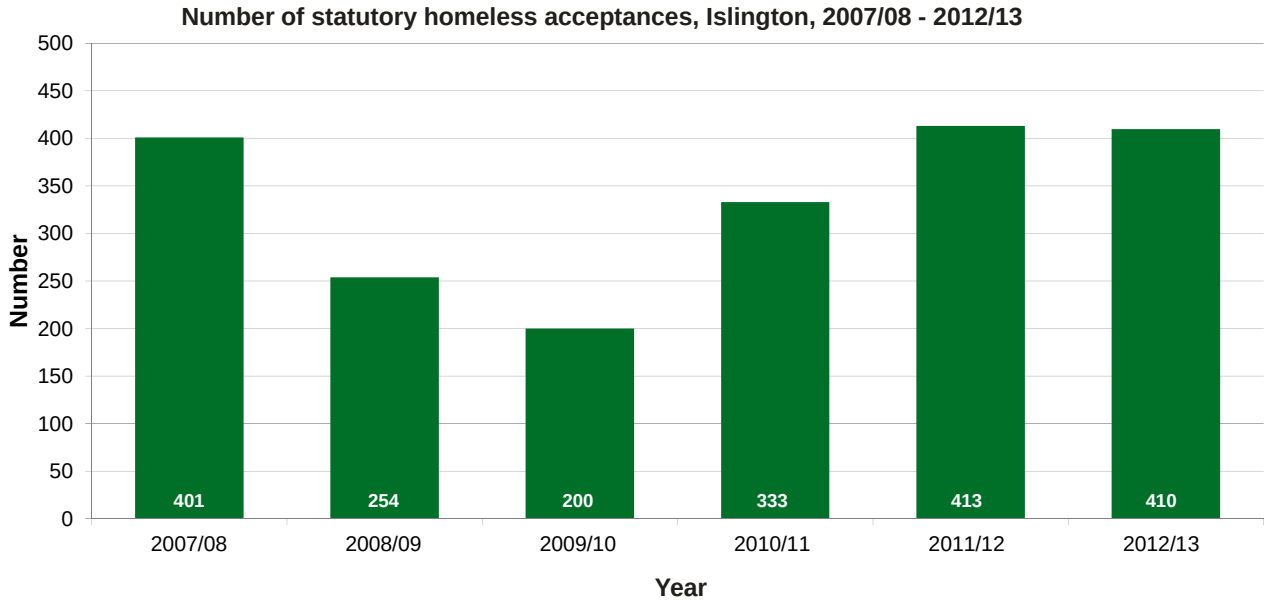
- The potential effects of homelessness on adults include physical ill-health and mental health problems. The potential impact on children include anxiety, depression and poorer school attendance and performance.
- Sleeping on the streets, in hostels, in squats or in substandard or overcrowded accommodation can impact on physical and mental wellbeing.
- Homeless people can additionally lack adequate access to healthcare services.
- Recent welfare reform changes and decreased housing benefit may lead to increased pressure on families and increased homelessness.
- The majority of households living in temporary accommodation are fully dependent on state benefits, due to all household members being out of work.
- Fifty-three percent of people living in temporary accommodation are from BME communities.

1.15i - Statutory homelessness - homelessness acceptances

The Islington picture - Households accepted as homeless



Source: Department for Communities and Local Government



Source: Islington's Homelessness Database, 2013

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

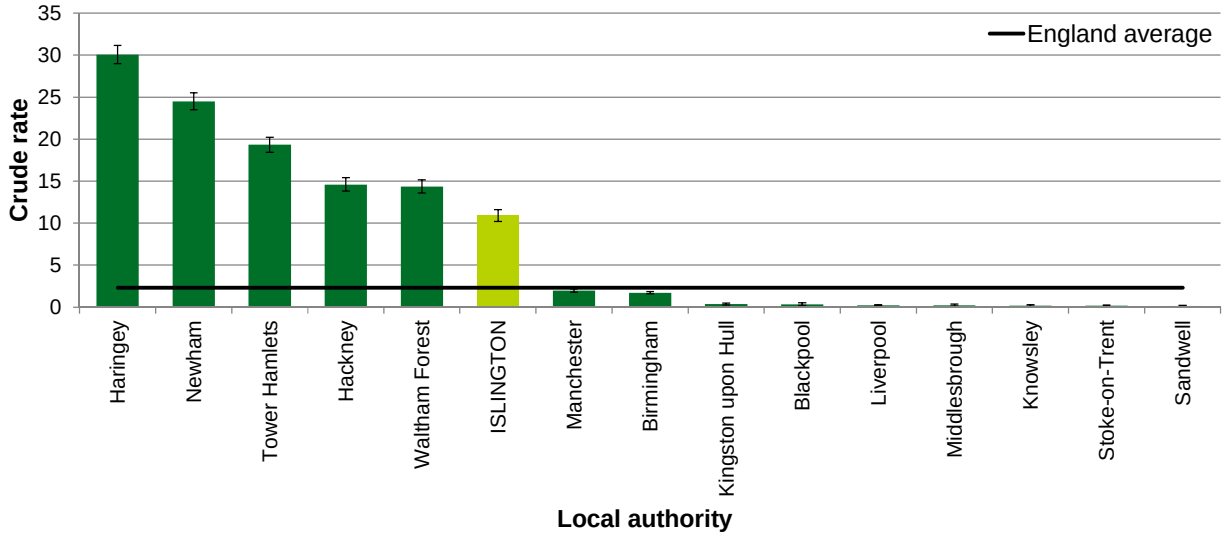
Numerator: Count of households who are eligible, unintentionally homeless and in priority need, for which the local authority accepts responsibility for securing accommodation under part VII of the Housing Act 1996 or part III of the Housing Act 1985.

Denominator: Number of households, rounded, 2008 mid-year estimate.

1.15ii - Statutory homelessness - households in temporary accommodation

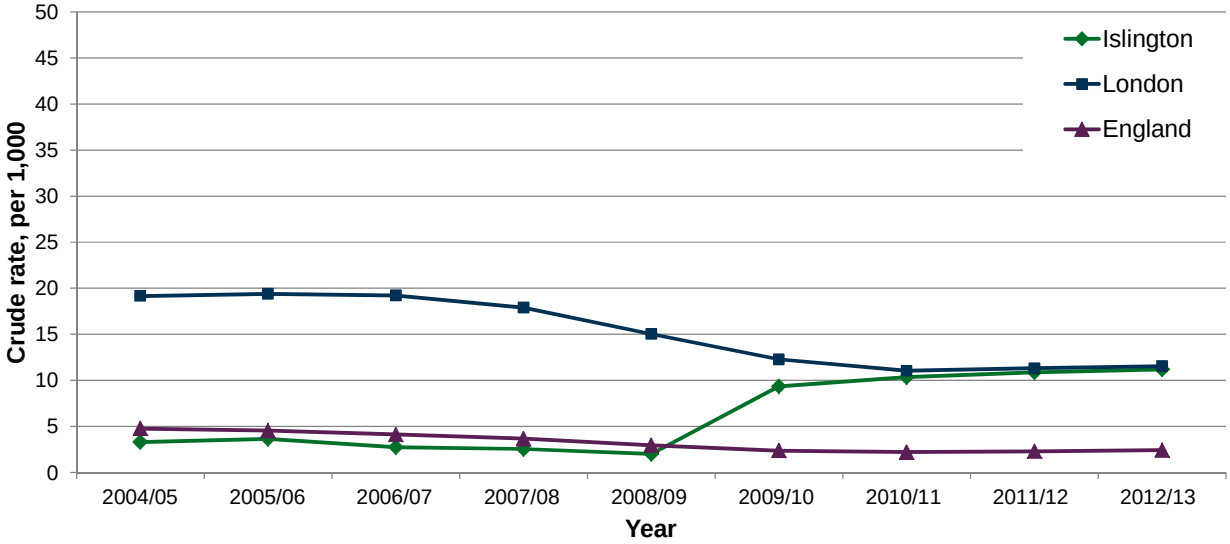
The Islington picture - Households in temporary accommodation

Crude rate of households in temporary accommodation, Islington and similarly deprived boroughs compared against the England average, all persons, all ages, 2012/13



Source: Department for Communities and Local Government

Crude rate of households in temporary accommodation per 1,000 households, Islington, London and England, 2004/05 - 2012/13



Source: Department for Communities and Local Government, 2013

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Count of households who are living in temporary accommodation provided under the homelessness legislation.

Denominator: Number of households, rounded, mid-year estimate.

1.15 - Statutory homelessness

Key programmes in Islington

Preventing homelessness

Any resident of the borough can access housing advice and assistance, the borough has a statutory duty to prevent homelessness where possible. Advice and assistance which prevents homelessness may include:

- Finding a property in the private rented sector and providing a deposit
- Negotiation with landlords, help to make a claim for discretionary housing benefit to meet a shortfall in rent payments
- Access to supporting people funded services

Targeted services

- Home Shelter, a sanctuary scheme to prevent homelessness for victims of domestic violence.
- Housing advice outreach surgeries are held at children's centres, and Eritrean, Turkish and Chinese community centres.
- A service funded jointly through the North London sub-region to assist offenders being released from prison.

Temporary accommodation

- All accommodation used is self contained, and unlike most other authorities, the council does not place households in bed and breakfast accommodation.
- We have dedicated specialist provision for homeless young people aged 16-21.
- The target for 2013-14 is to reduce the number of households in temporary accommodation by a quarter. We are hoping to achieve this by early intervention and preventing homelessness; by reducing the length of stay in temporary accommodation; and by assisting people to find longer term housing solutions either in the social or private rented sectors.

Targets

There are local targets to maintain the level of homelessness acceptances at less than 500, and to reduce number of households in temporary accommodation by 25%.

Further information

Homelessness

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Households in temporary accommodation

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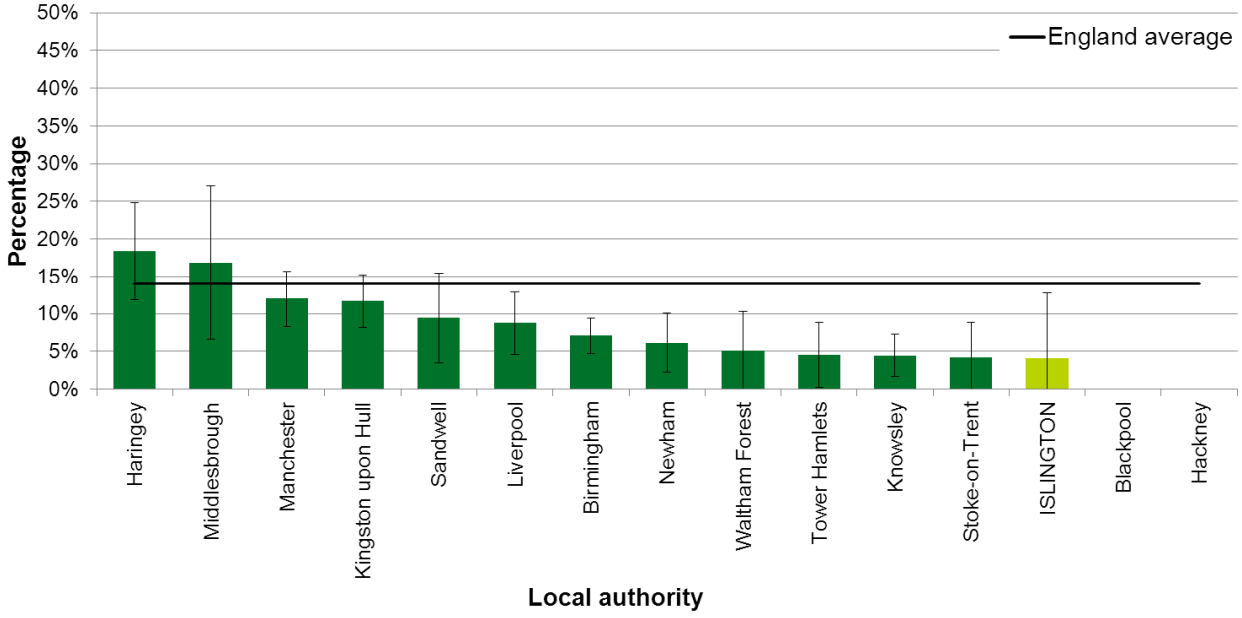
1.16 - Utilisation of outdoor space for exercise/health reasons

Rationale from DH Technical Specification, 2013

Inclusion of this indicator is recognition of the significance of accessible outdoor space as a wider determinant of public health. There is strong evidence to suggest that outdoor spaces have a beneficial impact on physical and mental well-being and cognitive function through both physical access and usage.

The Islington picture

Percentage of people utilising of outdoor space for exercise/health reasons, Islington and similarly deprived boroughs compared against the England average, all persons, 16 years and over, Mar 2009 - Feb 2012



Source: Natural England: Monitor of Engagement with the Natural Environment (MENE) survey

Islington has only 4% of the population utilising outdoor space for health reasons. This is significantly lower than the national average of 14%, although similar to other dense urban areas with high levels of deprivation. Islington has a relatively low proportion of public green space per head of population. We currently have 83 hectares (Ha) of publicly owned and managed green space in total. With a population of about 208,000, that equates to just 4 square meters of green space per person. This means access to natural spaces for passive or physical recreation is limited. Pressure on those spaces is also high with a lot of conflicting uses taking place in a relatively small space. This can be a real disincentive for people to use those spaces, for example anxiety about dogs can be a barrier for some users.

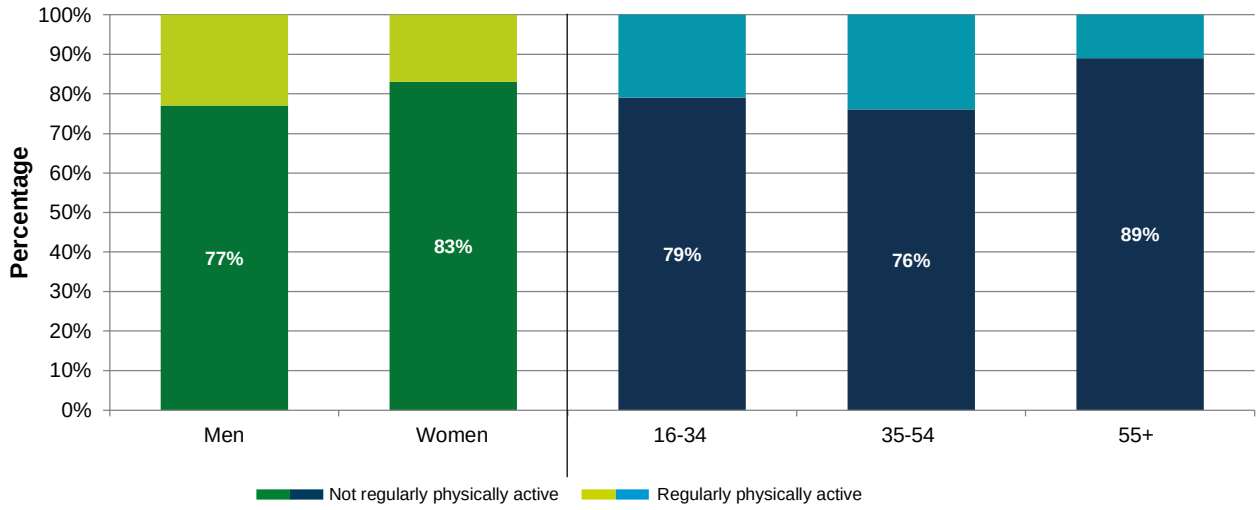
The borough has three Local Nature Reserves to provide access to nature and 10% of our parks are managed for nature conservation. A third of the borough is an Area of Natural Deficiency, i.e. it is more than a 1km walk to an area of significant natural space.

1.16 - Utilisation of outdoor space for exercise/health reasons

There has been significant investment in parks, play areas and outdoor sports facilities over the last few years. Of the 42 outdoor sports facilities, only 9 remain a high priority for investment (21%). Areas are prioritised for investment based on the physical condition of the facility, if they are an area of deprivation, if there is alternative provision of facilities nearby and accessibility. However there are still a limited number of facilities with one grass football pitch. Of the 55 play spaces in the borough, 21 are still a high priority for investment (38%).

The majority of outdoor sports facilities are geared towards sports such as football which is traditionally taken up much more by men and boys. We are looking to address this with the creation of a new netball facility at Highbury Fields which has massively increased participation among women and girls. There is also a significant drop in levels of physical activity in those aged 55+ years. A recent effort to address this is the introduction of free, off-peak, tennis for over 60s.

Estimated level of physical activity among Islington residents, by sex and age, 2009-2011



Source: Sport England, 2012

Equalities and health inequalities

There are specific user groups that are less likely to access green spaces:

- Disabled users have more limited access to spaces, as there is no parking and only the main parks will have accessible toilet facilities.
- People from BME communities have a lower profile of using public spaces.
- Older people are less likely to access public spaces.
- A lower percentage of women in Islington are regularly physically active compared to men.

1.16 - Utilisation of outdoor space for exercise/health reasons

Key programmes in Islington

There are several work streams that seek to increase the usage of parks and open spaces.

In 2012/13, we delivered and facilitated 294 events and delivered 58 educational sessions with an estimated 61,000 people attending. These included community gardening days, sports coaching, family fun days, nature events and a variety of others.

We run regular community gardening days in parks and the nature conservation volunteers meet weekly to manage and maintain the boroughs nature reserves. Last year we had over 3,000 volunteer hours.

We are improving the play value of parks to encourage and promote play and ensure young children remain active. We have adopted a risk benefit approach to play to ensure that it is more challenging and interesting and introduced natural play elements.

Last year we delivered over £1,000,000 of capital improvement works in Islington. This included the creation of a new flagship play space at King Square; a new community food growing space and accessible public space at Tiber Gardens; and improved play facilities at Highbury Fields and Whittington Park.

There are a number of targeted events at disabled, BME, young and old people to increase the profile of users. This includes a Deaf Lunch Club every week at the Ecology Centre; the 10th anniversary celebration of British Sign Language with over 3,000 deaf and hearing impaired people at Highbury Fields; dance workshops targeting young girls and tea dances for the elderly.

Targets

Islington Council have set a local target to deliver 230 outdoor events in 2013/14.

Indicator definition: **for a full definition please refer to the DH Technical Specification, 2013**

Numerator: Number of people reporting that they have taken a visit to the natural environment for health or exercise over the previous seven days

Denominator: Weighted number of respondents to survey (effective sample size of all survey respondents). The actual number of respondents is weighted to take account of differing response rates in different sub-groups of the population.

Further information

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Domain 2: Health improvement

Objective: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators (indicators which are still being finalised nationally are in italics)

2.01 Low birth weight
2.02 Breastfeeding
2.03 Smoking status at time of delivery
2.04 Under 18 conceptions
2.05 *Child development at 2-2.5 years*
2.06 Excess weight in 4-5 and 10-11 year olds
2.07 *Hospital admissions caused by unintentional and deliberate injuries in under 18s*
2.08 Emotional wellbeing of looked after children
2.09 *Smoking prevalence—15 year olds*
2.10 Hospital admissions as a result of self-harm
2.11 *Diet*
2.12 *Excess weight in adults*
2.13 Proportion of physically active adults
2.14 Smoking prevalence—adult (over 18s)
2.15 Successful completion of drug treatment
2.16 *People entering prison with substance dependence issues who are previously known to community treatment*
2.17 Recorded diabetes
2.18 Alcohol-related admissions to hospital
2.19 *Cancer diagnosed at stage 1 and 2*
2.20 Cancer screening coverage
2.21 Access to non-cancer screening programmes
2.22 Take up of the NHS Health Check Programme—by those eligible
2.23 Self-reported wellbeing
2.24 Falls and injuries in the over 65s

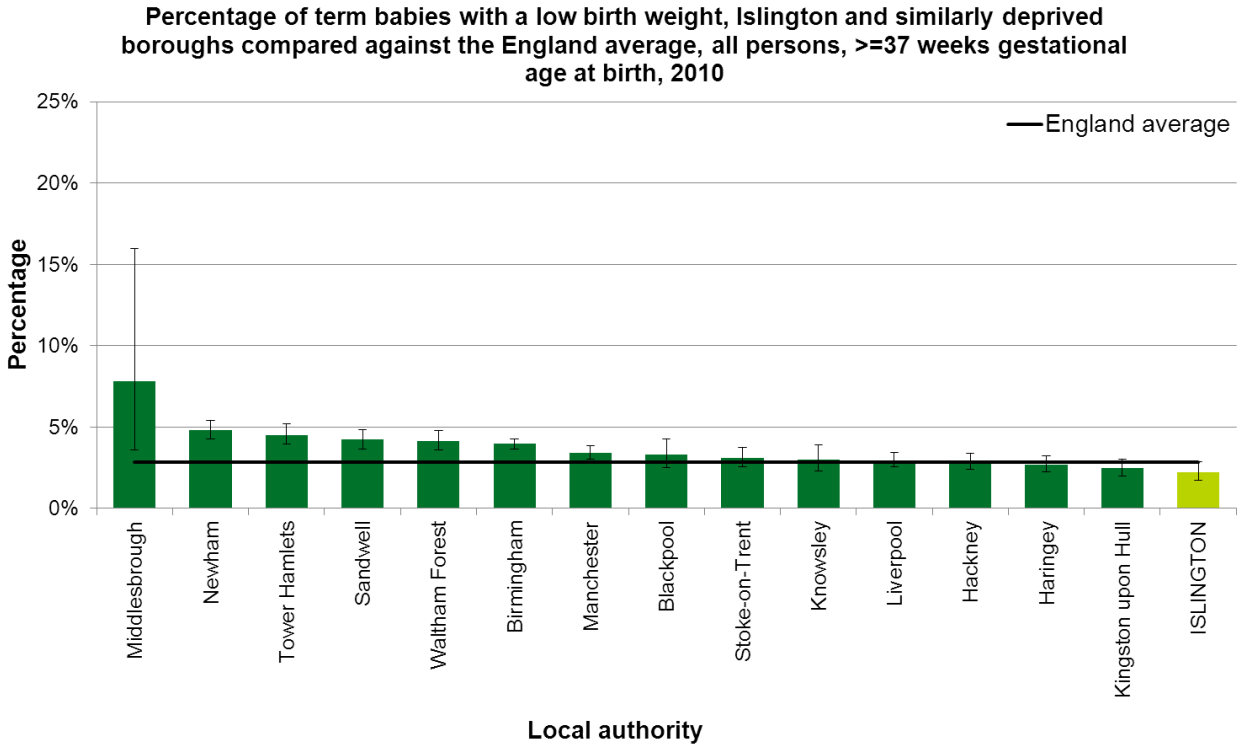
2.01 - Low birth weight of term babies

Rationale from DH Technical Specification, 2013

A baby's birth weight is an important determinant of perinatal, neonatal, and post-neonatal health outcomes. Low birth weight is defined as a birth weight less than 2500 grams and very low birth weight is less than 1500 grams. Low birth weight is recognised as a contributing factor in infant mortality, childhood morbidity, and poor health outcomes in later life.

Maternal heath status and lifestyle factors, such as smoking in pregnancy, maternal nutrition and socio demographic factors related to deprivation have an impact on a babies birth weight. Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life. At a population level there are inequalities in low birth weight and a high proportion of low birth weight births could indicate lifestyle issues of the mothers and/or issues with the maternity services.

The Islington picture



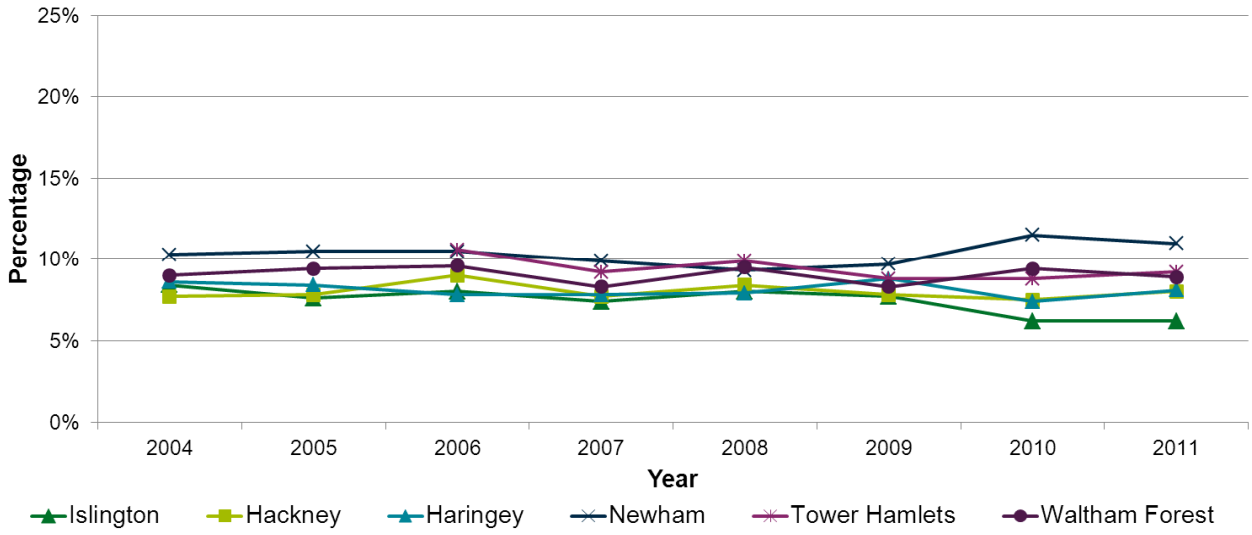
Source: Office for National Statistics

The proportion of term babies with low birth weight born in Islington is significantly lower than that of the boroughs of Manchester, Birmingham, Waltham Forest, Sandwell, Tower Hamlets, Newham and Middlesbrough. There is no significant difference in the proportion of low birth weight babies born in Islington, compared with the England average or with the boroughs of Blackpool, Stoke-on-Trent, Kingsley, Liverpool, Hackney, Haringey and Kingston upon Hull. In Islington the overall numbers of babies born with low birth weight is low (59 term babies in 2010).

2.01 - Low birth weight of term babies

Compared with London boroughs of similar deprivation levels, there has been a downward trend in the percentage of low birth weight babies at all gestational lengths born in Islington, from 8.4% in 2004 to 6.2% in 2011. The percentage of low birth weight babies born in Islington is lower than Haringey (8.1%), Hackney (8%), Tower Hamlets (9.2%), and significantly lower than Newham 11%.

Percentage of low weight births <2,500 grams, Islington and London boroughs with similar socio-demographic characteristics, all births, women of all ages, 2004-2011



Source: Health and Social Care Information Centre, 2013.
Note: Data for Tower Hamlets have not been published for 2004 and 2005.

Equalities and health inequalities

- Maternal health is an important determinant of birth weight. High medical risk (intra uterine growth restriction / foetal abnormalities / multiples / maternal weight) and / or high social risk (lone mothers, substance misuse in pregnancy, and living in poverty) are associated with increased risk of low birth weight babies.
- Maternal smoking during pregnancy is a major risk factor associated with low birth weight. Babies born to women who smoke weigh, on average, 200g less than babies born to non-smokers.
- The Millennium Cohort Study found an association between ethnicity and low birth weight, with Pakistani, Indian, Bangladeshi, Black African and Black Caribbean infants more likely to be born with a low birth weight compared to white infants. Socioeconomic inequalities amongst these groups also contribute to the difference.
- There is an association between infant mortality and low birth weight (associated with prematurity). Islington women experience many of the other risk factors associated with infant mortality including: living in deprivation, smoking during pregnancy, maternal obesity and babies born with a low and very low birth weight.

Targets

There are no local or national targets for this indicator.

2.01 - Low birth weight of term babies

Key programmes in Islington

Universal services

Ensuring that every child has the best start in life is one of the priority areas of Islington's Health and Wellbeing Board. The "First 21 months" programme is aimed at improving outcomes for children and families from conception, throughout pregnancy and up to the first year of a child's life. Improving the maternity offer at Children's Centre settings and improving communications and information sharing among professionals involved throughout the maternity pathway is a key priority.

Antenatal services

The early stages of pregnancy are a key time in a baby's development and a mother's health. Early access to maternity services, before the 13th week (12 weeks plus 6 days), is important to ensure that the health and social care needs of both mother and baby are assessed as early as possible in the pregnancy. Maternity and Primary Care services in Islington work together to ensure that all women can access maternity services before the 13th week of pregnancy. High risk pregnancies are closely monitored by maternity services to ensure that the mother and baby are receiving the appropriate care, treatment and services.

All pregnant women are encouraged and supported to maintain or adopt healthy lifestyles during pregnancy. This is done through many channels, including targeted stop smoking support, weight management, and support around substance misuse. Universal support is provided around maintaining a healthy pregnancy through healthy lifestyle behaviours including healthy start vitamin supplementation.

Postnatal services

Babies born with low birth weight are supported by appropriate levels of specialist and universal paediatric and neonatal services in order to: monitor weight gain and assess healthy progress and development against milestones. Parents are supported to engage in healthy lifestyle behaviours through services supporting them to, stop smoking support and/or reducing the levels that babies are exposed to second-hand smoke in the home, continue breastfeeding, undertake healthy weaning, and access healthy start vitamin supplementation.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of live births at term (>= 37 gestation weeks) with low birth weight (<2500g)

Denominator: Number of live births at term (>= 37 weeks) with recorded birth weight

Further information

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2.02 - Breastfeeding

Rationale from DH Technical Specification, 2013

Breast milk provides the ideal nutrition for infants in the first stages of life. There is evidence that babies who are breast fed experience lower levels of gastro-intestinal and respiratory infection. Observational studies have shown that breastfeeding is associated with lower levels of child obesity and diabetes. Benefits to the mother include a faster return to pre-pregnancy weight and possibly lower risk of breast and ovarian cancer.

Increases in breastfeeding are expected to reduce illness in young children. This in turn will reduce hospital admissions for the 0-1 age group.

The Islington picture

Breastfeeding initiation and prevalence at 6-8 weeks rates continue to be higher than those for London and England and are also higher than most boroughs with similar levels of deprivation.

In 2011/12 90% of Islington women initiated breastfeeding, whereas the percentages for London and England were 87% and 74% respectively.

Since 2009, breastfeeding rates have remained fairly stable in Islington, London, and England. The rate has increased slightly from 86% to 90% in Islington.

75% of mothers who initiated breastfeeding were still breastfeeding at 6-8 weeks (1,590). 531 mothers had discontinued breastfeeding at 6-8 weeks. These figures are similar to those from 2010/11 and fall within the range of figures observed since 2009; prevalence has fluctuated between 74% and 78%. Breastfeeding prevalence at 6-8 weeks is significantly higher in Islington than both London (69%) and England (47%).

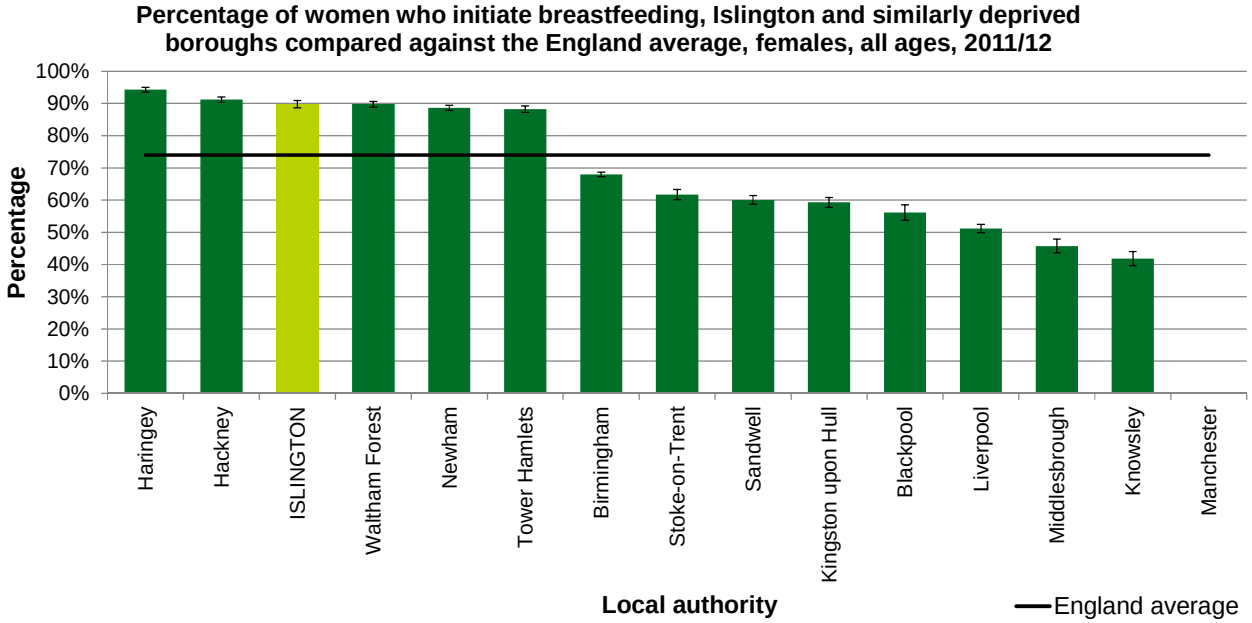
Islington's breastfeeding rates are likely to be high because of the local demographic profile. Islington has a high number of older women from ethnic minority groups who are typically more likely to initiate and continue with breast feeding.

Equalities and health inequalities

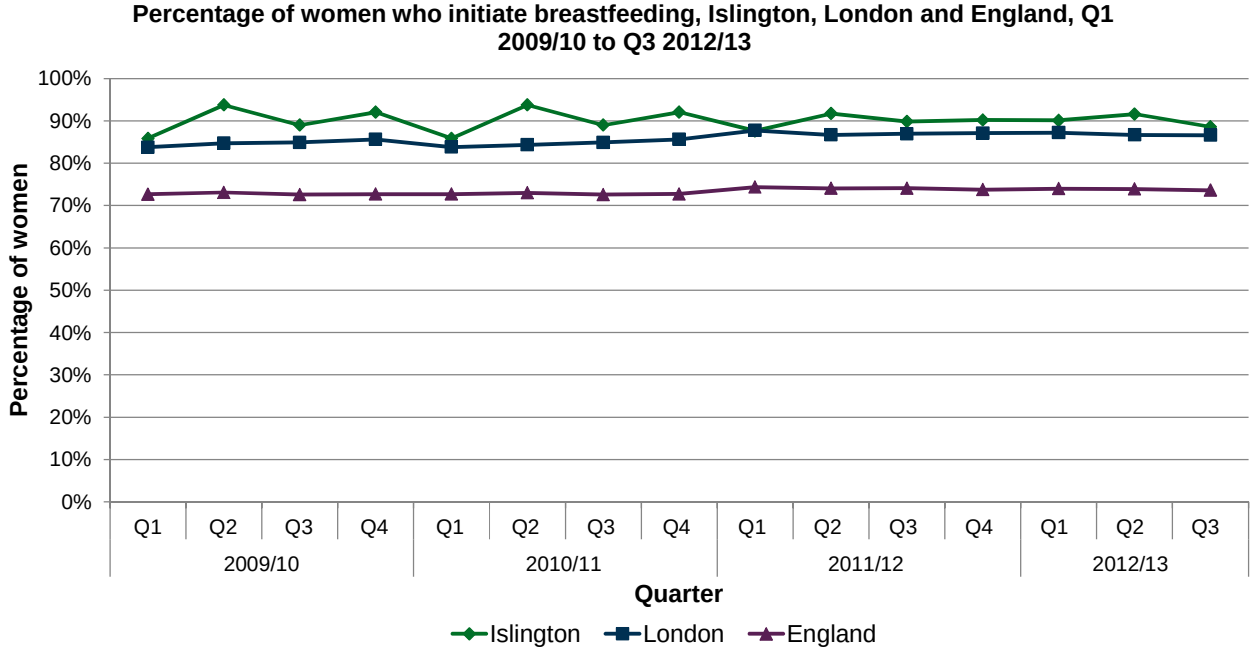
- Research shows that there are patterns in which women are less likely to initiate and continue to breast feed: White Caucasian women in the lower social classes are less likely to breast feed, as are less educated women living in deprived and vulnerable situations. Younger women are also known to be more likely to give their babies formula milk rather than breast feed. These groups are offered targeted support, for example through the Family Nurse Partnership programme.

2.02i - Breastfeeding - Breastfeeding initiation

The Islington picture



Source: Calculated by Public Health England Knowledge and Intelligence Team (East) using Department of Health (DH), Integrated Performance Monitoring Return
Note: At the time of publication, data were not available for Manchester.



Source: DH, 2013

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

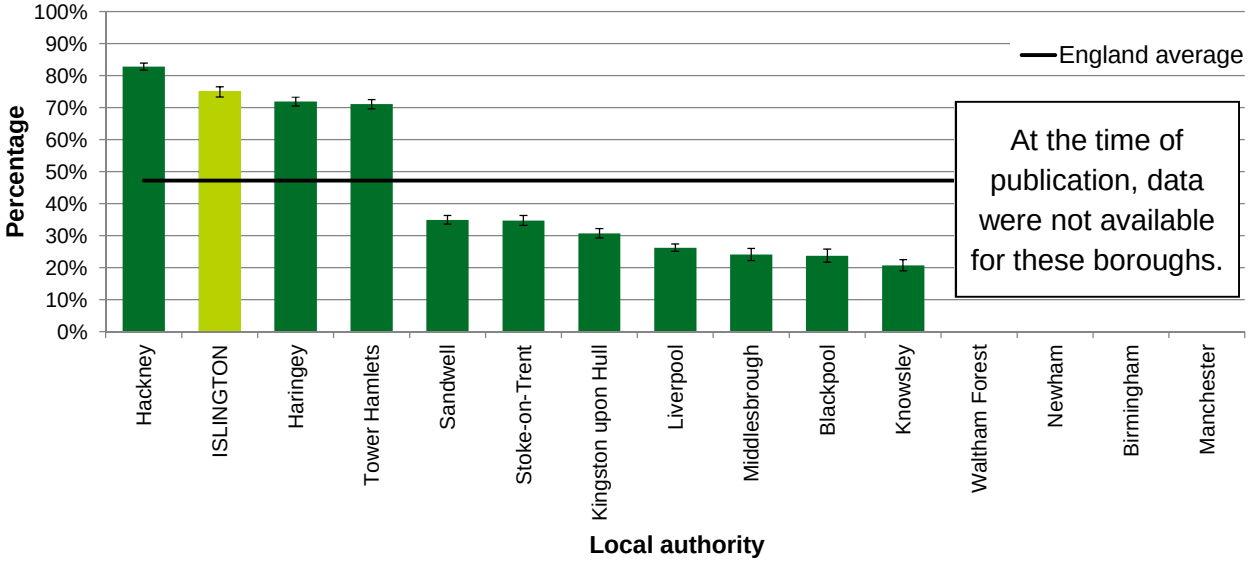
Numerator: Number of women giving birth who initiate breast feeding in the first 48 hours after delivery. Numerator counts for local authorities are estimated from counts for PCTs.

Denominator: Number of maternities. Denominators for local authorities are estimated from denominators for PCTs.

2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth

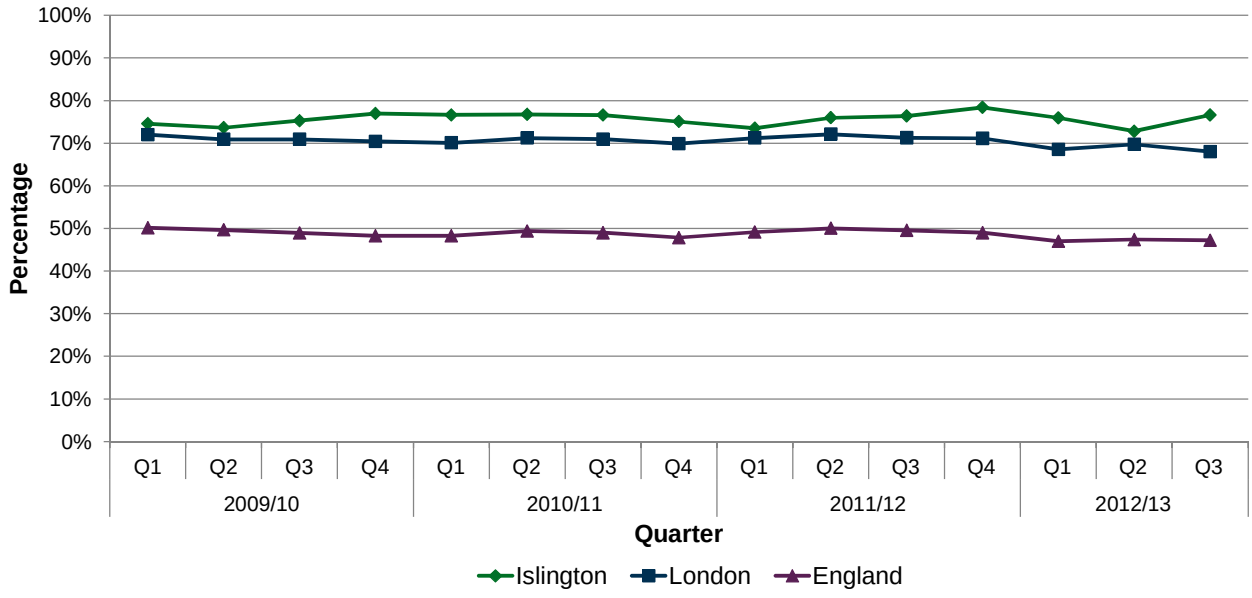
The Islington picture

Prevalence of breastfeeding at 6-8 weeks after birth, Islington and similarly deprived boroughs compared against the England average, all persons, 6-8 weeks, 2011/12



Source: Calculated by Public Health England: Knowldge and Intelligence Team (East) using Department of Health (DH), Integrated Performance Monitoring Return

Prevalence of breastfeeding at 6-8 weeks after birth, Islington, London and England, Q1 2009/10 to Q3 2012/13



Source: DH, 2013

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of infants at the 6-8 week check who are totally or partially breastfeeding. Numerator counts for local authorities are estimated from counts for PCTs.

Denominator: Number of infants due for 6-8 week checks. Denominators for local authorities are estimated from denominators for PCTs.

2.02 - Breastfeeding

Key programmes in Islington

Universal services

Islington is following the UNICEF baby friendly programme to ensure that there is a whole systems approach to adopting a breast feeding culture.

All mothers are offered support to breast feed at birth. Islington also commissions the Islington Breastfeeding Peer Supporter programme. The peer supporters contact all new mothers within 48 hours of delivery. They continue to offer advice until the initiation of weaning. The Health Visitor and Early Years team in the Children's Centres offer on-going support with feeding and nutritional issues, with a particular focus on the first 21 months through the '21 month programme'. Teenage mothers enrolled on the Family Nurse Partnership Programme can access a structured programme of support until their child reaches two years of age.

Targeted services

Specific support is offered to those mothers experiencing difficulties with feeding. The Islington Healthy Children's Centres offer targeted support to those mothers who request it.

Targets

There are no local or national targets for this indicator.

Further information

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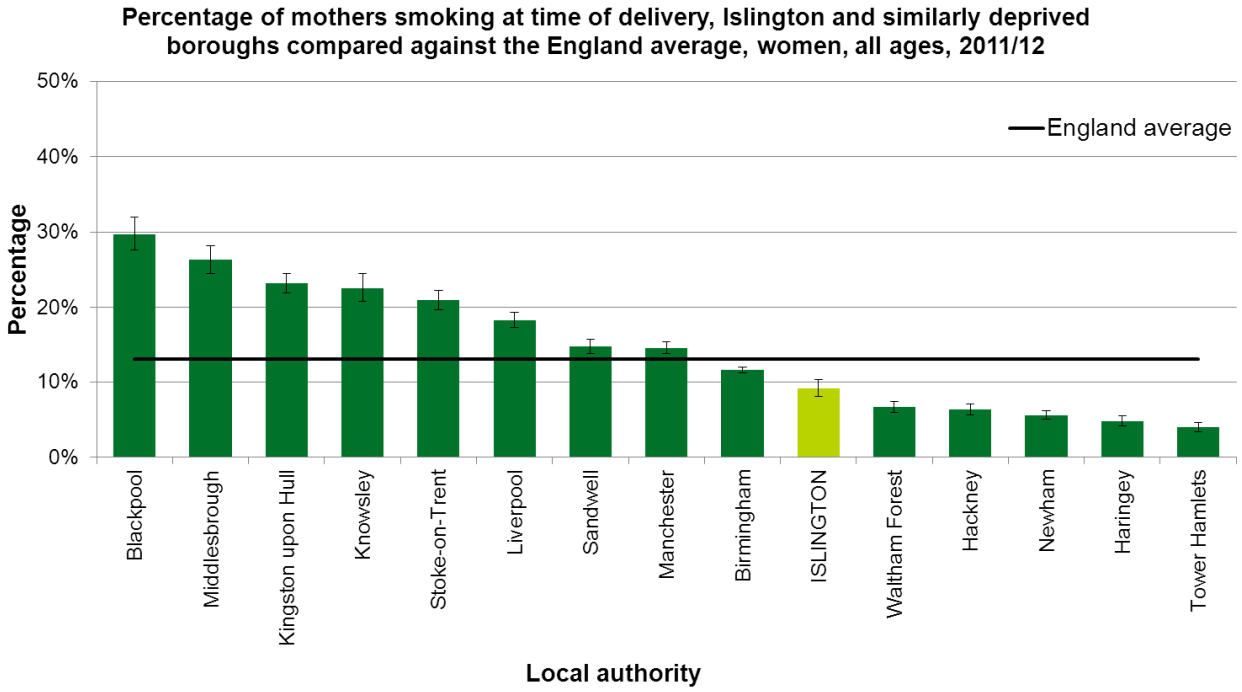
2.03 - Smoking status at time of delivery

Rationale from DH Technical Specification, 2013

Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes. Encouraging pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant.

The Islington picture



Source: Calculated by ERPHO from the Health and Social Care Information Centre's return on Smoking Status At Time of delivery (SSATOD)

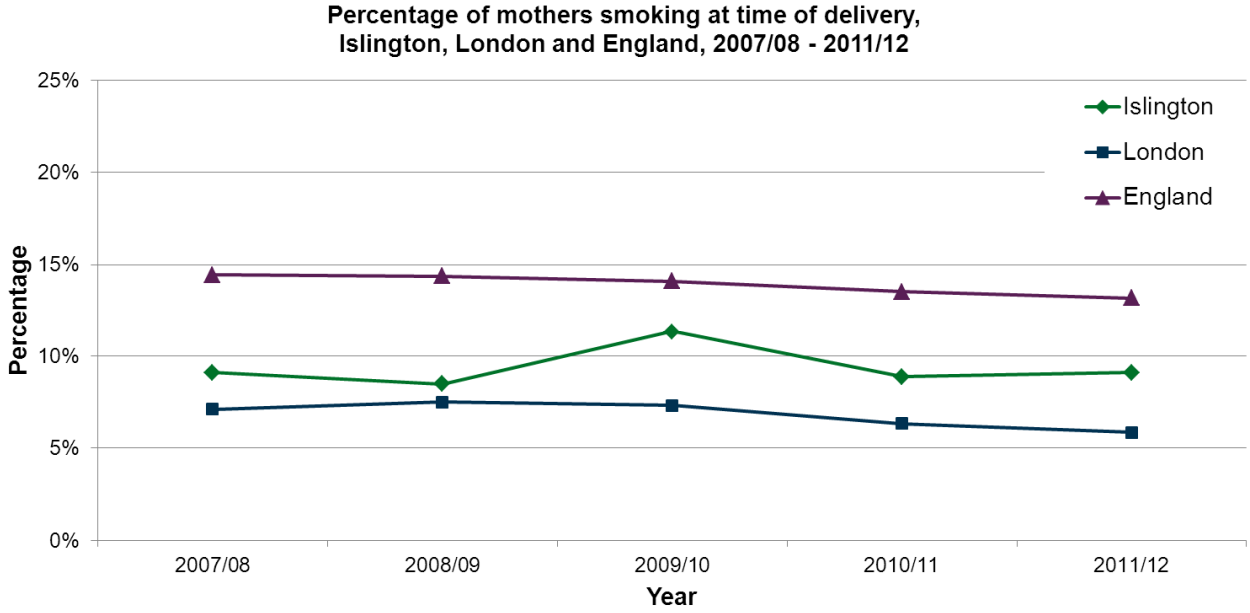
Islington has a relatively low rate of women recorded as smoking at the time of delivery at 9% which is significantly lower than the England average of 13%. When compared to the 15 areas of England with similar levels of socio-economic deprivation, Islington has the 6th lowest rate. However this rate is significantly higher than other the London boroughs in the comparison group.

The overall prevalence of women smoking at the time of delivery appears to have met the national target. However these figures are likely to be an under estimate as they rely on self reporting which is affected by the stigma associated with maternal smoking. This will affect the number of pregnant women that are prepared to confirm that they smoke and / or access services for cessation support.

2.03 - Smoking status at time of delivery

In 2012-13 fewer pregnant women used the NHS for support to stop smoking than the previous year (84 vs 103) but achieved a higher quit rate. This suggests that continuing to advise and encourage pregnant smokers to stop smoking and use NHS support to do so will result in positive outcomes.

Pooled data from 2007-2012 indicates that the proportion of Islington women recorded as smokers at the time of delivery remains below the rate for England but is higher than the average for London (6%).



Source: Department for Health, 2012

Equalities and health inequalities

- Women that smoke during pregnancy are likely to be younger, of lower educational achievement and found in unskilled occupations compared to the general population.
- Pregnant women that used the Islington Stop Smoking Service in 2012-13 achieved a better quit rate than the general population (53% compared with 49%).

2.03 - Smoking status at time of delivery

Key programmes in Islington

Universal services

Level One training is in place for midwives, health visitors and family support teams working in Children's Centres. It is also available to front line staff from any discipline that works with pregnant women and / or families with young children. Training highlights the harms of continued smoking and exposure to second hand smoke, and also introduces the "Three As" best practice advocating Brief Advice by Asking about smoking status, Advising on the benefits of stopping smoking, and Acting by referring smokers to local services for cessation support.

Pregnant women are able to access cessation support from community pharmacies and the NHS in Islington.

Targeted services

There is hospital based cessation support at the Whittington. Midwives and health visitors follow NICE guidance requiring them to record the smoking status of pregnant women presenting for services. Health Visitors will also conduct brief advice at the new birth visit which takes place within 14 days after birth. The Lifestyle Support Officer working across all Children's Centres is also trained to deliver direct cessation support, and supports centres to develop their own referral pathways to local cessation services.

Targets

The national Tobacco Control Plan for England, Healthy Lives, Healthy People's aim is to reduce the proportion of pregnant women recorded as smoking at delivery to 11% by 2015.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of women known to smoke at time of delivery. Numerator counts for local authorities are estimated from counts for PCTs.

Denominator: Number of maternities. Denominators for local authorities are estimated from denominators for PCTs.

Further information

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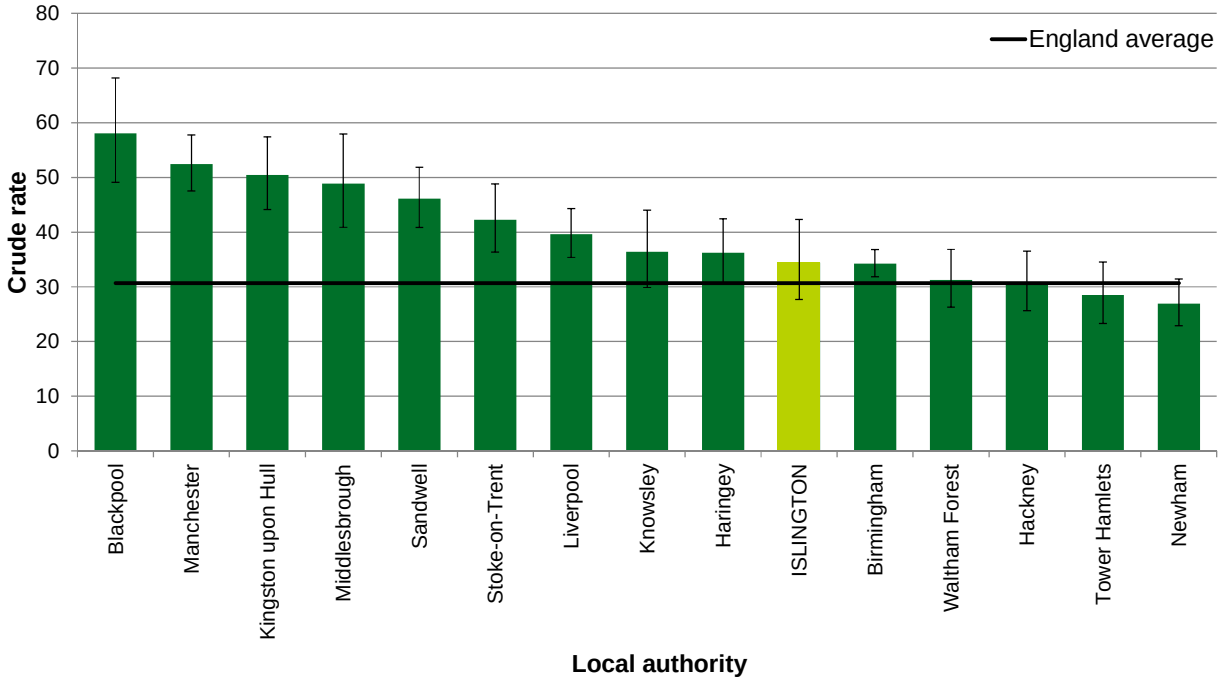
2.04 - Under 18 conceptions

Rationale from DH Technical Specification, 2013

Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS. And while for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty. Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.

The Islington picture

Crude rate of under 18 conceptions, Islington and similarly deprived boroughs compared against the England average, females, <18 years, 2011

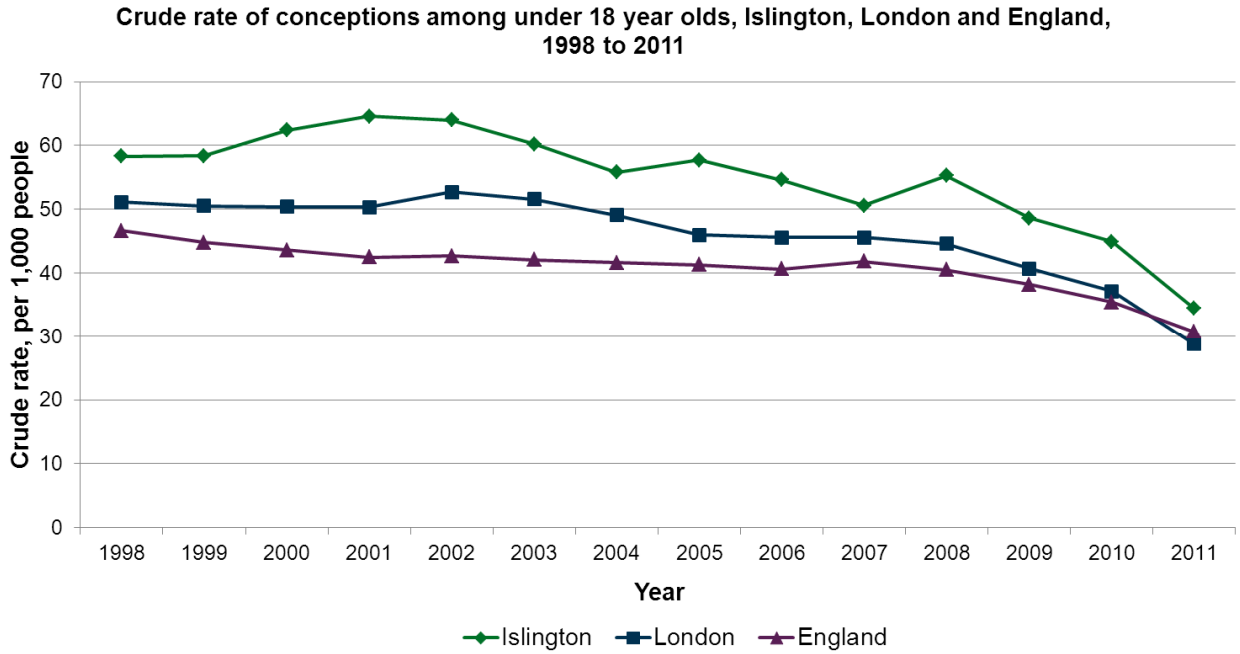


Source: Office for National Statistics (ONS)

Islington's teenage pregnancy rates have fallen and are not significantly different to London and England or to other similarly deprived London boroughs. In 2011 the annual rate for Islington was 34.4 per 1000 15-17 year old girls compared to 28.7 per 1000 in London and 30.7 per 1000 for England. The 2011 rate is a 41% decrease from the 1998 baseline. Five of Islington's wards are within the top 5% nationally. In 2011 there were 90 conceptions to girls aged 15-17 years.

2.04 - Under 18 conceptions

In 2011 69% of teenage conceptions were terminated which is higher than the London average of 61% and England 49%. It is also higher than the previous year when 55% of teenage conceptions in Islington ended in abortion.



Source: Association of Public Health Observatories

Equalities and health inequalities

Teenage pregnancy is a complex issue affected by young peoples' knowledge about sex and relationships, their ability to access advice and contraceptive services, their peer groups and aspirations. However there are well evidenced risk factors that make some young people more vulnerable to becoming pregnant than others. Deprivation and social exclusion are key risks, however these are compounded by other social, economic, personal and environmental factors. Where a young person has more than one risk factor present in their lives their vulnerability to teenage pregnancy is increased.

Key underlying risk factors are living in an area of high social deprivation, poor educational attainment and disengagement from school

Local maternity and termination sources suggest that young women of Black ethnic origin have a higher conception rate and young women of Asian ethnic origin a lower rate than the average rate for the borough. Termination rates showed a similar pattern. Care needs to be taken in interpreting these rates since there are strong links between deprivation and ethnicity in teenage pregnancy.

2.04 - Under 18 conceptions

Key programmes in Islington

Islington's teenage pregnancy strategy is comprised of several strands encompassing both universal provision and targeted work with those at higher risk: These include sex and relationship education at primary and secondary school, in youth clubs and outreach settings. Improving access to contraceptive services in a range of young people specific clinical and non clinical settings. The provision of free condoms as part of the Pan London C–Card scheme and support to young parents through Family Nurse Partnership (FNP) programme, Youth careers service and parenting programmes in children's centres.

Young people's sexual health clinics are provided at Pulse, Archway and Brook Euston. For teenagers who do have unprotected sex, free emergency hormonal contraception can be accessed at 29 Islington pharmacies, Pulse N7, Archway young people's clinics, Integrated Youth Hubs and family planning clinics.

Pulse nurses will follow up pregnant teenagers who are referred for a termination to ensure uptake of contraception post termination and a protocol is in place to follow up those not referred via Pulse.

Teenagers who decide to continue the pregnancy will be referred to the Family Nurse Partnership if they meet the eligibility criteria. The FNP supports pregnant teenagers and young parents until their child is two. Those not eligible for FNP will be provided support from the Children's Centre family support workers.

Targets

There are no national or local targets for this indicator

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of pregnancies that occur to women aged under 18, that result in either one or more live or still births or a legal abortion under the Abortion Act 1967.

Denominator: Number of women aged 15-17 living in the area

Further information

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2.06 - Excess weight in 4-5 and 10-11 year olds

Rationale from DH Technical Specification, 2013

The UK is experiencing an epidemic of obesity affecting both adults and children. The Health Survey for England found that among boys and girls aged two to 15, the proportion of children who were classified as obese increased from 11.7% in 1995 to 16% in 2010, peaking at 18.9% in 2004. There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older. Studies tracking child obesity into adulthood have found that the probability of overweight and obese children becoming overweight or obese adults increases with age. The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.

The Islington picture - 4-5 year olds

Reducing childhood obesity remains a priority for Islington. One in four in Reception children were overweight or very overweight (obese) in 2011/12, but this prevalence (24%) is not statistically significantly different to the England average (23%) or to any of the comparator boroughs with similar levels of deprivation.

In 2011/12, 92% of Reception children in Islington were weighed and measured; this is above the national target of 85%, but lower than both London (94%) and England (94%).

In Islington, 13.7% of 4-5 year olds were overweight and 10% obese. However, there has been a decrease of 2.8% in the Reception year pupils to be found either overweight and obese compared to 2010/11 data (27%).

The proportion of Reception children with excess weight in Islington for 2011/12 is similar to London and England; with Islington showing a slight decrease in 2011/12 after a couple of years above the London and England averages.

The Islington picture - 10-11 year olds

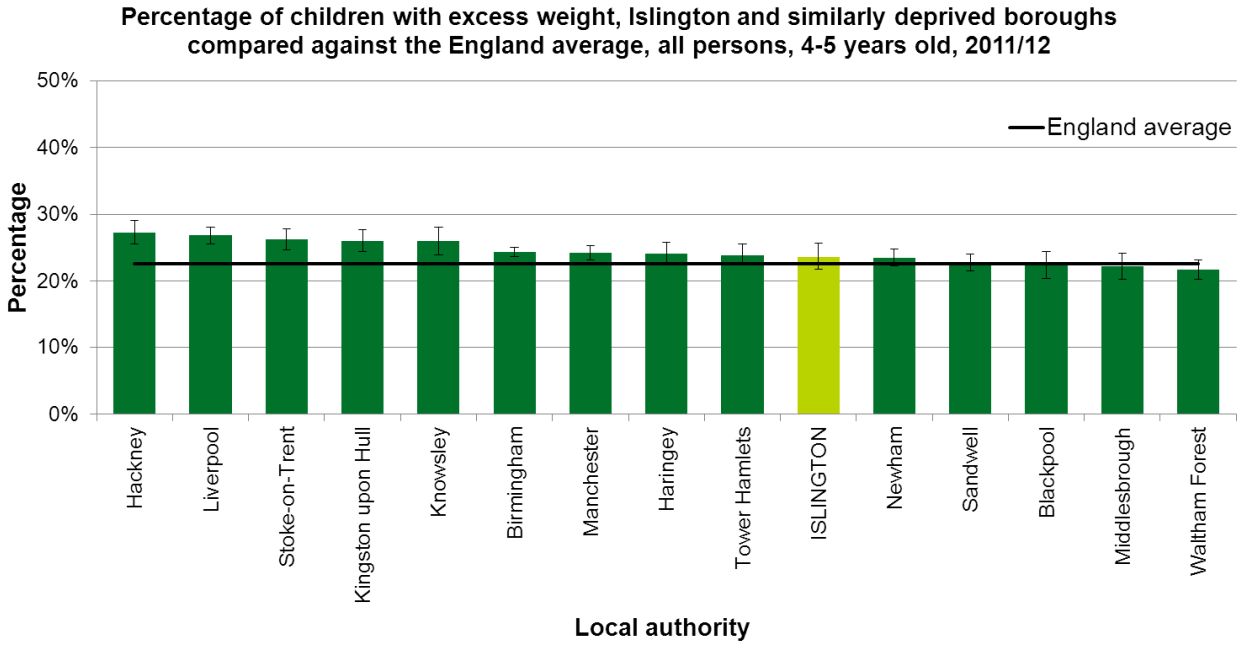
More than one in five Year 6 children were very overweight in 2011/12. 92% of Year 6 pupils in Islington were weighed and measured in the 2011/12; this is slightly lower than England (94%) but higher than the 85% national target.

The prevalence of excess weight among 10-11 year olds in Islington is significantly higher than the England average, but not significantly different from London and most similarly deprived boroughs. However, there has been little change in Islington for the past five years, although the gap between Islington and London and England has narrowed slightly.

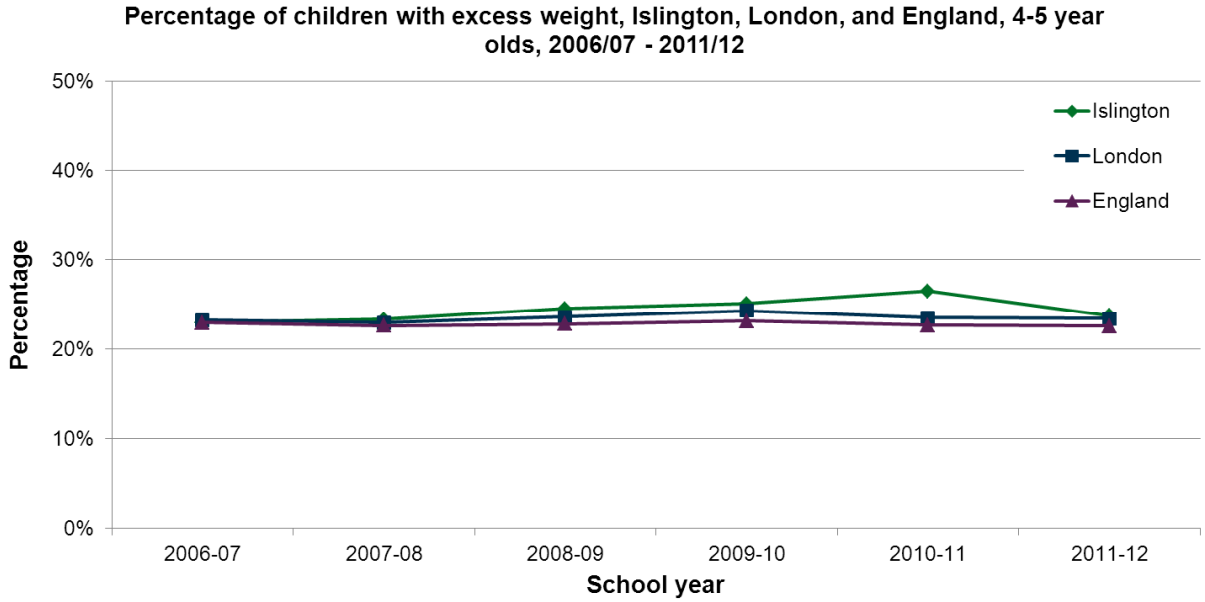
In Islington, 38% of Year 6 children were identified with excess weight in 2011/12 (16% overweight and 22% obese).

2.06i - Excess weight in 4-5 year olds

The Islington picture - 4-5 year olds



Source: Health and Social Care Information Centre



Source: Health and Social Care Information Centre

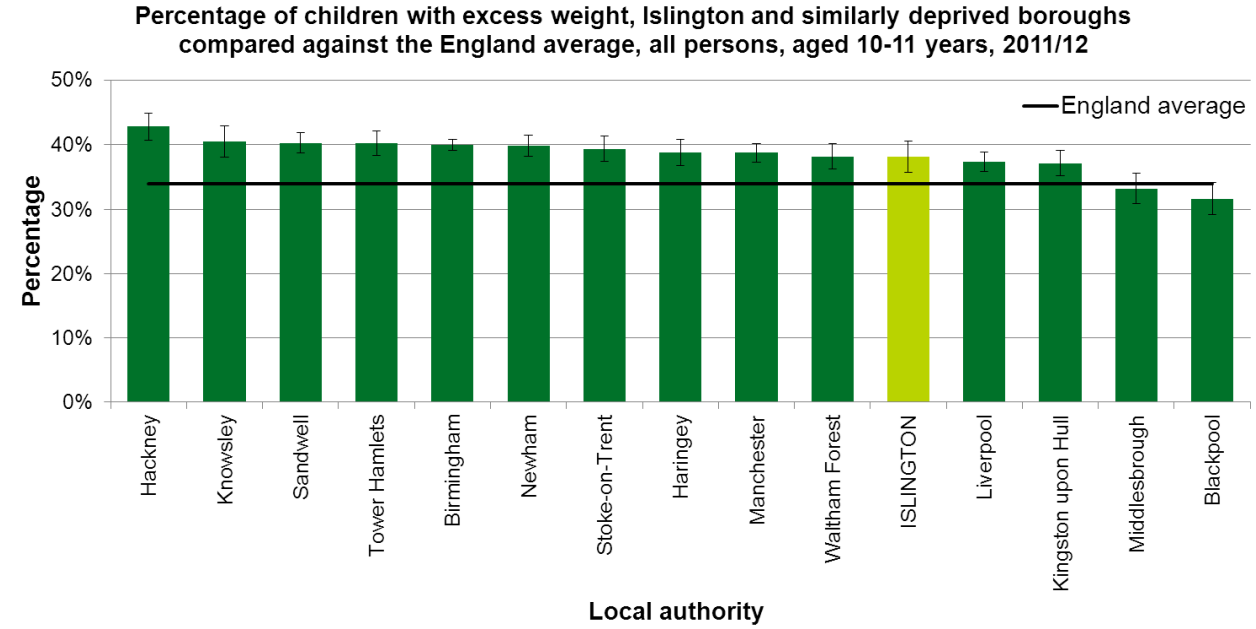
Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of children in Reception classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference according to age and sex.

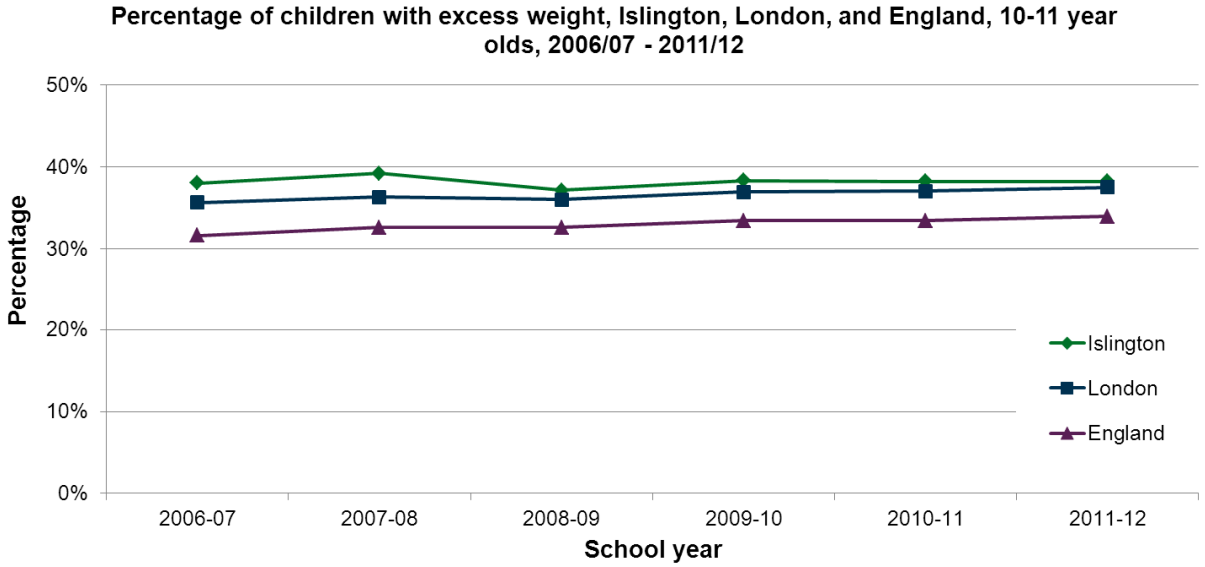
Denominator: Number of children in Reception (aged 4-5 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England.

2.06ii - Excess weight in 10-11 year olds

The Islington picture - 10-11 year olds



Source: Health and Social Care Information Centre



Source: Health and Social Care Information Centre

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of children in Year 6 classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference according to age and sex.

Denominator: Number of children in Year 6 (aged 10-11 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England.

2.06 - Excess weight in 4-5 and 10-11 year olds

Key programmes in Islington

Universal services

- There are a wide range of services offered in Islington to promote healthy weight and development. Universal services/settings, including maternity, health visiting, primary care, and Children's Centres, are all important in the first year of life. They are also part of a longer-term approach that combine later on with other services (e.g. Healthy Schools programme) focusing on prevention strategies such as encouraging healthy eating and physical activity initiatives.

Targeted services

- Healthy weight programmes for children and families, such as Stay and Play, and Family Kitchen for 2-4 year olds and 7-11 year olds, are offered locally.
- MoreLife is commissioned to provide a community weight management service to decrease overall energy intake, increase physical activity levels and decrease levels of sedentary behaviour for overweight children and young people aged 4-17 years.
- The Healthy Children's Centre and Healthy Schools programme support schools and children's centres to address childhood obesity in a structured approach, to promote healthy eating and physical activity.

Equalities and health inequalities

- Obesity prevalence is related to deprivation; obesity rates are higher among children who live in areas with a high level of free school meal eligibility, a proxy for deprivation.
- In Islington, 25% of boys in Reception had excess weight compared to 22% of girls, in 2011/12. That is a decrease from 2010/11 rates of 27% and 26% respectively. For 10-11 year olds, the gap was wider, 41% of boys had excess weight compared to 36% of girls.
- Ethnicity data is not available locally, but nationally obesity prevalence among boys in Reception is highest in the Black African, Black Other, and Bangladeshi groups; and significantly higher for all minority ethnic groups in Year 6. For girls in at both ages, obesity prevalence is highest among those from Black African, and Black Other ethnic groups.

Targets

Locally the target is to "Reduce childhood obesity through increasing opportunities for healthy eating and physical activity".

Further information

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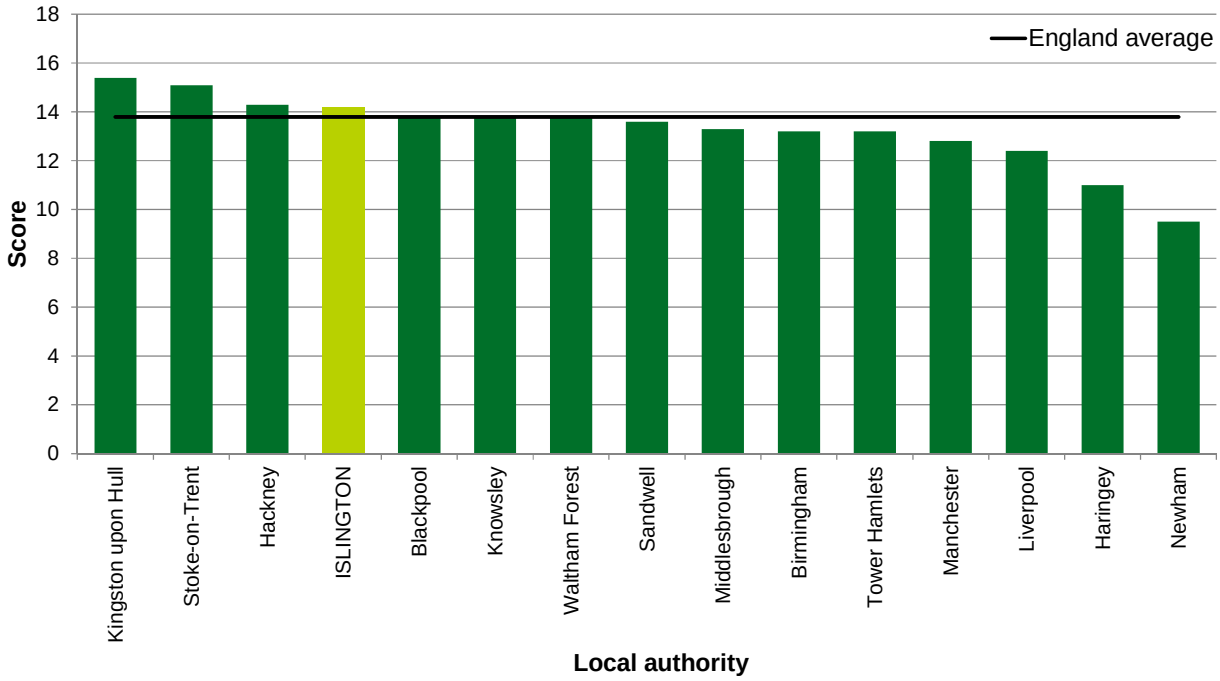
2.08 - Emotional well-being of looked after children

Rationale from DH Technical Specification, 2013

The mental health of all children is important. With half of adult mental health problems starting before the age of 14, early intervention to support children and young people with mental health and emotional well-being issues is very important. Without an indicator covering this group, there would be a risk of an even greater increase in rates of undiagnosed mental health problems, placement breakdown, alcohol and substance misuse, convictions and care leavers not in education, employment or training

The Islington picture

Score of emotional wellbeing of looked after children, Islington and similarly deprived boroughs compared against the England average, all persons, 4-16 year olds, 2011/12



Source: Department for Education

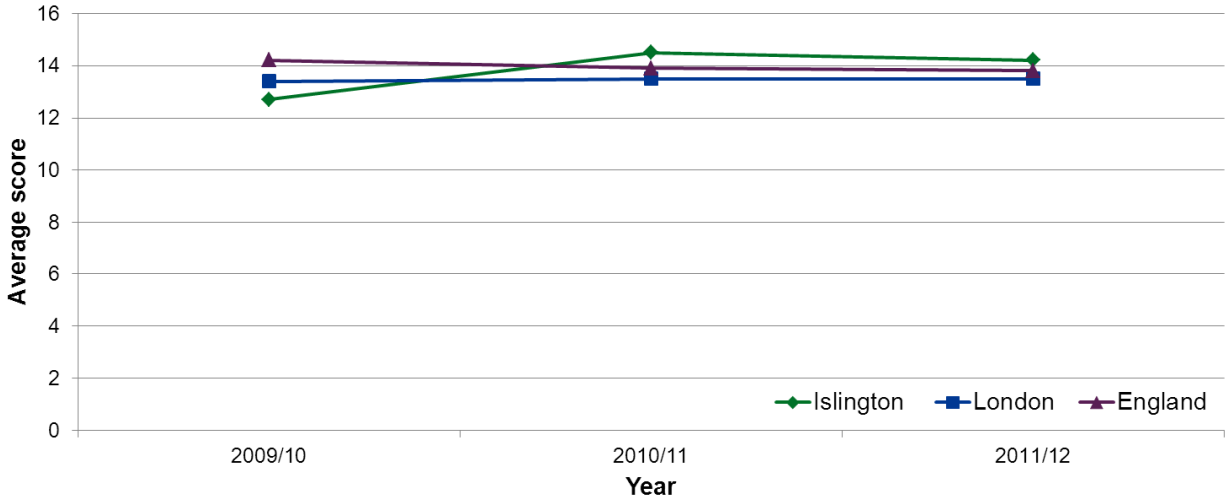
This indicator is based on responses to the Strengths and Difficulties Questionnaire (SDQ) for children who have been looked after continuously for at least 12 months, as at the 31st of March each year. A higher score on the SDQ indicates more emotional difficulties. The average score for Islington's looked after children in 2012 was 14.2. This is lower than the Islington score of 14.5 in 2011. In 2013, the average score has fallen again, to 14.0. This indicator is based on the average score. In Islington, scores were submitted for 91% of this group in 2012, higher than the London and England averages, and higher than most of the similarly deprived local authorities listed above. In 2013, scores were submitted for 94% of the group in Islington.

2.08 - Emotional well-being of looked after children

In 2011/12, 11% of Islington's looked after children had a SDQ score that indicated a borderline cause for concern (14 to 16) and 39% had a score that is considered a cause for concern (17 or more). The proportion of looked after children whose SDQ score indicated a cause for concern was marginally higher in Islington than the London or England averages in 2012, and it was also higher than the 2011 Islington average.

Islington's average score in 2011/12 was fourth highest among English boroughs with a similar level of deprivation. Similarly, when compared to its statistical neighbours as defined by the Department for Education (different to the authorities listed in the previous chart) Islington's average score in 2011/2012 was the third highest. Although, the proportion of children for whom a score was submitted was higher for Islington than the comparator average.

Average emotional wellbeing score of looked after children, Islington, London and England, 2009/10 to 2011/12



Source: Department for Education, 2012

Equalities and health inequalities

- Looked after children and young people have many of the same health risks and problems as their peers, but often to a greater degree. They often enter care with a worse level of health than their peers in part due to the impact of poverty, abuse and neglect.
- Research by the Office of National Statistics (2003) found that, across the country, over half the looked after boys who were surveyed had an identifiable mental disorder, compared to over a third of the looked after girls who were surveyed.
- The same research found that identifiable mental health disorders were more common amongst looked after children from older age groups.
- The relationship between age and the prevalence of mental ill health is influenced by the age at entry into care and this has been reported to be the key predictor.
- Children in residential care have been found to be more likely to have mental health problems than those in family-type foster care or those in kinship care.

2.08 - Emotional well-being of looked after children

Key programmes in Islington

Islington Clinical Commissioning Group commission a specialist Children and Adolescent Mental Health Service (CAMHS) for Children Looked After (CLA) by Islington. The Service's key objectives are:

- To improve the mental health and emotional well being of children looked after by Islington
- To offer responsive and accessible CAMHS assessment / intervention to CLA identified with mental health problems
- To contribute to the stability of family placements through the provision of psychological interventions when emotional / behavioural presentation is a significant factor
- To increase the confidence of social workers to understand and manage emotional and behavioural difficulties of CLA through the provision of consultation.

A range of assessment and psychological therapies for CLA, their carers and professionals network is provided by Islington CAMHS. The team works with young people placed in borough as well as ensuring that Children Looked After placed out of borough are also able to access the appropriate CAMHS input that they require.

Targets

There are no local or national targets for this indicator.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Sum of SDQ scores of eligible children

Denominator: Number of eligible children with an SDQ score

Further information

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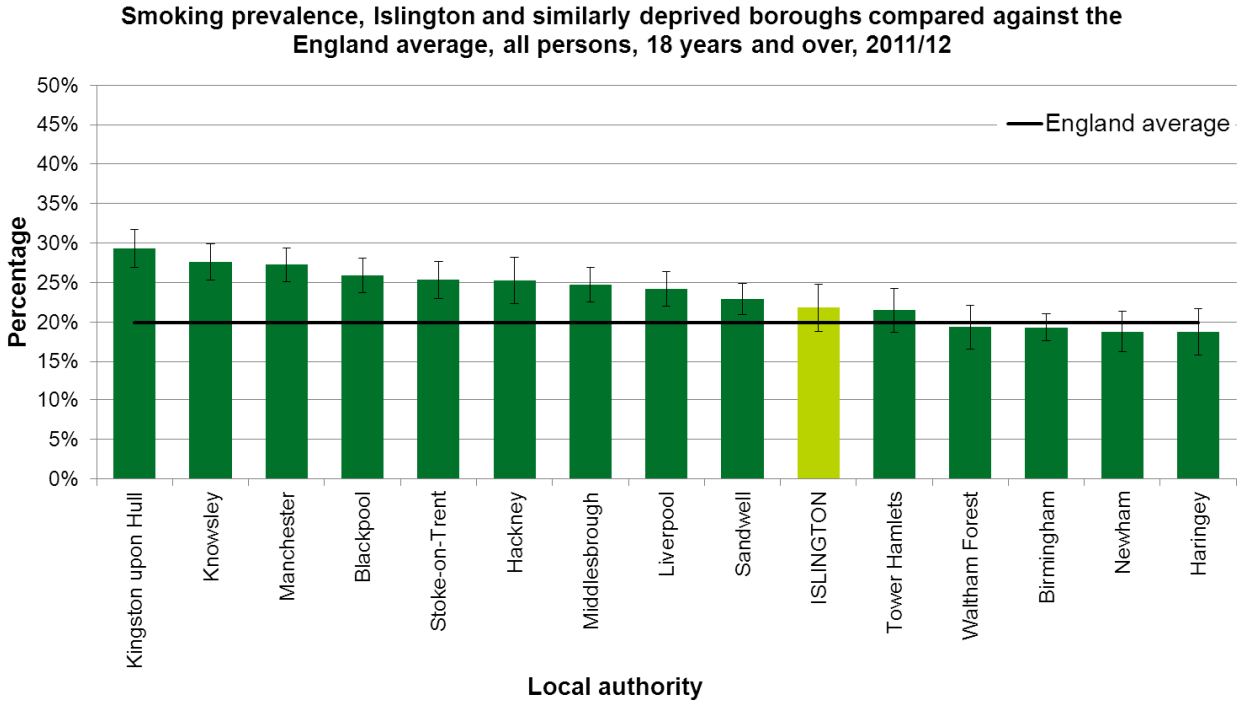
2.14 - Smoking prevalence - adults (over 18s)

Rationale from DH Technical Specification, 2013

Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix. In 2008/09, some 463,000 hospital admissions in England among adults aged 35 and over were attributable to smoking, or some 5% of all hospital admissions for this age group (NHS Information Centre (2010). Statistics on Smoking: England, 2010, NHS Information Centre, Leeds). Illnesses among children caused by exposure to second-hand smoke lead to an estimated 300,000 general practice consultations and about 9,500 hospital admissions in the UK each year (Royal College of Physicians (2010). Passive Smoking and Children. Royal College of Physicians, London). Smoking is a modifiable lifestyle risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population.

The Islington picture



Source: Integrated Household Survey. Analysed by DH and published by LHO.

Islington has a recorded smoking prevalence of 22% among adults over 18, which is not significantly different from the England average of 20%. When compared to the areas of England with similar levels of socio-economic deprivation, Islington has a rate that is not statistically different from 11, and significantly lower than three (Kingston upon Hull, Knowsley, and Manchester).

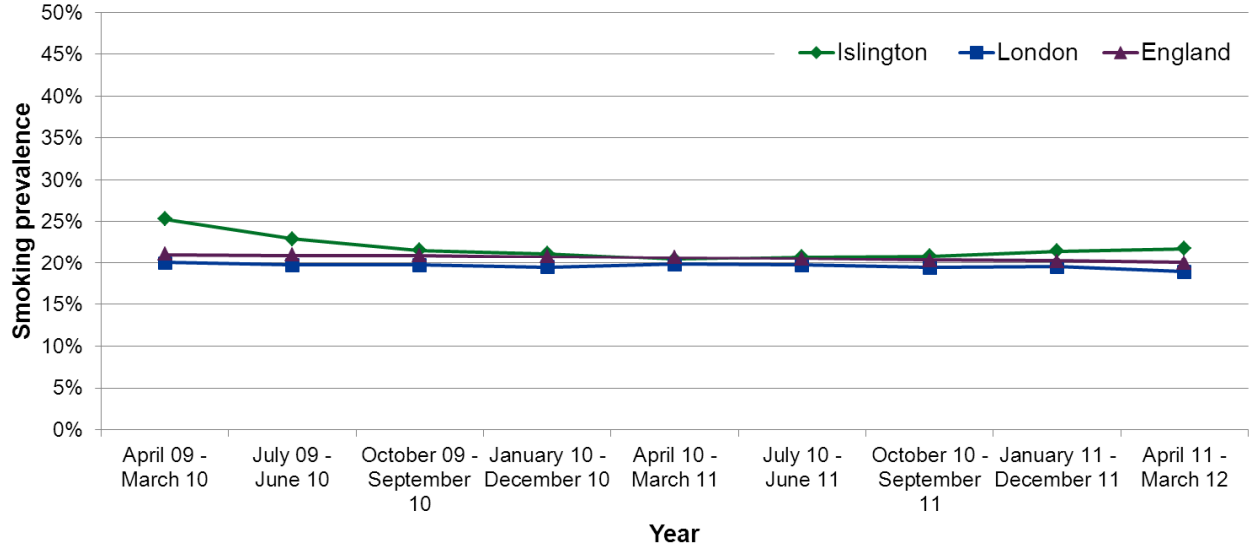
Reducing smoking is an important contributor to achieving cross-government objectives on inequalities in life expectancy and infant mortality, and mortality from coronary heart disease, diabetes, and cancer.

2.14 - Smoking prevalence - adults (over 18s)

It is too early to say whether the overall national target will be met. Records from Islington GPs suggest that 25% of the registered population over 18 years of age are recorded as smokers. It is not known why this discrepancy exists, nor which figures are correct, but it is likely that the 22% recorded in national tables is an under estimate.

Islington's Stop Smoking Service supported 2,246 smokers to successfully quit during 2012/13 and is consistently one of the best performing services in London. This exceeded the target agreed with NHS London (2,229 4-week quitters) and is achieved by having a network of cessation advisers available from most community pharmacies, general practice and in community settings.

Smoking prevalence in adults aged 18+, Islington, London and England, April 2009-March 2010 to April 2011-March 2012 (rolling 12 month quarterly)



Source: London Health Observatory, 2012

Equalities and health inequalities

- The highest rates of smoking are among White & Black Caribbean at 34%, White Irish (28%) with White Other (which includes Turkish, black Caribbean and White British at 26% and are estimated to be even higher among men from Islington's Somali and Bangladeshi populations
- Quit rates increase with age for men and women being highest amongst those aged 60 plus.
- In 2011/12 those in the most deprived areas had a lower quit rate than those in the second and third most deprived quintiles, because of an increase in the quit rates among the latter two groups.

Targets

The national Tobacco Control Plan for England, Healthy Lives, Healthy People's aim is to reduce the proportion of smokers to 18.5% by 2015.

2.14 - Smoking prevalence - adults (over 18s)

Key programmes in Islington

Universal services

The NHS stop smoking service is available to any smoker aged over 15 that lives, works or studies in Islington from most pharmacies and the community based service for those not registered with an Islington GP and from all Islington GPs for registered patients. Most Islington smokers prefer 1:1 support but group and drop in clinics are available for smokers that prefer these settings.

Level One training is available to all front line staff promoting the Brief Advice / Three As best proactive model “Ask, Advise, Assist” to encourage a conservation about smoking status, advice about the benefits of stopping and signposting to the most appropriate cessation access point for support to stop

Level Two training is in place which equips staff to facilitate smoking cessation and includes behavioural support skills and treatment with appropriate pharmacotherapy

Targeted services

Programmes supporting communities with the poorest health outcomes to stop smoking are in place and regularly reviewed to meet local need. Patients with long term conditions and those which are pregnant can also access cessation services a the Whittington. Leads from Turkish, Irish, Somali and Bangladeshi communities receive level one training, with Level Two training available for direct interventions.

Temporary clinics are set up in areas of deprivation or among identified population groups, with multi agency campaigns such as Smokefree Homes working with families to reduce exposure to second-hand smoke, decrease the risk of domestic fires with smoking as the attributed cause an support parents of young children to stop smoking.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: The number of persons aged 18+ who are self-reported smokers in the Integrated Household Survey (IHS). The number of respondents has been weighted to improve representativeness of the sample.

Denominator: Total number of respondents (with valid recorded smoking status) aged 18+ in the IHS. The number of respondents has been weighted in order to improve representativeness of the sample.

Further information

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2.15 - Successful completion of drug treatment

Rationale from DH Technical Specification, 2013

Individuals achieving this outcome demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health. It aligns with the ambition of both public health and the Government's drug strategy of increasing the number of individuals recovering from addiction. It also aligns well with the reducing re-offending outcome [Indicator 1.13] as offending behaviour is closely linked to substance use and it is well demonstrated that cessation of drug use reduces re-offending significantly. This in turn will have benefits to a range of wider services and will address those who cause the most harm in local communities.

The Islington picture

Estimates suggest that in 2010/11 Islington had 2,330 **opiate and/or crack users**. The prevalence rate (15 per 1,000 working age adults) was nearly twice as high as the London rate (9 per 1,000 working age adults), and was the second highest of both the similarly deprived boroughs shown in the chart below, and all London boroughs.

Latest figures suggest small improvements in the overall number of successful drug treatment completions, but services have struggled to improve successful treatment completions among opiate users despite sustained efforts over the past year. This is in the context of a changing treatment population in Islington; there has been a drop in the proportion (and numbers) of very low and low complexity clients and a growth in the proportion of very high complexity clients.

Islington has a large number of **non-opiate users**, although exact numbers are not known.

There has been a small downward trend in the proportion of non-opiate users successfully completing treatment over the last two quarters, and performance is below the average for England. However, Islington has a particularly complex group and the numbers of non opiate users in the treatment system has increased from 271 to 314, since when there has been a slight increase in numbers successfully completing treatment.

There are on-going expectations that treatment becomes ever more recovery orientated in line with the Government Drug Strategy and the Public Health Outcomes Framework. Over the coming years we are putting a much stronger emphasis on recovery. This places a greater responsibility on individuals to seek help and overcome dependency, while also requiring services to take a more holistic approach, addressing issues related to social inclusion, offending, employment and housing. A recovery plan is in place to support providers in improving rates of successful completion, and changes to the direct access service model in 2013 aim to support the renewed focus on recovery and improve successful treatment outcomes.

Equalities and health inequalities

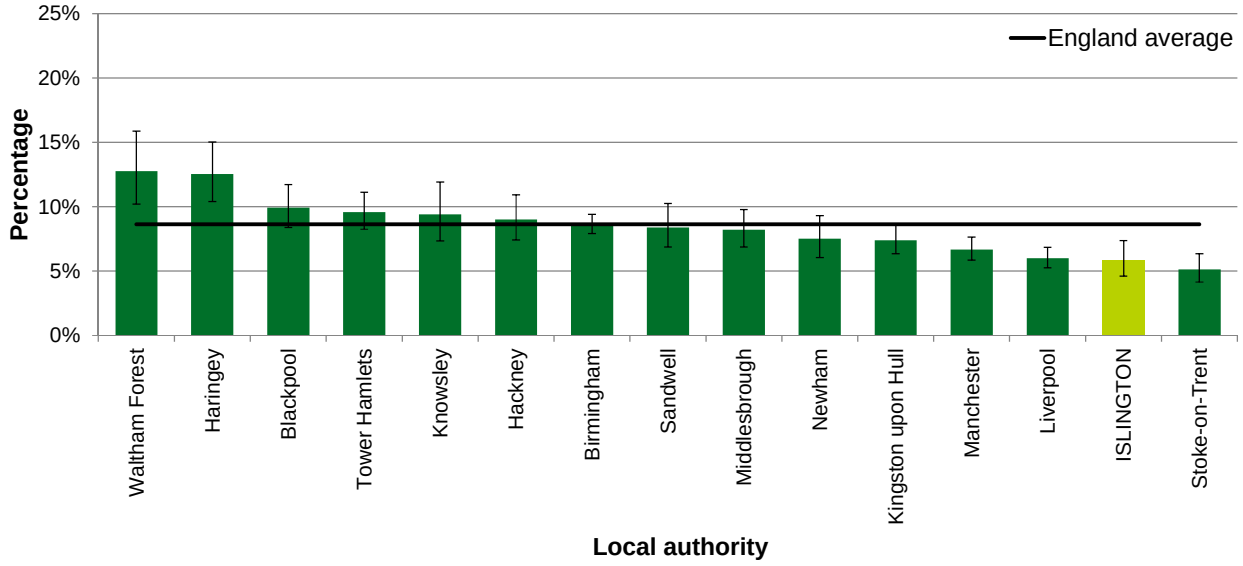
Islington has a particularly complex group of service users who may have mental health issues as well as substance misuse problems. This is similar to the national picture.

Although on a national level blood borne virus (BBV) transmission amongst injecting drug users is reported to be decreasing, prevalence of Hepatitis C among people who inject drugs was reported to be at 49%, and Hepatitis B prevalence was reported to be at 17% (HPA, 2010).

2.15i - Successful completion of drug treatment - opiate users

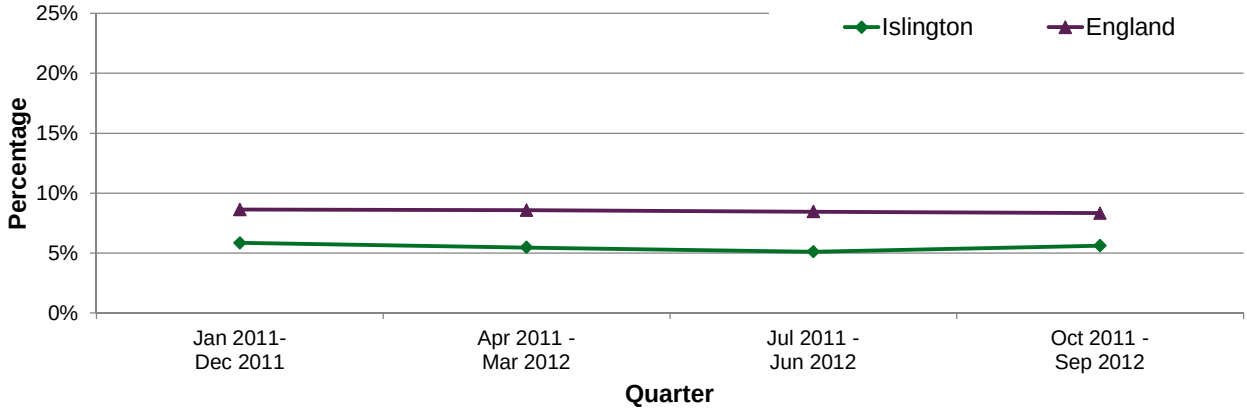
The Islington picture - drug treatment completion among opiate users

Percentage of opiate users successfully completing drug treatment, Islington and similarly deprived boroughs compared against the England average, all persons in treatment, aged 18-75 years old, 2011



Source: National Drug Treatment Monitoring System

Percentage of opiate users successfully completing drug treatment programmes, Islington and England, all persons in treatment, aged 18 and over, rolling 12 month figures



Source: National Drugs Treatment Monitoring System, 2013

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

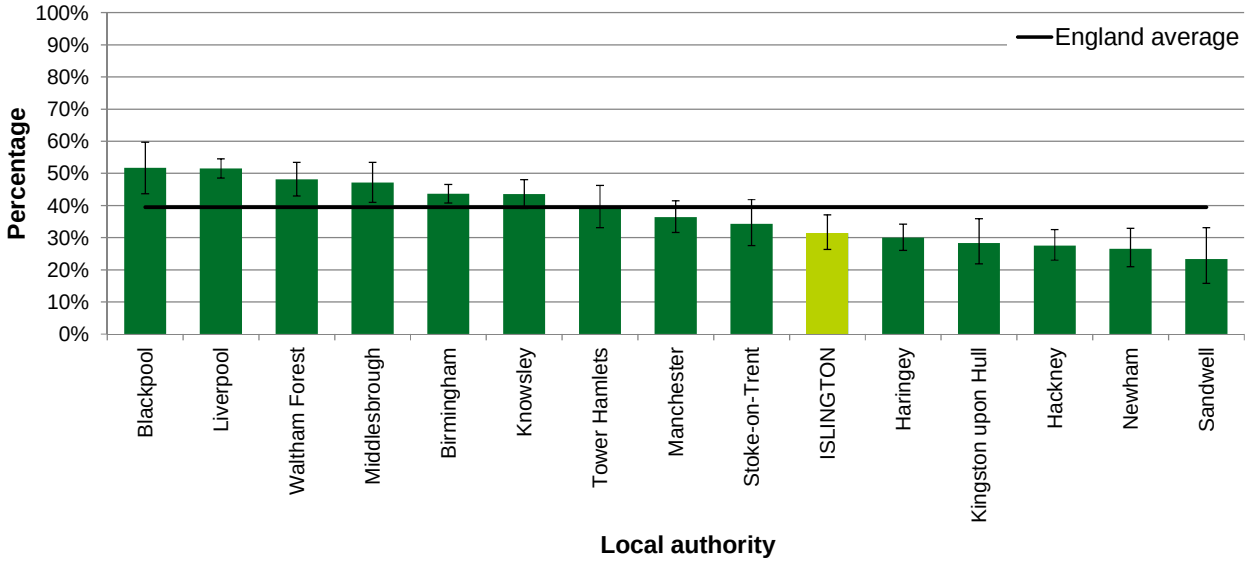
Numerator: The number of adults that successfully complete treatment for opiates in a year and who do not re-present to treatment within 6 months.

Denominator: The total number of adults in treatment for opiate use in a year.

2.15ii - Successful completion of drug treatment - non-opiate users

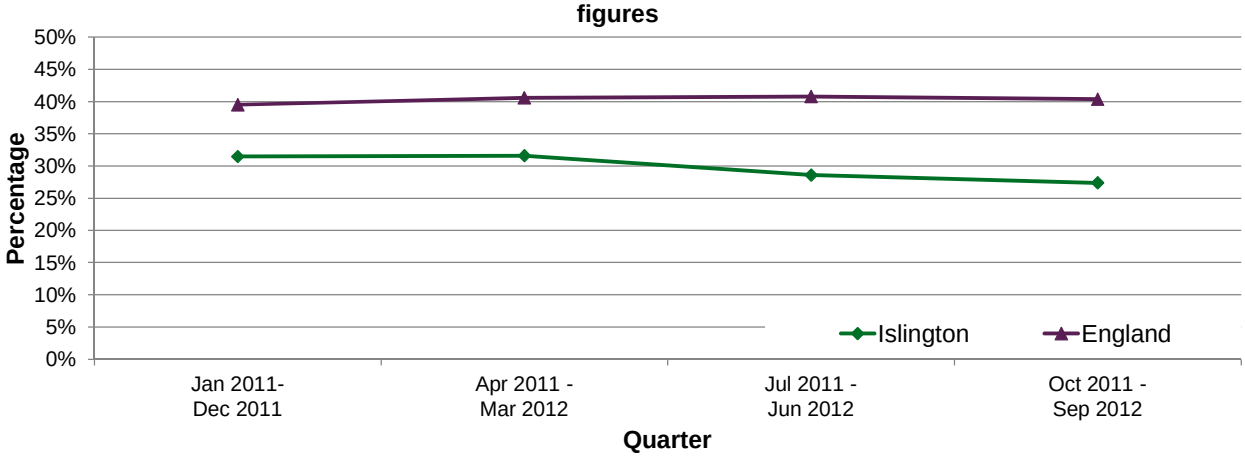
The Islington picture - drug treatment completion among non-opiate users

Percentage of non-opiate users successfully completing drug treatment, Islington and similarly deprived boroughs compared against the England average, all persons in treatment, aged 18-75 years old, 2011



Source: National Drug Treatment Monitoring System

Percentage of non-opiate users successfully completing drug treatment programmes, Islington and England, all persons in treatment, aged 18 and over, rolling 12 month figures



Source: National Drugs Treatment Monitoring System, 2013

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: The number of adults that successfully complete treatment for non-opiates in a year and who do not re-present to treatment within 6 months.

Denominator: The total number of adults in treatment for non-opiate drug use in a year.

2.15 - Successful completion of drug treatment

Key programmes in Islington

Islington residents can access a range of universal services that support their successful completion of drug treatment. These services include employment support, housing and welfare benefits advice. By taking a holistic approach, drug treatment services work with service users to improve health outcomes, reduce BBV transmission, and support improvements in health.

There are a range of specialist drug and alcohol services available in Islington working in a variety of locations including: GP practices, police custody suites, the probation services, supported housing, and community-based services, as well as in-patient and residential settings.

Drug and Alcohol Services offer a range of treatment options including counselling, group work, complementary therapies and prescribed services for opiate dependent users. Services include:

ISIS: a 'one stop shop' for anyone wanting treatment and support in relation to substance misuse. ISIS is currently provided by Cranstoun, CRI and Whittington Health, working in partnership.

Primary Care Alcohol and Drug service: provides support to Islington GP practices and the Whittington Hospital for the treatment of patients experiencing problem alcohol or drug use.

IDASS: a specialist substance misuse services provided by Camden and Islington NHS Foundation Trust, supporting clients with complex needs. The service acts as a gateway to residential rehab and detox for alcohol and drug users.

Aftercare Services

Change and Recovery @28b: run by Cranstoun Drug and Alcohol Services working with those affected by drug and alcohol problems to improve their ability to remain drug free through a structured day programme.

Single Homeless Project Aftercare Service: a new service aiming to help users access education, training, and employment opportunities - including accredited qualifications and work placements.

Families, Partners and Friends: a service run by Blenheim offering support to those affected by a loved one's substance misuse, this is a key resource to support successful treatment outcomes.

Targets

The borough target for successful completions is 15% for opiate and non-opiate users.

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2.17 - Recorded diabetes

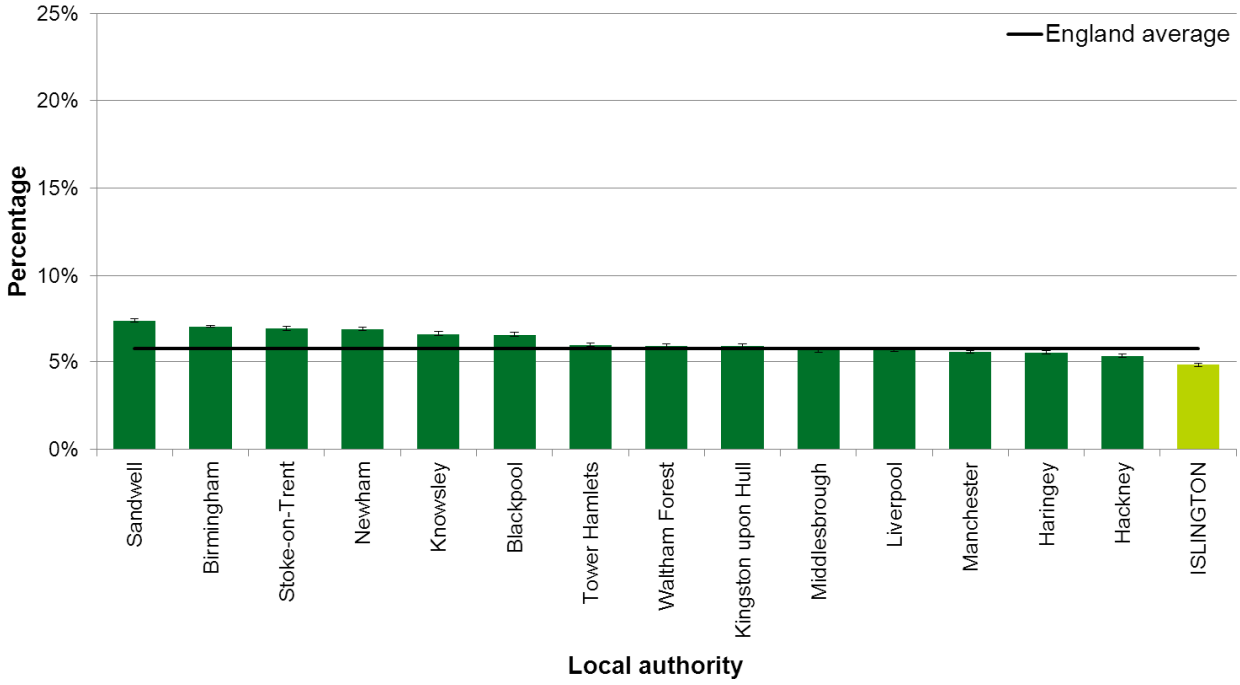
Rationale from DH Technical Specification, 2013

The indicator will raise awareness of trends in diabetes among public health professionals and local authorities.

Diabetes complications (including cardiovascular, kidney, foot and eye diseases) result in considerable morbidity and have a detrimental impact on quality of life. Type 2 diabetes (approximately 90% to 95% of all diagnosed case diabetes) is partially preventable – it can be prevented or delayed by lifestyle changes (exercise, weight loss, healthy eating, reduce alcohol consumption). Earlier detection of Type 2 diabetes followed by effective treatment reduces the risk of developing diabetic complications.

The Islington picture

Recorded prevalence of diabetes, Islington and similarly deprived boroughs compared against the England average, all persons, 17 years and over, 2011/12



Source: Information centre for health and social care (IC). QOF information is derived from the Quality Management Analysis System (QMAS), a national system developed by NHS Connecting for Health.

In 2011/12, the proportion of recorded diabetes for over 17 years and over in Islington was 4.8% (9,064), lower than London (5.6%) and England (6.4%) prevalence estimates. Similarly, Islington has the lowest rate of recorded diabetes compare to other deprived boroughs, including Sandwell which has the highest rate of recorded diabetes with over 7%. However, these rates do not take into account differences in age structure or the ethnic makeup of the population.

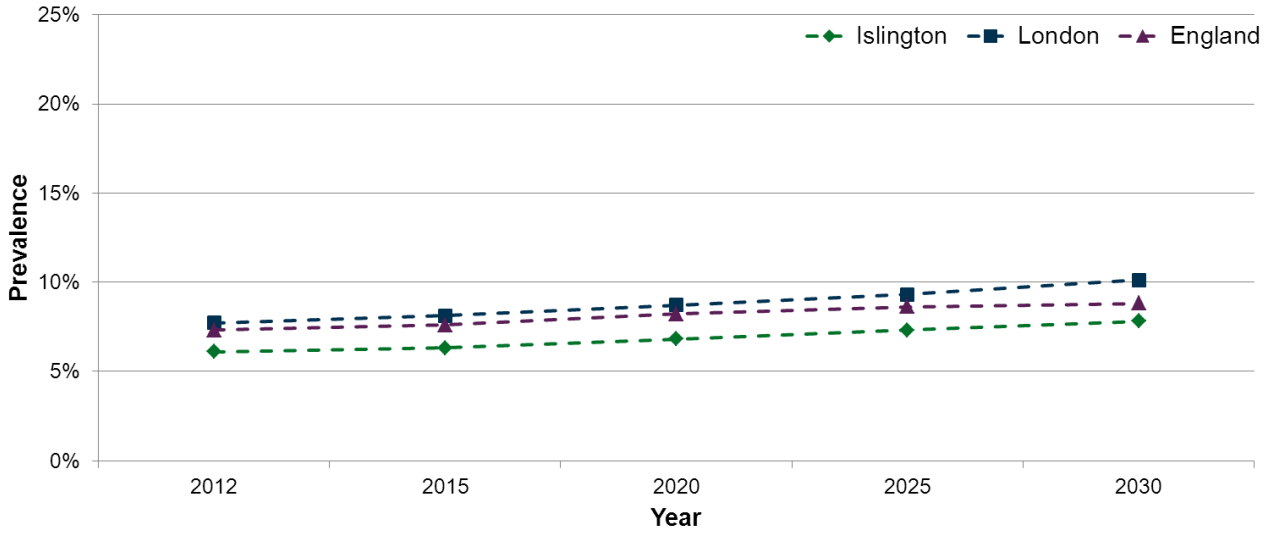
The lower prevalence rate in Islington is likely to reflect the borough's young population, as diabetes is more common in older people (over 40 year olds).

2.17 - Recorded diabetes

People with diabetes often do not have symptoms of diabetes when they are first diagnosed. Statistical models suggest that the total prevalence of diabetes that would be expected in Islington is 6.8%. In Islington this equates to 3,996 of people aged 17 years and over are expected to have undiagnosed diabetes.

Prevalence of diabetes has been rising in Islington, London, and England, and is forecast to continue to rise. As obesity is a key risk factor for diabetes, it is likely that the rise in obesity nationally and locally is a major reason for this increase in prevalence. In addition, as diabetes is more prevalent in older populations, an ageing population will also contribute to increased rates of diabetes.

Forecast prevalence of diabetes (diagnosed and undiagnosed), Islington, London, and England, 2012-2030



Source: YHPHO diabetes prevalence model, 2012

Targets

There are no targets set for this indicator.

Equalities and health inequalities

- The risk of Type 2 diabetes increases with age, and is highest in those aged over 40. In Islington, Diabetes affects more men than women (4.5% of men and 3.3% of women are diagnosed with diabetes in Islington).
- Diabetes is more common in some ethnic groups. In Islington, Asian population groups are about four times more likely to be diagnosed with diabetes than the white population groups and black population groups are over twice as likely compared to white population groups.
- Type 2 diabetes is more prevalent among less affluent populations. Those in the most deprived one-fifth of the population are over one-and-a-half times more likely than average to have diabetes at any given age.
- People with learning disabilities are likely to have similar predisposition to diabetes as the population as a whole, but other risk factors may be more common in this group by getting diabetes i.e. those who have problems with their weight would be at high risk of diabetes.

2.17 - Recorded diabetes

Key programmes in Islington

Lifestyle services (primary prevention)

Islington has a number of public health lifestyle programmes designed to tackle some of the risk factors for diabetes, including a new adult weight management service offering a 12 week programme of physical activity and educational sessions. It aims to support patients to lose 5-10% of their body weight over 12 weeks and maintain this weight loss for 12 months, post programme. The programme is designed for those aged 18+ with a BMI ≥30 (or ≤27.5 for South Asian people), or BMI ≥25 with a co-morbidity (including Type 2 diabetes).

Other examples of services include stop smoking, exercise on referral and Islington Direct Access service for alcohol-related problems.

Finding the undiagnosed

Closing the prevalence gap is a new programme being developed in Islington which involves GP practices identifying those people on their practice register that are at risk of certain conditions, including diabetes, and inviting them in for tests. Individuals found to either have diabetes that was previously undiagnosed, or be at particularly high risk of diabetes, are then be followed up and managed in primary care, and referred into lifestyle services as appropriate.

The NHS Health Checks programme aims to identify people at high risk of diabetes (and other diseases), followed by referral for diagnostic tests. If an individual is diagnosed with diabetes then they are referred to appropriate management and care. The programme also aims to identify undiagnosed patients in particular high risk groups, closing the gap between diagnosed and expected prevalence.

Management of diabetes

A newly commissioned service in general practice aims to improve outcomes for people across the spectrum of diabetes from those found to be particularly high risk of developing diabetes to those with diabetes at high risk of developing complications. The service incentivises systematic recall of patients and full review including care planning.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Patients registered with GP practices, with a coded diagnosis of diabetes and aged 17 and over at midnight on 31st March (in a particular year). (QOF DM19).

Denominator: Patients registered with GP practices aged 17 and over. The practice list sizes included in the QOF prevalence dataset are obtained from the Prescription Services Division of the NHS Business Services Authority (BSA) and relate to the final quarter of the reporting year.

Further information

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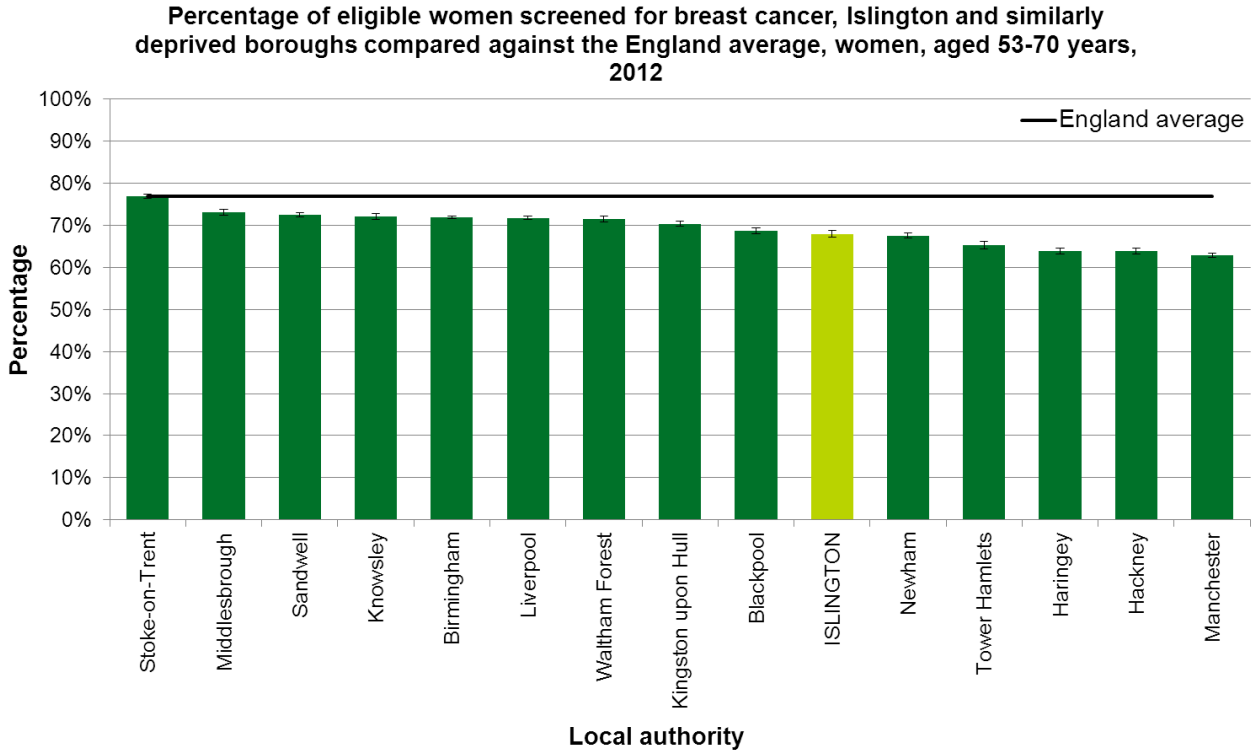
2.20i - Cancer screening coverage - breast cancer

Rationale from DH Technical Specification, 2013

Breast screening supports early detection of cancer and is estimated to save 1,400 lives in England each year. Inclusion of this indicator will provide an opportunity to incentivise screening promotion and other local initiatives to increase coverage of cancer screening. Improvements in coverage would mean more breast cancers are detected at earlier, more treatable stages.

The Islington picture



Source: NHS Connecting for Health (Open Exeter)/East Midlands Public Health Observatory

The graph above compares the breast screening coverage rate in Islington to other boroughs in England that have a similar socioeconomic status. At March 2012 the breast screening coverage rate in Islington was 68%. This is significantly lower than the England average of 77% and significantly below the 70% screening target. However, coverage in Islington is significantly higher than all but one comparable London borough (Waltham Forest).

In Islington, approximately 102 women are diagnosed with breast cancer each year (2006-2008). It is the second most common cause of cancer death in the borough. In 2008-10, the directly standardised mortality rate from breast cancer in Islington was 33 per 100,000 women, compared to a rate of 25 per 100,000 women for London and 25 per 100,000 women for England.

During 2008-2010, 30 women living in Islington died each year on average from breast cancer. 14 of these women were aged under 75.

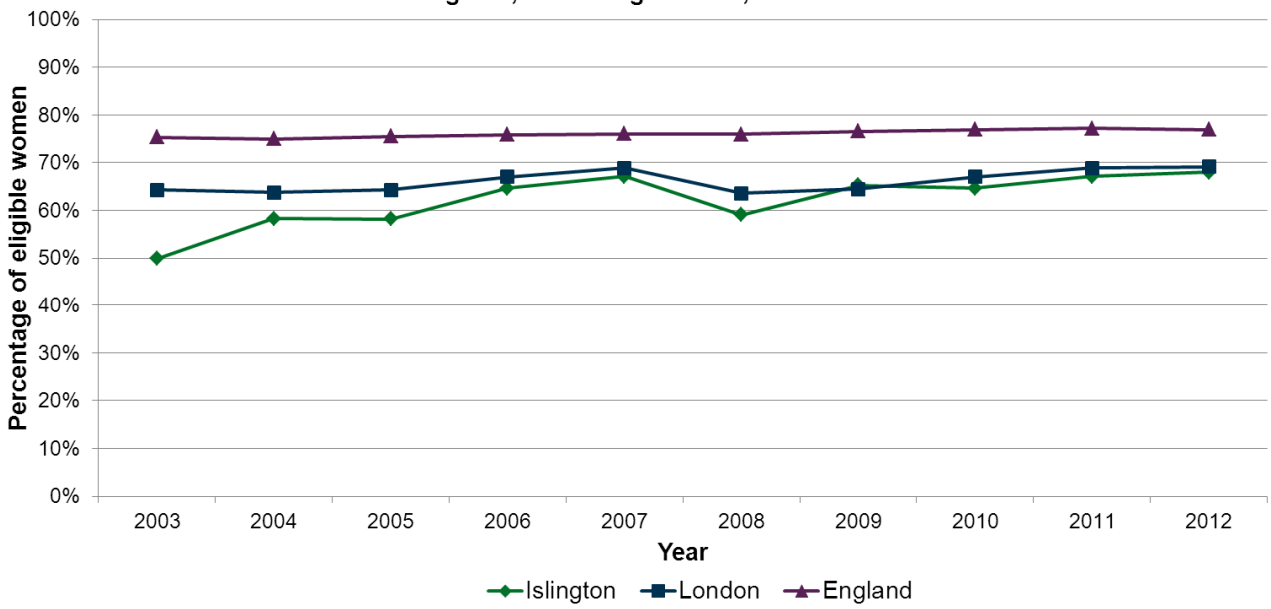
2.20i - Cancer screening coverage - breast cancer

Participation in the breast cancer screening programme can reduce deaths from breast cancer by about 35% among women who are regularly screened.

Breast cancer screening coverage in Islington has improved over the years. In 2003 the proportion of eligible women in Islington who had been screened in the last three years was 50%. By March 2012 the coverage rate had increased to 68%.

At March 2013 the number of unscreened women in the borough was 4,432. In order to achieve the 70% target a further 359 women would need to be screened. Breast screening coverage in Islington varies by GP practice ranging from 44% to 75% at the end of March 2013.

Percentage of eligible women screened for breast cancer, Islington, London and England, women aged 53-70, 2003-2012



Note: The 2003-2007 eligible population was 53-64 year old women but from 2008 onwards was 53-70 year old women.
Source: NHS Connecting for Health

Equalities and health inequalities

Results from Islington's breast cancer screening equity analysis (2008-12) showed that:

- There are significant differences between screening uptake in the most deprived areas of the borough (68%) compared to the least deprived areas (74%).
- No age groups have a significantly lower uptake than the average however, women aged between 60-64 have a significantly higher uptake than the average.
- Variation exists between local areas with 65% of women in Tollington ward being screened compared to 76% in Highbury East.

Nationally, research suggests that women with a disability are less likely to attend breast cancer screening, as are Muslim women and women from BME groups.

2.20i - Cancer screening coverage - breast cancer

Key programmes in Islington

Breast cancer screening programme

In Islington, breast cancer screening is offered to women aged 50 to 70 every three years. This will be extended to women aged 47 to 73 in the next few years. Breast cancer screening invitations are sent out on a three year rolling schedule based on GP practice. Islington's last active screening round finished in 2011 and the next round will begin in 2013. Women over the age of 70 are encouraged to attend although they are not routinely invited.

Improving uptake

The Central and East London Breast Screening Services (CELBSS), who organise breast cancer screening in Islington, are working to reduce the number of women who do not attend their breast screening appointment. Initiatives include online booking, text message reminders and timed appointments for women who did not attend their first appointment.

The NCL Breast Cancer Screening Action Plan includes work with General Practices to improve systems to increase attendance of breast cancer screening. Initiatives include:

- Encouraging 'list maintenance' - ensuring patient primary care information records, such as addresses and telephone numbers, are accurate and up to date.
- Using reminder flags on patient records to alert practitioners to missed breast screening appointments and prompt a discussion with the patient regarding breast screening.

NHS England now hold the responsibility for the commissioning and the quality assurance of the breast cancer screening programme.

Targets

The national three year coverage target for breast cancer screening is 70%.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of women aged 53–70 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous three years.

Denominator: Number of women aged 53–70 resident in the area (determined by postcode of residence) who are eligible for breast screening at a given point in time.

Further information

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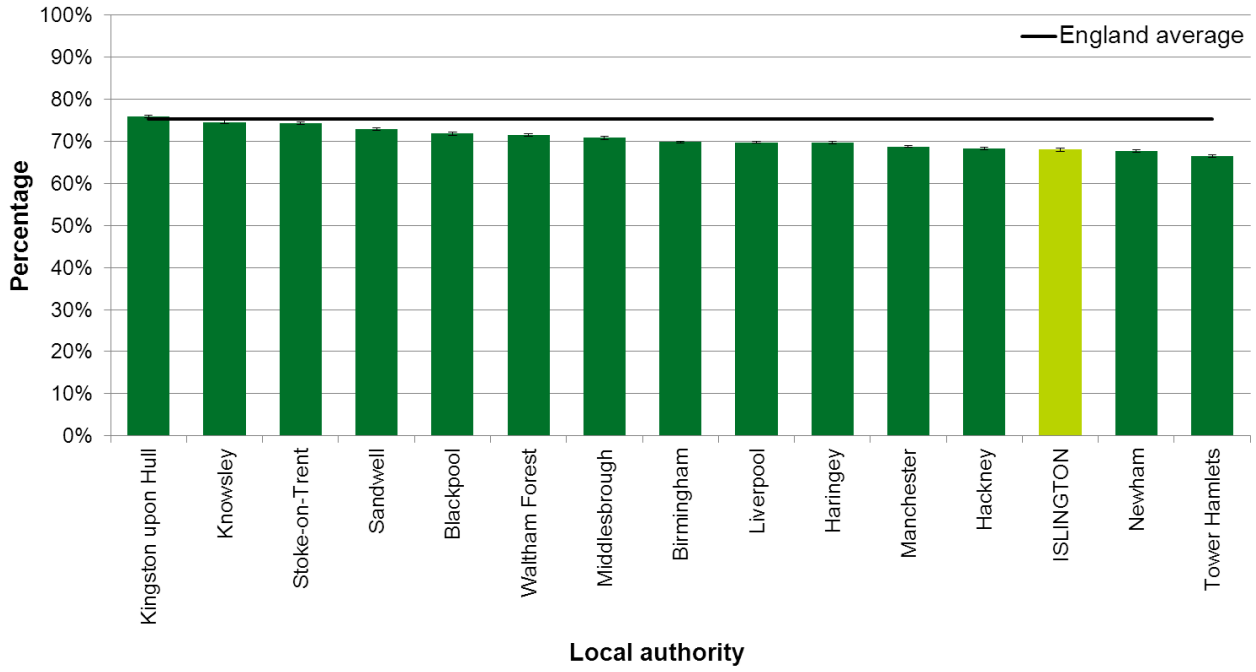
2.20ii - Cancer screening coverage - cervical cancer

Rationale from DH Technical Specification, 2013

Cervical cancer screening supports detection of symptoms that may become cancer and is estimated to save 4,500 lives in England each year. Inclusion of this indicator will provide an opportunity to incentivise screening promotion and other local initiatives to increase coverage of cancer screening. Improvements in coverage would mean more cervical cancer is prevented or detected at earlier, more treatable stages.

The Islington picture

Percentage of eligible women screened for cervical cancer, Islington and similarly deprived boroughs compared against the England average, women, aged 25-64 years, 2012



Source: NHS Connecting for Health (Open Exeter)/East Midlands Public Health Observatory

In Islington, on average nine new cases of cervical cancer were diagnosed each year between 2007 and 2009, and less than five deaths occurred on average each year between 2008-2010.

The graph above compares the cervical screening coverage rate in Islington to other boroughs in England that have a similar socioeconomic status. At 31st March 2012, the proportion of eligible women (aged 25 to 64) in Islington who had been screened in the last 3.5 or 5.5 years (depending on their age) was 68%. This is lower than the England rate of 75% and below the national target of 80%. However the coverage rate in Islington is similar to that of other comparable boroughs.

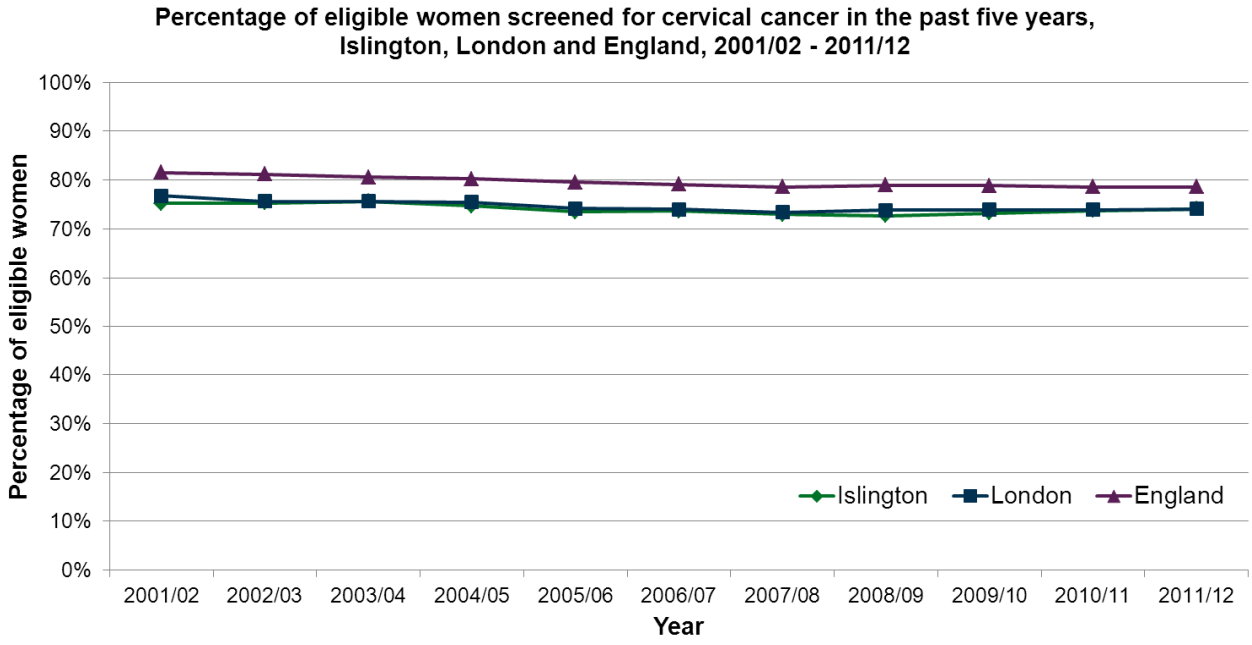
Local data show cervical cancer screening coverage in Islington varies by GP practice, ranging from 64% to 81% (five year coverage, March 2013).

2.20ii - Cancer screening coverage - cervical cancer

Regular cervical screening can prevent around 45% of cervical cancer cases in women in their 30's, increasing with age to 75% in women in their 50s and 60s.

Cervical screening uptake is lowest in the 25-34 year age group. Over a third of Islington women aged 25-34 have never had a cervical smear. As Islington has a comparatively young population, this age group accounts for 50% of the total 'never been screened' population. Research carried out in Islington in 2011, found low awareness of cervical screening and the belief that cervical cancer is associated with older women, were reasons for low uptake in this age group.

Uptake of cervical cancer screening has been steady over recent years. In 2011/12 the proportion of women who had been screened in the last five years in Islington was 74% compared to 75% in 2001/02.



Source: NHS Information Centre

Equalities and health inequalities

Results from Islington's cervical screening equity analysis (2008-12) showed that:

- A significantly lower proportion (55%) of women aged 25-34 take up cervical screening compared to the older age groups.
- Variation exists between local areas with 67% of women in Bunhill ward being screened compared to 74% in Highbury West.

There is evidence at a London level of lower uptake of cervical screening among people with physical and learning disabilities.

Research at a national level has found women from black, Asian and minority ethnic groups are less sure on their risk of cervical cancer compared to white women.

2.20ii - Cancer screening coverage - cervical cancer

Key programmes in Islington

Cervical Cancer Screening Programme

Women aged 25-49 are routinely invited for cervical screening every three years and those aged 50-64 invited every five years.

In 2012, HPV testing was introduced in Islington for women who have undergone a cervical screening test and have received a mild or borderline result. This additional laboratory test will help to quickly assess and, when appropriate, refer women for a colposcopy. Additional HPV testing (known as 'test of cure') has also been introduced for women who have already undergone treatment. This should help reduce the amount and length of follow up care that is needed.

Increasing Coverage

In 2012, the information booklet and reminder letter sent to women who have not yet attended screening, were redesigned with the aim to make them more relevant and appealing to younger women. These were sent to a random sample of 25-34 year olds in Islington and Camden in October-March 2012/13, and are currently being evaluated to assess their impact on young women and cervical screening coverage.

NHS England now hold the responsibility for the commissioning and the quality assurance of the cervical cancer screening programme.

Targets

The national five year coverage target for cervical screening is 80%.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: The number of women aged 25–49 resident in the area with an adequate screening test in the previous three years plus the number of women aged 50-64 resident in the area with an adequate screening test in the previous five years.

Denominator: Number of women aged 25–64 resident in the area (determined by postcode of residence) who are eligible for cervical screening at a given point in time.

Further information

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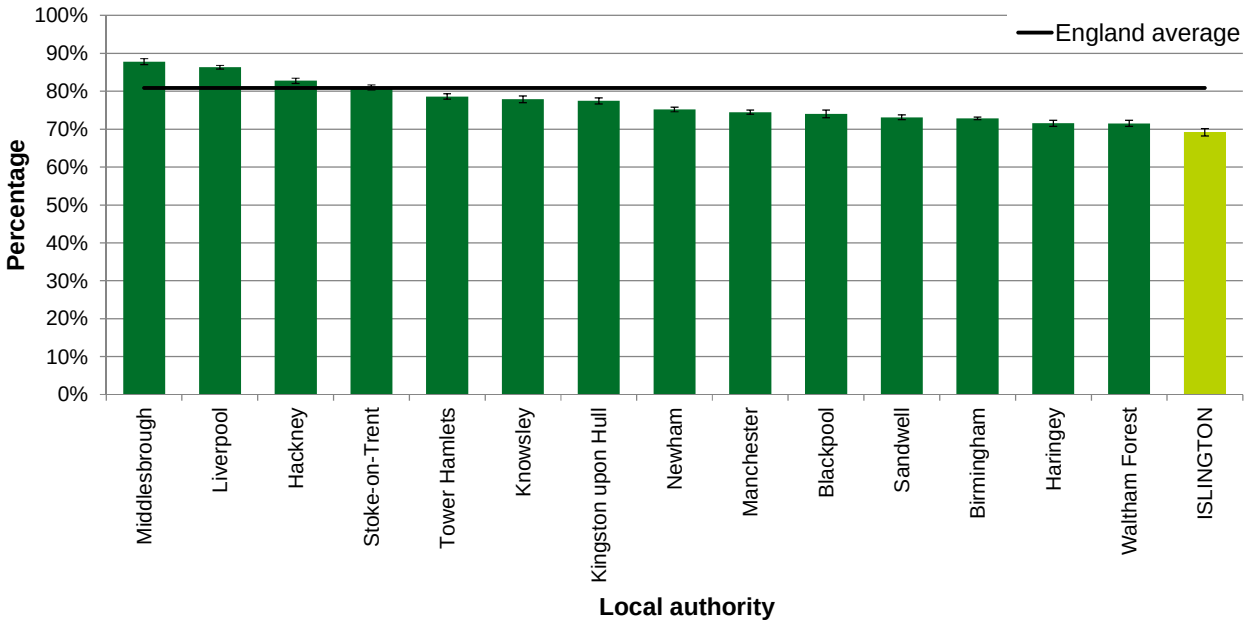
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy

Rationale from DH Technical Specification, 2013

Diabetic retinopathy is one of the most common causes of blindness in the UK. Regular screening allows prompt identification and effective treatment if necessary of sight threatening diabetic retinopathy.

The Islington picture

Percentage of people with diabetes who have been tested at a digital screening encounter, as a proportion of all those offered screening, Islington and similarly deprived boroughs compared against the England average, 12 years old and over, 2011/12



Source: Department of Health: Unify2 data collection - VSMR (NB now Integrated Performance Measures Return - IPMR)

Islington has the lowest rates of uptake of diabetic retinopathy screening compared to similarly deprived boroughs. Islington's figure is also significantly lower than the England average.

Since 2012, the uptake of screening tests has been rising steadily in Islington with 6,012 people screened between 2012-2013. This is, in part, due to raising awareness in collaboration with local GP practices by offering practice-specific clinics in GP practices to help increase patients' attendance.

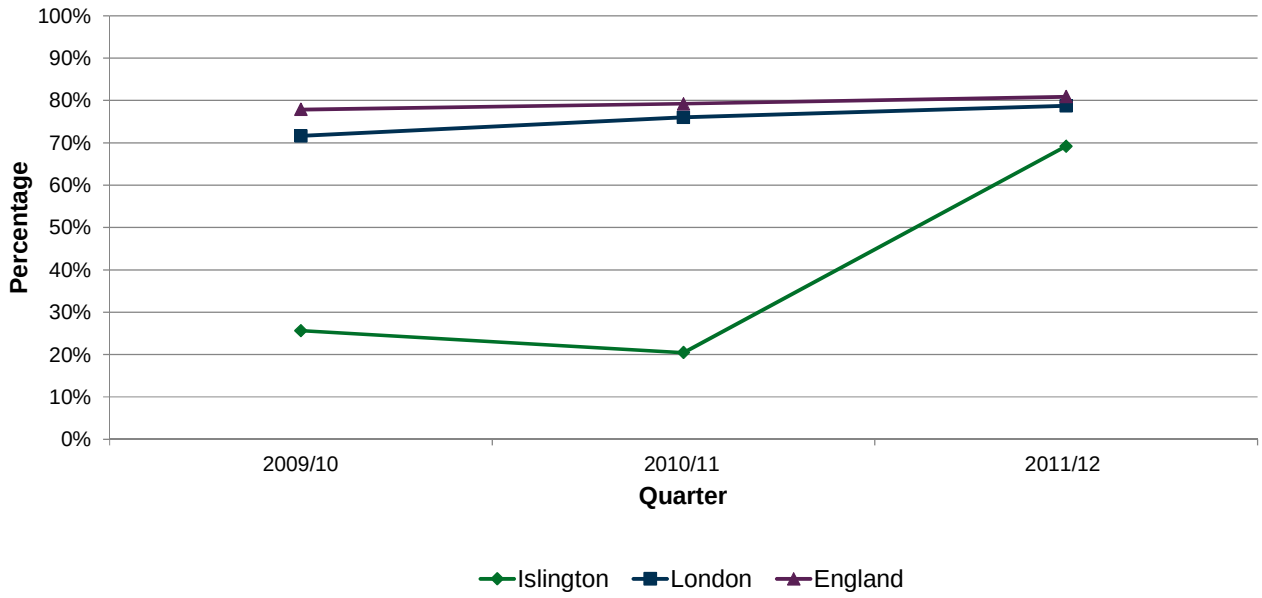
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy

Risk of sight loss is heavily influenced by socioeconimc factors (including age, ethnicity, deprivation, etc.) and can increase the risk of depression, falls and hip fractures.

Eye screening is one of nine key areas of care recommended for all people with diabetes to receive annually in Islington. It is estimated that screening could save more than 400 people per year from sight loss in England.

Changes to the way in which the local eye screening programme is provided are likely to result in improved performance in this area in the coming year and significantly reduce the incidence of sight loss through the prompt identification and effective treatment of the disease.

Percentage of patients with diabetes tested for diabetic retinopathy at a digital screening encounter, Islington, London and England, of all patients aged 12 years old and over who were offered screening, 2009/10 to 2011/12



Source: Department of Health, 2012

Equalities and health inequalities

- The number of people with diabetes is rising, and is forecast to continue to rise. This is linked to the rise of obesity and an ageing population in the borough.
- Asian and Black populations are more likely to be diagnosed with diabetes than White population groups. However, attendance at the diabetes retinopathy service was higher amongst the White population groups.
- Early data from 2012-13 suggest that 50% of eligible men had accessed the diabetes retinopathy service in Islington, compared to 44% of women.

2.21vii - Access to non-cancer screening programmes - diabetic retinopathy

Key programmes in Islington

Primary prevention

Actions being taken to increase awareness of the Diabetes Eye Screening Programme include:

- Engagement of local GPs in the programme
- Distribution of promotional post cards by local pharmacists to all diabetic patients collecting medications.

A mobile screening service is also due to start later this year in local community settings (e.g. shopping centres) and GP practices to raise awareness and increase screening uptake among people with Type 1 and 2 diabetes aged 12 or over.

Case findings/Early diagnosis and Screening

The Diabetic Eye Screening Programme aims to screen people with diabetes every year. This reduces the risk of sight loss from diabetic retinopathy, through early detection and appropriate treatment.

Targets

The local target is to screen every eligible person each year.
Following screening, the national target is to maximise the number of patients who receive a consultation within four weeks after being diagnosed with diabetic retinopathy after a screening. An 80% consultation rate is defined as ‘Acceptable’, and 95% is considered ‘Achievable’. This is Key Performance Indicator Diabetic Eye 3 (KPI DE3).

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: The number of subjects offered screening who attended a digital screening encounter during the reporting period.

Denominator: The number of eligible people with diabetes offered a screening encounter which was due to take place within the reporting period.

Further information

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2.22 - Take up of NHS Health Checks Programme by those eligible

Rationale from DH Technical Specification, 2013

The NHS Health Checks programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. A high take up of NHS Health Checks is important to identify early signs of poor health leading to opportunities for early interventions.

The Islington picture

Islington was one of the early implementers of NHS Health Checks, and this is illustrated by the borough's continued high performance. The graphs which follow show that in 2012/13 Islington performed significantly better than the national average for both the proportion of eligible people offered an NHS Health Check and the percentage of eligible people who received one.

In 2012/13 Islington offered an NHS Health Check to 24% of its eligible population, placing the borough second best in terms of performance compared to boroughs with a similar level of socio-economic deprivation. Performance was also significantly higher than the national average of 16%. Islington has also comfortably surpassed the national target to offer a Health Check to 20% of its population.

Figures for the delivery of Health Checks show that 70% of those offered an NHS Health Check in Islington in 2012/13 received one, which equates to 17% of all eligible people having received a Health Check. This is substantially above the national average. Islington was the borough with the highest performance on health checks delivered amongst the country's most deprived boroughs at a similar level of socio-economic deprivation. Islington had set a local target of delivering an NHS Health check to 10% of the eligible population in 2012/13; as with the target for Health Checks offered, this target has been significantly exceeded.

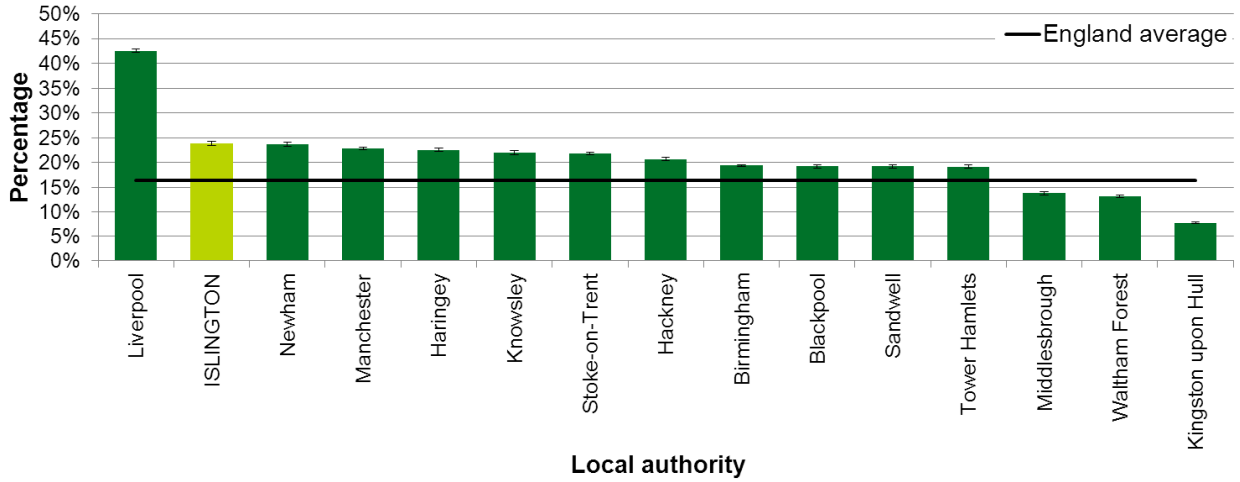
Equalities and health inequalities

- Islington has expanded the local eligibility to 35-74 year olds (compared to 40-74 year olds nationally) because the borough experiences high levels of mortality and morbidity from cardiovascular disease, so that appropriate intervention and prevention strategies can be implemented from an earlier age. (Data presented here are for 40-74 year olds).
- The NHS Health Check programme in Islington includes the delivery of checks in community outreach settings, targeting areas of high deprivation. This is to ensure the programme is easily accessible to people living in these areas and who may not regularly present in health care settings. Around 3,000 checks per year are delivered in these settings.
- Over the past few years, GP practices have been prioritising patients at high risk of developing cardiovascular disease for NHS Health Checks. This means the programme has been very successful in targeting those groups with the highest need in terms of health inequalities. For example, by September 2012, 27% of people from an Irish ethnic background had been given a check in Islington GP practices, compared to 17% in people with other white backgrounds. Mortality and morbidity from cardiovascular disease is particularly high in the Islington Irish population aged 35-74.

2.22i - Take up of NHS Health Checks Programme by those eligible - health check offered

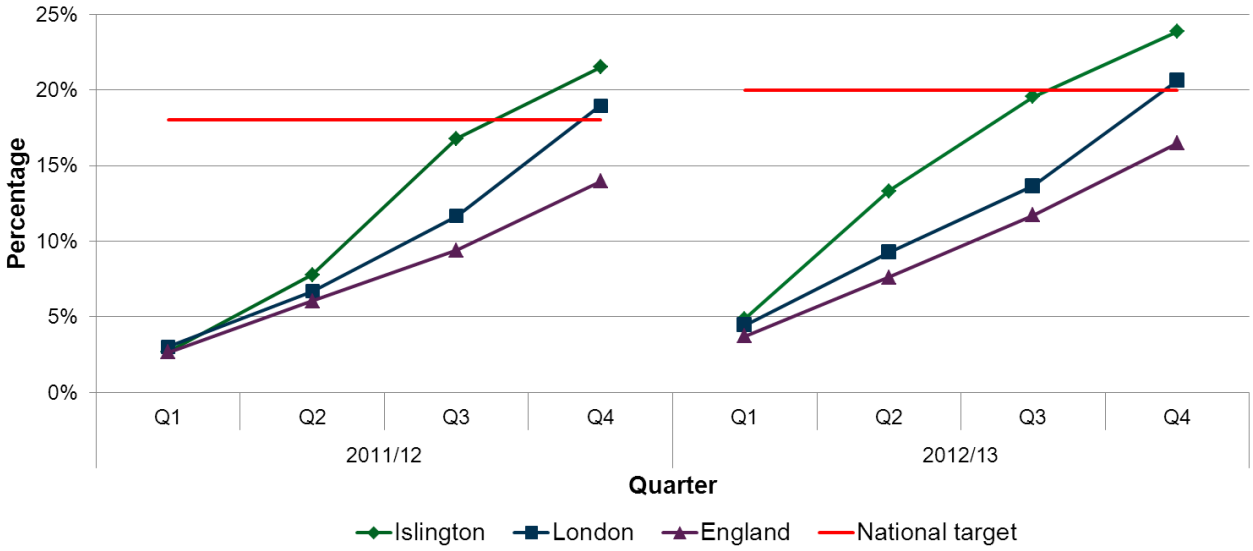
The Islington picture - health check offered

Percentage of people offered an NHS Health Check, by those eligible, Islington and similarly deprived boroughs compared against the England average, all persons, 40-74 years, 2012/13



Source: Integrated Performance Measures Monitoring Return (IPMR_1), Department of Health
Note: This graph shows the percentage of people receiving an NHS Health Check in the total eligible population. This is different to the figure shown in the PHE report, which shows the percentage among those who have been offered a Health Check.

Percentage of eligible people who were invited for an NHS Health Check, Islington, London and England, cumulative figures, 2011/12 and 2012/13



Source: Department of Health, 2013

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

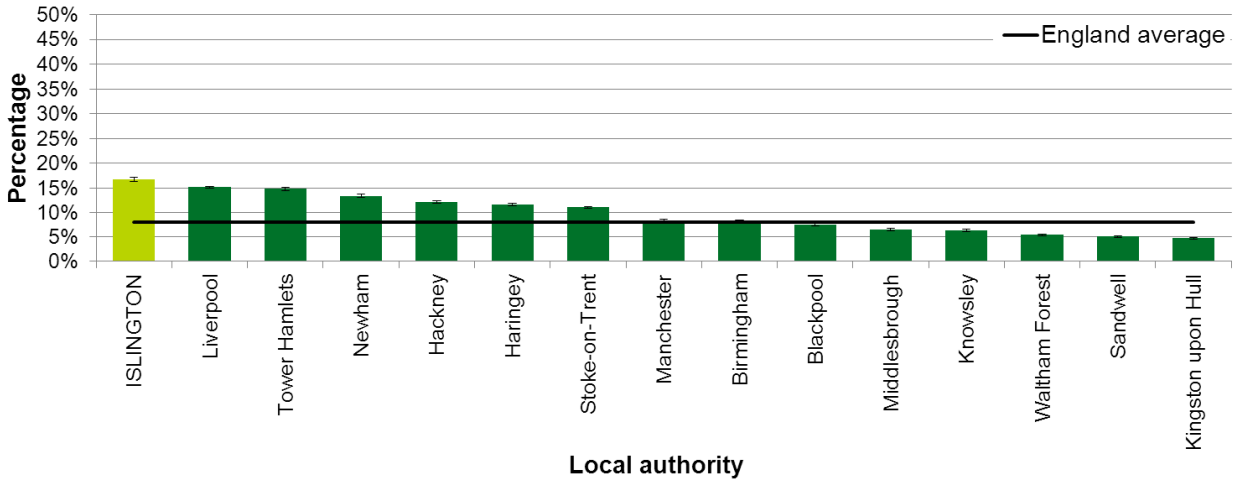
Numerator: Number of people aged 40-74 eligible for an NHS Health Check who were offered an NHS Health Check in the financial year.

Denominator: Number of people aged 40-74 eligible for an NHS Health Check in the financial year. Denominators for local authorities are estimated from denominators for PCTs.

2.22ii - Take up of NHS Health Check programme by those eligible - health check take up

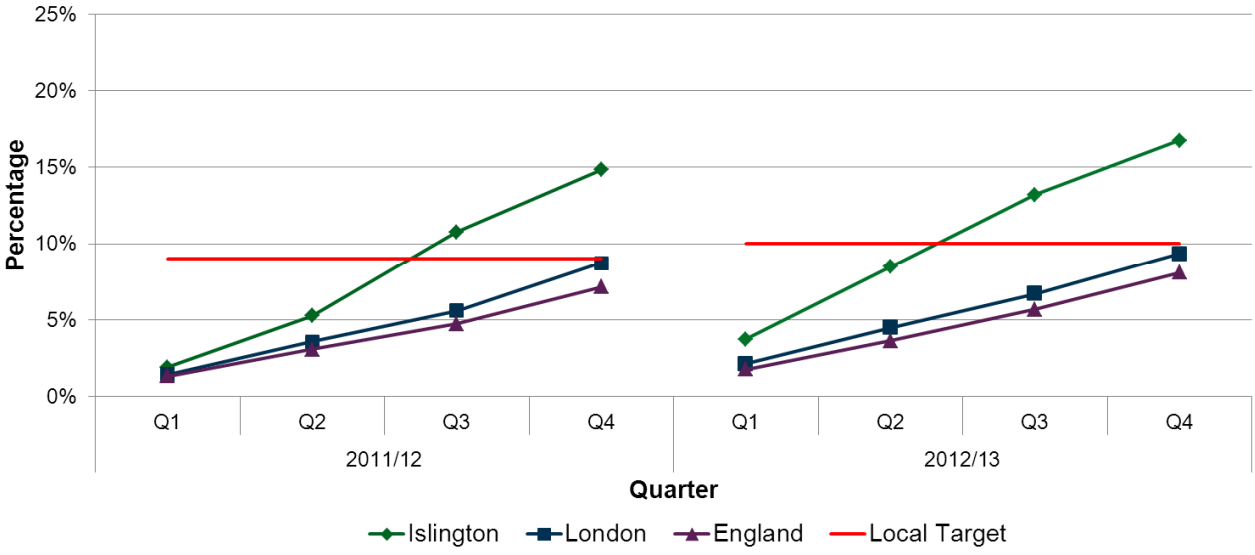
The Islington picture - health check take up

Percentage of people receiving an NHS Health Check, by those eligible, Islington and similarly deprived boroughs compared against the England average, all persons, 40-74 years, 2012/13



Source: Integrated Performance Measures Monitoring Return (IPMR_1), Department of Health
Note: This graph shows the percentage of people receiving an NHS Health Check in the total eligible population. This is different to the figure shown in the PHE report, which shows the percentage among those who have been offered a Health Check.

Percentage of eligible people that received an NHS Health Check, Islington, London and England, cumulative figures, 2011/12 and 2012/13



Source: Department of Health, 2013

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of people aged 40-74 eligible for an NHS Health Check who received an NHS Health Check in the financial year.

Denominator: Number of people aged 40-74 eligible for an NHS Health Check who were eligible for an NHS Health Check in the financial year. Denominators for local authorities are estimated from denominators for PCTs. This is a different denominator to the one used in the Public Health England report.

2.22 - Take up of NHS Health Check Programme by those eligible

Key programmes in Islington

The NHS Health Check programme in Islington is being delivered in three settings:

- GP Practices
- Two community pharmacies
- Outreach settings

In addition to the NHS Health Checks Programme itself, a key aim of the programme is that people who have a health check and are identified to have risk factors such as being overweight or obese, hypertensive, being a smoker, or inactive are given appropriate advice and management as well as signposted to key lifestyle services.

There is continued investment in smoking cessation services, particularly focusing on supporting people from key groups to quit, such as those living with long term conditions and people from deprived communities with high levels of smoking (including Bangladeshi, Somali, and Turkish communities).

There is also a Weight Management Pathway which GPs use to support adults identified as over weight or obese (a key risk factor for diabetes and CVD).

GPs can refer people with a range of underlying health conditions, including high blood pressure, to the Exercise on Referral programme. There is support for those who already have long term conditions to better self manage through programmes such as Cardiac Rehabilitation and the Diabetes Education and Self Management or Ongoing and Newly Diagnosed (DESMOND) (diabetes is a key risk factor for CVD).

Targets

The national target to offer Health Checks to 20% of the eligible population, and there is a local target to deliver Health Checks to at least 10% of the eligible population.

Further information

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2.23 - Self-reported well-being

Rationale from DH Technical Specification, 2013

Well-being is a key issue for the Government and ONS are leading a programme of work to develop new measures of national well-being. People with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health. Local data on well-being is likely to be a key component of local Joint Strategic Needs Assessments and form an important part of the work of local Health and Wellbeing Boards.

The Islington picture

There are four indicators for well-being included in the framework. The four indicators are self-reported well-being scores to the following four questions:

- Overall, to what extent do you feel the things you do in your life are worthwhile?
- Overall, how satisfied are you with your life nowadays?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?

Based on the national survey, results have been estimated for groups of boroughs according to their socio-economic position. Islington is grouped with a number of other inner London boroughs. In common with these boroughs, Islington is currently rated as having low well-being scores relative to the England average. This makes the graphed comparison with statistical neighbours of little value. Since no locally collected data are yet available, this is a feature of the relationship between well-being and deprivation, estimated from the national survey rather than a specific measurement of wellbeing in the borough.

Influences on well-being that are relevant to Islington and other inner London boroughs are factors such as levels of employment, housing, education, community cohesion and safety, empowerment and health inequalities. At an individual level, the characteristics that promote well-being can broadly be categorised as control, contact (i.e. good social networks) and confidence.

This is the first full year of data from these questions and is being treated as an experimental statistic. As this data is from 2011/12 the impact of austerity and welfare changes may still emerge in future data.

Equalities and health inequalities

Well-being is generally seen to be about feeling good and functioning well.

Many of the wider determinants of health and health inequalities such as income, housing, education, employment and social inclusion impact on well-being.

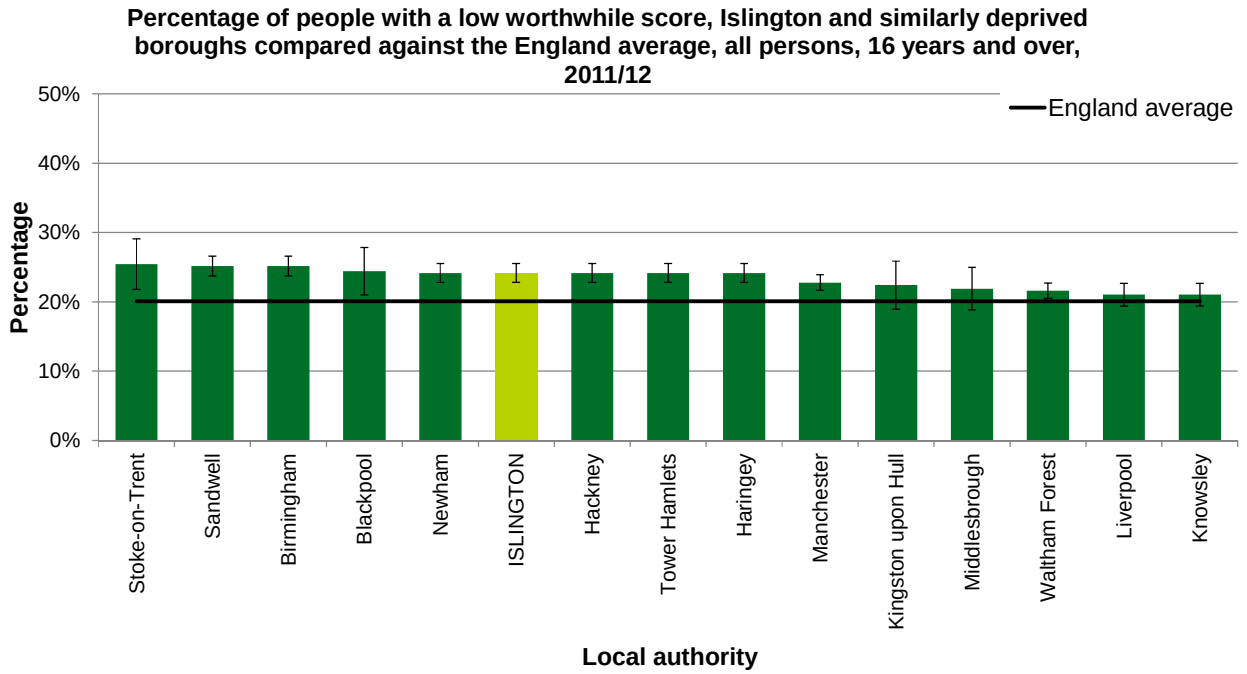
There are also individual characteristics that impact on well-being and resilience. These can be positively influenced through better public understanding of the factors that influence well-being such as the “five ways to well-being”: connect, be active, take notice, keep learning and give.

People with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health. It is also an underlying facilitator of good health.

Local data on well-being is likely to become a key component of local Joint Strategic Needs Assessments, and form an important part of the work of local Health and Wellbeing Boards.

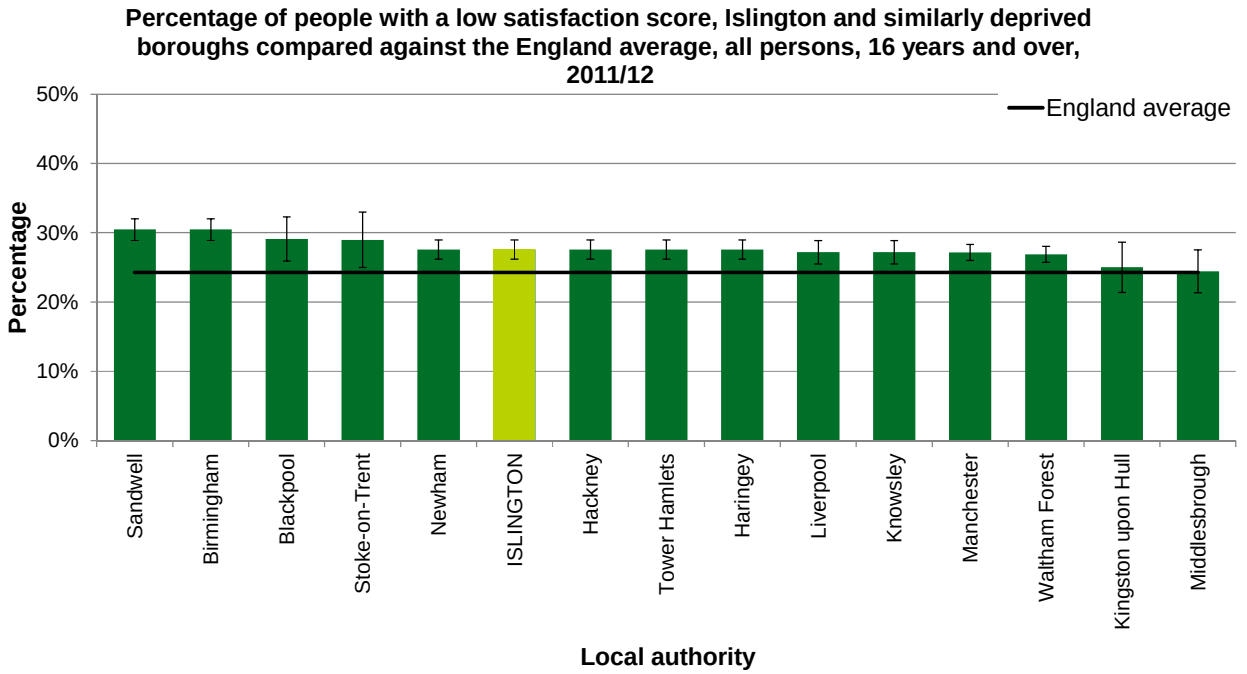
2.23 - Self-reported well-being

Worthwhile



Source: Estimates of subjective well-being from the first annual experimental Annual Population Survey (APS) Subjective Well-being dataset: by country, region, unitary authority and county, April 2011 to March 2012. ONS.

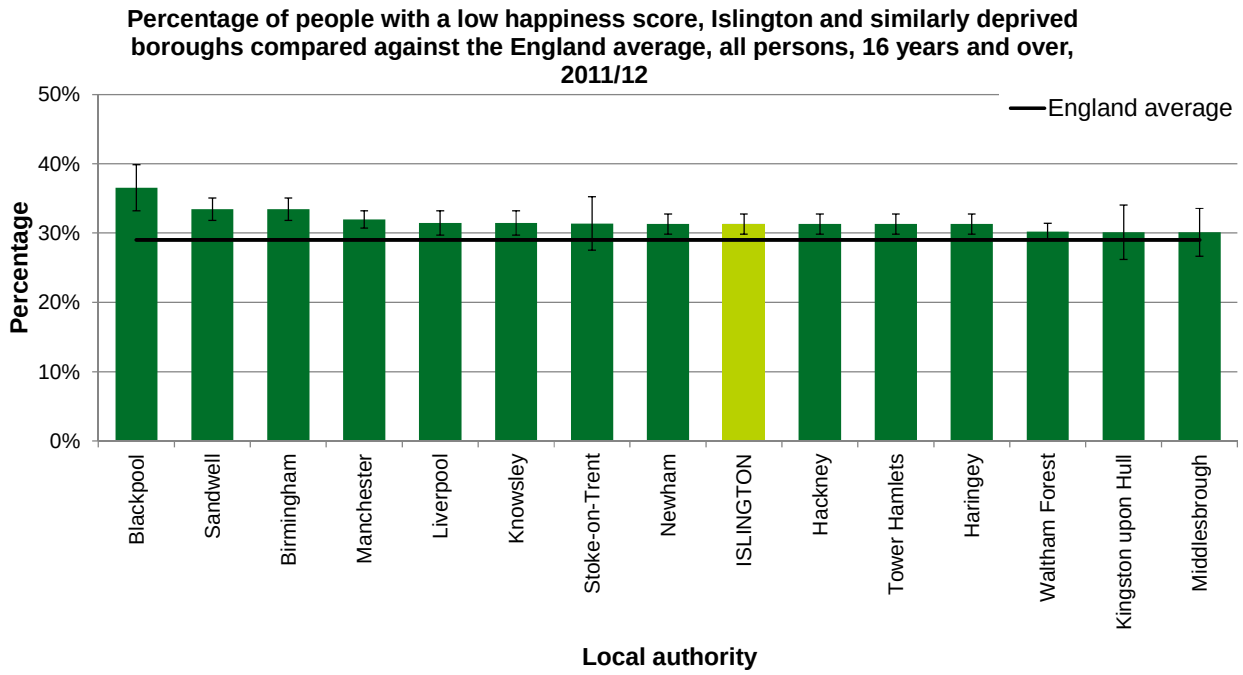
Life satisfaction



Source: Estimates of subjective well-being from the first annual experimental Annual Population Survey (APS) Subjective Well-being dataset: by country, region, unitary authority and county, April 2011 to March 2012. ONS.

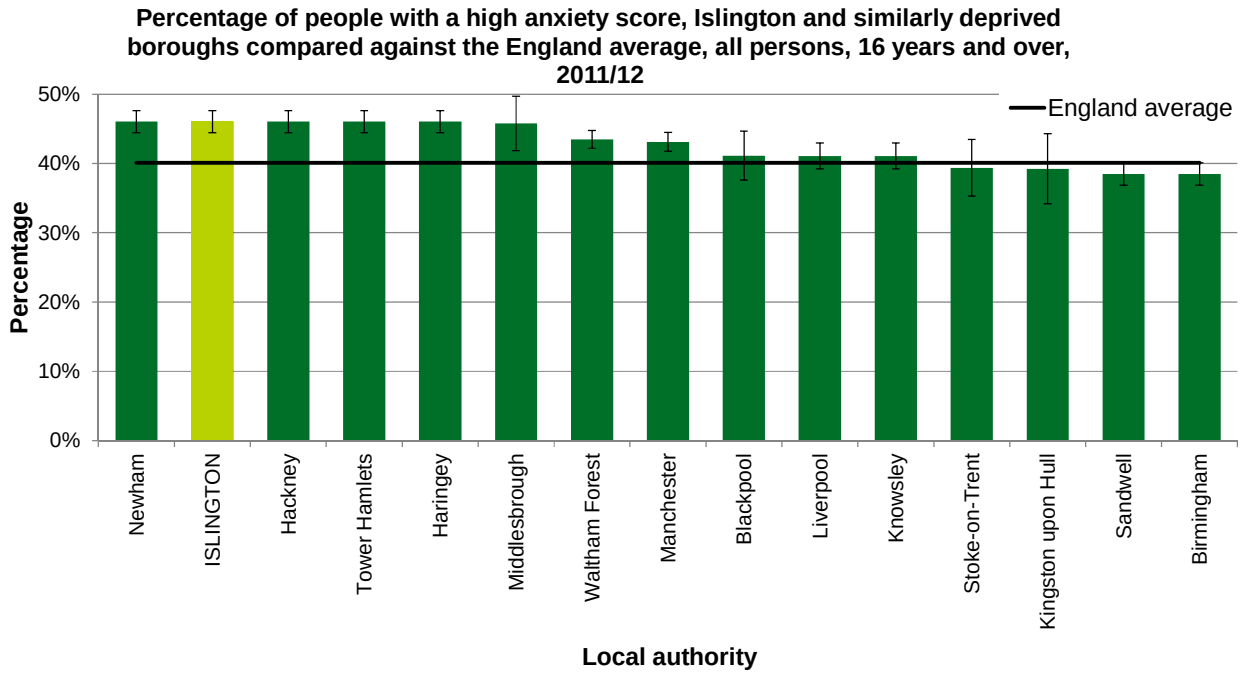
2.23 - Self-reported well-being

Happiness



Source: Estimates of subjective well-being from the first annual experimental Annual Population Survey (APS) Subjective Well-being dataset: by country, region, unitary authority and county, April 2011 to March 2012. ONS.

Anxiety



Source: Estimates of subjective well-being from the first annual experimental Annual Population Survey (APS) Subjective Well-being dataset: by country, region, unitary authority and county, April 2011 to March 2012. ONS.

2.23 - Self-reported well-being

Key programmes in Islington

Universal services

Many universal services contribute to an individual's well-being, particularly those that offer:

1. A good start in life: good early development, health and home experiences and a good education
2. Good mentors and role models and good social engagement
3. Employment, adequate income and housing that build self-esteem and a sense of control and confidence.
4. Community safety, community inclusion and good community facilities
5. Healthy lifestyles that minimise illness and disability

Targeted services

1. iCOPE run "feeling good" groups that promote individual residence and the ability to cope with everyday stressors
2. iCOPE offer groups to help manage low mood, anxiety and other common problems
3. Social care and community services that address isolation

Targets

There are no local or national targets for this indicator.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: The number of people who rated themselves as low (or high for anxiety) on each of the indicators. Responses were weighted to ensure that the sample accurately represented the local population.

Denominator: The number of people responding directly to the Annual Population Survey. Non-respondents not included.

Further information

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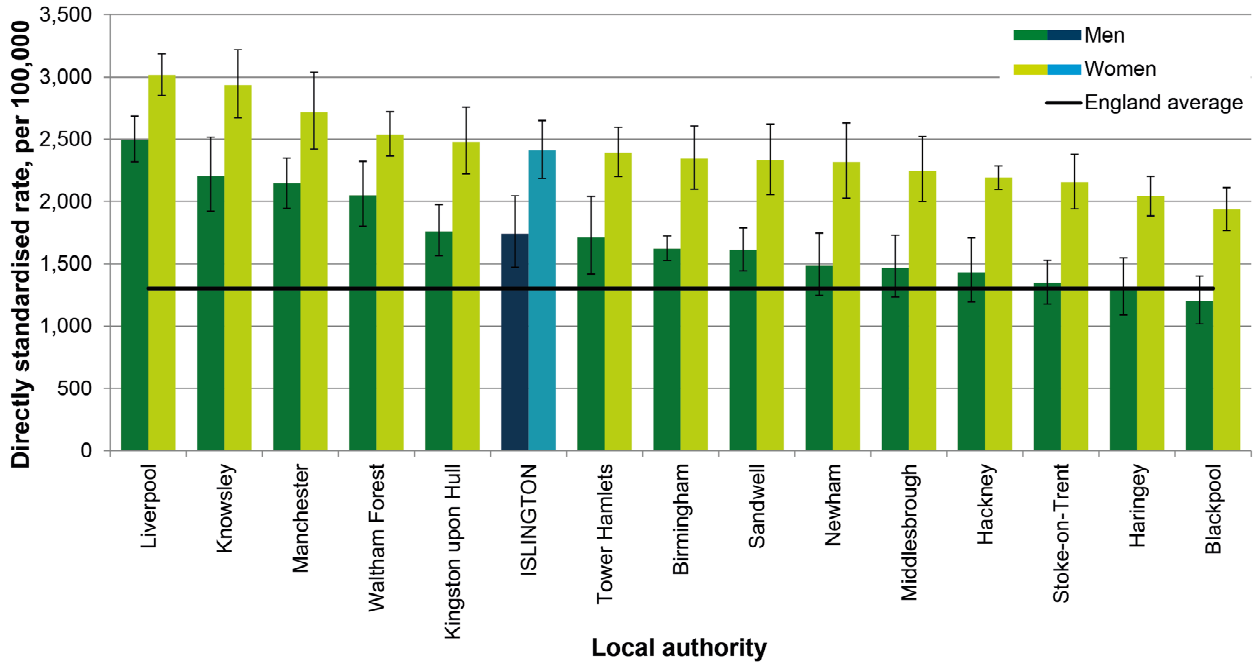
2.24i - Injuries due to falls in people aged 65 and over (Persons)

Rationale from DH Technical Specification, 2013

Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. being a major precipitant of people moving from their own home to long-term nursing or residential care. Interventions for recently retired and active older people are likely to be different in provision and uptake for frailer older people.

The Islington picture

Directly standardised rate of injuries due to falls in people aged 65 and over, Islington and similarly deprived boroughs compared against the England average, men and women, 65 years and over, 2011/12



Source: Calculated by West Midlands Knowledge and Intelligence Team from data from the Information Centre for Health and Social Care - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates

Islington has a similar rate of injuries due to falls among people aged 65 or over to boroughs at a similar level of deprivation, but a higher rate than the national average. Women have higher rates of injuries due to falls than men, in each of the boroughs. This is likely due to the increased risk factors for osteoporosis in women.

Given Islington's position in related indicators (see 4.14i, Hip Fractures in people aged 65 and over) this position is somewhat surprising. Islington has identified further resources to complete a whole pathway review of falls in 2014. This will seek to improve our understanding of falls, and inform a targeted local response.

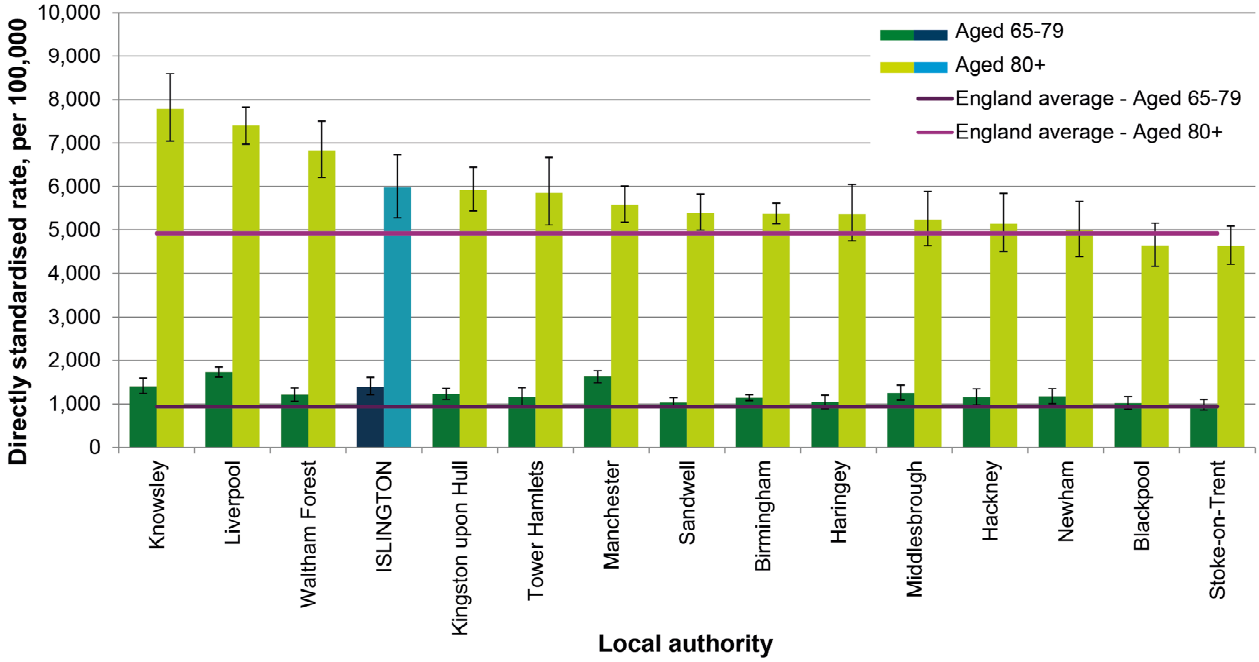
2.24i - Injuries due to falls in people aged 65 and over (Persons)

In 2011/12, 329 people aged 65 and over were admitted to hospital as a result of a fall. Some people were admitted more than once, with a total of 382 emergency admissions for injuries relating to falls. The majority of these admissions were at the Whittington Hospital (240); other significant hospitals were University College London Hospital (99) and Homerton (14).

In Islington in 2011/12, Black people had a lower percentage of admissions due to falls or fall injuries than other ethnic groups.

Islington Council want to better understand how we can work to effectively prevent and minimise injuries from falls, and ensure effective response to the fall.

Directly standardised rate of injuries due to falls in people aged 65-79 and 80 and over, Islington and similarly deprived boroughs compared against the England average, all people, 2011/12



Source: Calculated by West Midlands Knowledge and Intelligence Team from data from the Information Centre for Health and Social Care - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates

Equalities and health inequalities

- The risk of falling, and thereby breaking a bone, increases with age.
- Deprivation may play a role in the risk of falling; one study suggests that within the most deprived wards there was a 10% higher admission rate for falls when compared with the most affluent wards.
- People living alone are more likely to fall and/or be injured than those cohabiting.
- Inadequate nutrition (for example Vitamin D deficiency which can increase the likelihood that a fall will cause a serious injury) is often associated with people from the most deprived sections of the community.

2.24i - Injuries due to falls in people aged 65 and over (Persons)

Key programmes in Islington

Universal services

Islington has developed an ‘exercise on referral’ service, which provides a 8-week course to increase physical activity and improve self-management.

Islington has developed a Locally Enhanced Service to provide assessment for all people aged over 75 at their GP.

Targeted services

Providing services to prevent or respond to falls requires an integrated approach. Islington has created an Intermediate Care pooled budget, funded by Islington CCG and the London Borough of Islington. This helps Islington CCG and Islington Council’s Joint Commissioning team work together to fund services to help people recover from a hospital admission or other period of ill-health.

Whittington Health and Islington Council support people at home with help from occupational therapists, physiotherapists, social workers and home carers, as well as providing specialist inpatient support at hospitals and care homes.

Islington Council offers telecare devices to people at risk of falling, including call alarms and fall sensors. These can help mitigate the impact of a fall and increase confidence amongst people living alone.

Targets

There are no local or national targets for this indicator.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Emergency admissions for falls injuries classified by primary diagnosis code and external cause and an emergency admission code. Males/females aged 65 and over at admission.

Denominator: Local Authority estimates of resident population, Office for National Statistics (ONS)

Further information

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Domain 3: Health protection

Objective: The population's health is protected from major incidents and other threats, while reducing health inequalities

Indicators (indicators which are still being finalised nationally are in italics)

3.01 Air pollution
3.02 Chlamydia diagnoses (15-24 year olds)
3.03 Population vaccination coverage including targeted, childhood adolescent, and adult immunisations
3.04 People presenting with HIV at a late stage of infection
3.05 Treatment completion for tuberculosis
3.06 Public sector organisations with board-approved sustainable development management plan
3.07 *Comprehensive, agreed inter-agency plans for responding to public health incidents*

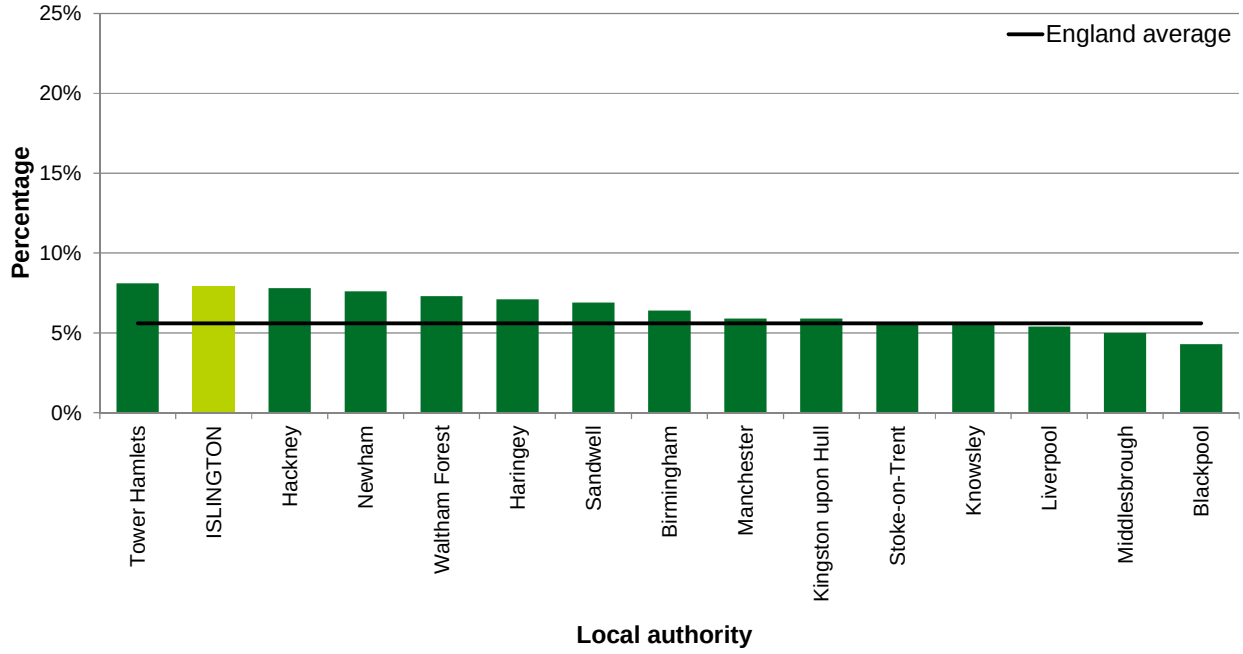
3.01 - Fraction of mortality attributable to particulate air pollution

Rationale from DH Technical Specification, 2013

Poor air quality is a significant public health issue. The burden of particulate air pollution in the UK in 2008 was estimated to be equivalent to nearly 29,000 deaths at typical ages and an associated loss of population life of 340,000 life years lost.

The Islington picture

Percentage of mortality attributable to particulate air pollution, Islington and similarly deprived boroughs compared against the England average, all persons, 30 years and over, 2010



Source: Defra

This chart shows an estimate of the percentage of deaths in those aged 30 and over attributable to long-term exposure to fine particulate air pollution (particles of 2.5 thousandths of a millimetre; $PM_{2.5}$). The same estimate for the percentage of deaths due to air pollution is used for all areas, hence the graph reflects differences in the concentration of air pollution between local authorities.

In Islington, an estimated 7.8% of the annual deaths in those aged 30 and over are due to air pollution. This is based on an estimate of an additional 6% of deaths occurring for every 10µg/m^3 increase in $PM_{2.5}$. This is equivalent to 100 deaths per year.

Care should be taken when interpreting Islington's position against the areas with similarly deprived boroughs and against the England average, as this indicator is published without confidence intervals and is based on modelled air pollution, rather than actual measured levels of pollution.

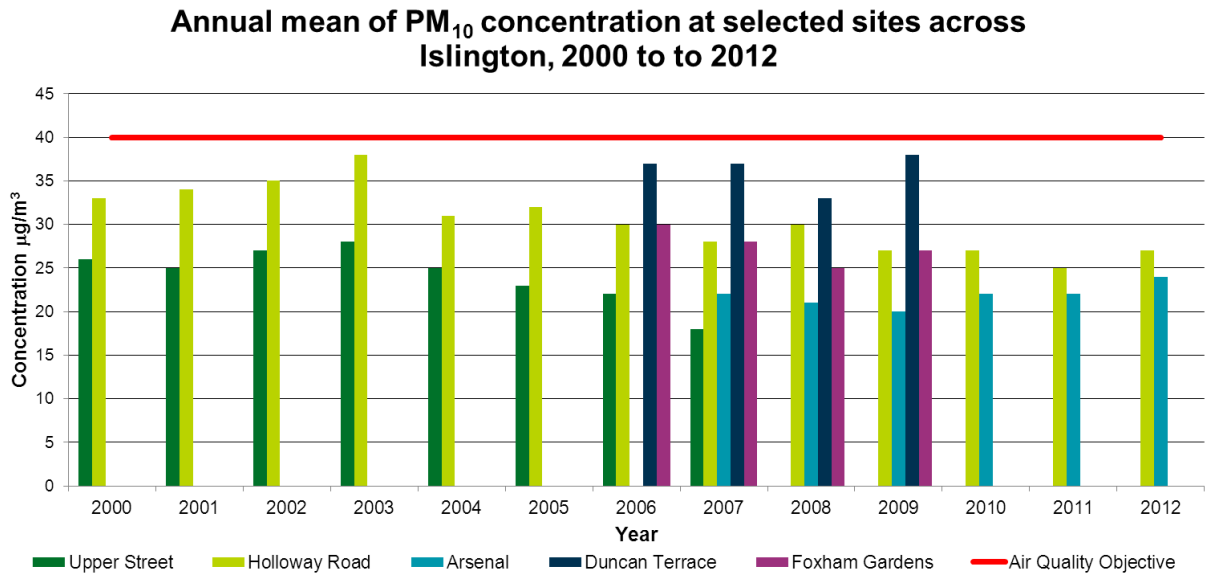
3.01 - Fraction of mortality attributable to particulate air pollution

Air pollution itself does not cause death, but long-term exposure to particles is associated with increased levels of fatal cardiovascular and respiratory diseases, including lung cancer. Fine particulate matter ($PM_{2.5}$) is of particular concern because, compared to larger particles of 10 thousandths of a millimetre or less (PM_{10}), $PM_{2.5}$ travels deeper into the lungs and often comprises matter that has greater toxicity.

Although some particulate matter and other air pollutants originate from outside London, cross-sectional research by King's College London Environmental Research Group shows that most air quality problems arise from local emission sources. The major sources of $PM_{2.5}$ generated in Islington include exhaust emissions, tyre and brake wear, and road abrasions from road traffic.

The graph below shows the annual mean concentration of PM_{10} (particles of 10 thousandths of a millimetre or smaller, which includes $PM_{2.5}$) recorded at Islington monitoring sites between 2002 and 2012. The graph shows that annual mean concentrations did not exceed the legally binding limit value (maximum) for PM_{10}.

$PM_{2.5}$ is not monitored in Islington, but concentrations of PM_{10} are used as a proxy indicator, and it is possible to model concentrations of $PM_{2.5}$ from sites across London monitored by the Department for Environment, Food and Rural Affairs.



Source: Islington Council Air Quality Monitoring , 2013

Equalities and health inequalities

The greatest burden of air pollution tends to fall on the most vulnerable in the population, in particular the young (who are at increased risk of developing asthma, pneumonia and other lower respiratory infections) and elderly (who are more likely to have a long-term condition). Many studies report associations between outdoor air pollution, especially $PM_{2.5}$, and low birth weight and an increased risk of chronic disease in later life, both of which are likely to have an impact on premature mortality.

Disadvantaged communities tend to experience higher concentrations of pollution, often because of their proximity to major transport routes, and also have a higher prevalence of cardiovascular, respiratory and other diseases.

3.01 - Fraction of mortality attributable to particulate air pollution

Key programmes in Islington

Reducing emissions from transport:

- Enforcement of emissions regulations, particularly around idling engines in hot-spot areas including bus terminals, schools and events
- Islington currently reserves over 200 car club spaces across the borough
- Islington operates an emissions based parking charge for residential permits
- Driver education targeted at residents, schools, businesses and council's own fleet to ensure that emissions are reduced whilst maximising fuel efficiency.
- Islington promotes walking and cycling using less-polluted routes to raise awareness of air quality and reduce emissions by encouraging a modal shift to sustainable active travel.

Reducing emissions from development:

- Air quality neutral standard to be met on all new major developments.
- Air quality assessments required to show neutral standard and how new residents in areas of existing poor air quality will be protected.
- Construction management plans to reduce emissions during construction phase
- Energy strategies to show reduction in all pollutants harmful to health.

Informing the public

- Residents can receive poor-air pollution forecasts from the airTEXT service which warns them of when pollution is expected to be high and therefore behaviour can be adapted to reduce exposure and avoid areas of high air pollution.
- Events such as Islington Environment Forum, Car Free Day and the Air Quality Summit will inform resident groups about what action can be taken to improve health.
- Work with schools and businesses to reduce emissions and exposure.

Targets

The target value for $PM_{2.5}$ in the United Kingdom has been an annual mean of 25µg/m^3 since 2010. Target values are not legally binding, but the Secretary of State must ensure that all necessary measures not entailing disproportionate costs are taken to ensure that concentrations of $PM_{2.5}$ do not exceed the target values.

Indicator definition: **for a full definition please refer to the DH Technical Specification, 2013**

The indicator is an estimated proportion. It represents the estimated annual mortality attributable to air pollution in the population aged 30+, as a proportion of total deaths of those aged 30+.

Further information

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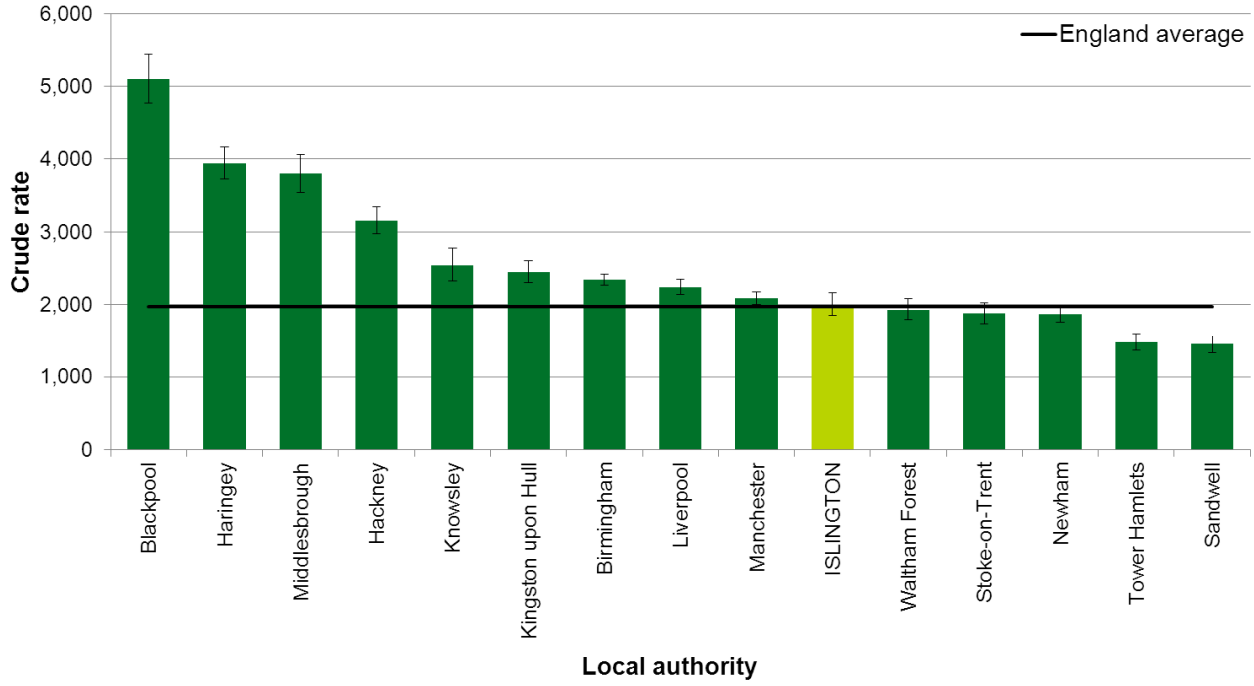
3.02 - Chlamydia diagnoses (15-24 year olds)

Rationale from DH Technical Specification, 2013

Chlamydia causes avoidable sexual and reproductive ill-health, including symptomatic acute infection and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility. The chlamydia diagnosis rate among under 25 year olds is a measure of activities to help control chlamydia that represents infections tested (reducing risk of health complications in those patients) and can be correlated to changes in chlamydia prevalence. Increasing the diagnostic rate, with good partner notification and follow up arrangements and ensuring vulnerable and at risk populations are reached, should reduce the prevalence of infection over time.

The Islington picture

Crude rate of chlamydia diagnoses, Islington and similarly deprived boroughs compared against the England average, all persons, 15-24 year olds, 2012



Source: Public Health England

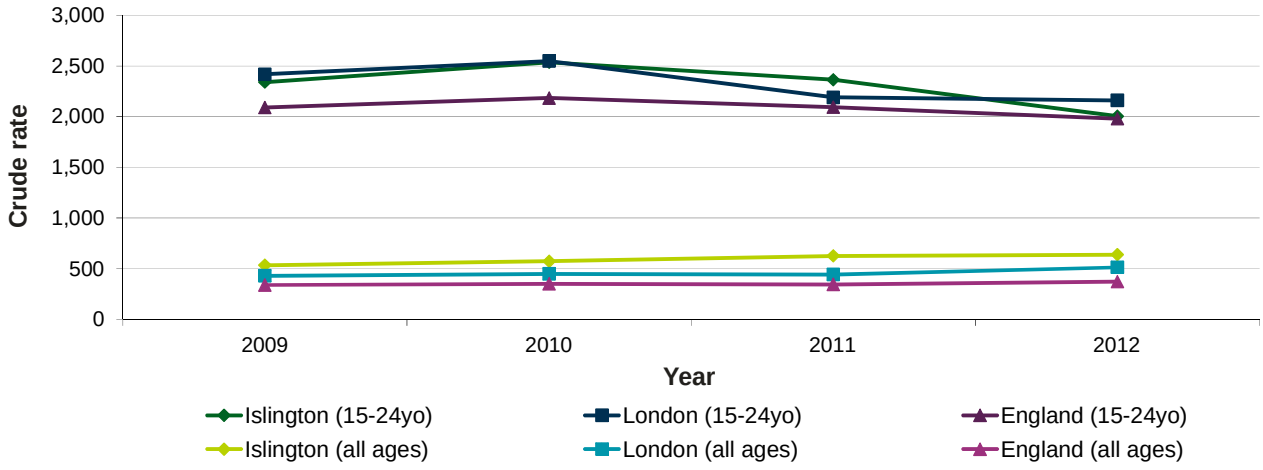
In Islington, 612 young people (aged 15-24) were diagnosed at least once with chlamydia in 2012. This equates to a diagnosis rate of 2,003 per 100,000 young people (aged 15-24 years), not significantly different from the England average of 1,979 per 100,000. London generally has higher rates of diagnosed chlamydia than national averages.

Public Health England recommends that boroughs should be working towards achieving a diagnosis rate of at least 2,300 per 100,000 population (provisional).

3.02 - Chlamydia diagnoses (15-24 year olds)

There appears to be a downward trend in the rate of chlamydia diagnosis in 15-24 year olds in Islington. However, data for 2012 are based on the newly created Chlamydia Testing Activity Dataset (CTAD) so are not directly comparable with previous years. When compared to similar London boroughs, Islington has a significantly lower diagnosis rate than Hackney (3,157 per 100,000) and Haringey (3,943 per 100,000), but a significantly higher diagnosis rate than Tower Hamlets (1,478 per 100,000). Waltham Forest and Newham have similar rates to Islington. In 2012, a total of 7,771 chlamydia tests were undertaken in Islington 15-24 year olds. The majority (64%) were undertaken in genitourinary medicine (GUM) clinics. Other tests were undertaken in community sexual health services, GPs, pharmacies and pregnancy termination providers. The number of tests to screen for chlamydia was equivalent to about 25% of Islington's 15-24 year old population (although some may have been tested more than once), with 8% testing positive.

Rate of chlamydia diagnoses in Islington, London, and England, per 100,000 population, 2009-2012



Source: Health Protection Agency, 2013
Note: Data for 2012 are based on the newly-created Chlamydia Testing Activity Dataset, so are not directly comparable with previous years.

Equalities and health inequalities

National evidence shows:

- The prevalence of chlamydia infections is highest in sexually active 15-24 year olds, accounting for over two-thirds of chlamydia diagnoses, with the peak in 20-24 year olds. In Islington, compared to 15-19 year olds, four times as many 20-24 year old males are diagnosed, and in females, twice as many 20-24 year olds are diagnosed than 15-19 year olds. Young people who report two or more sexual partners within the past 12 months are more likely to have chlamydia than those who have had fewer (12% vs. 8%).
- Chlamydia diagnosis rates in Islington were 1.5 times higher in women than men. In London diagnosis rates for women were 1.8 times higher than men, whilst across all areas of England diagnosis rates for women were 1.6 to 2.1 times higher than men.
- In Islington, among those who are tested, young Black people - particularly from Black Caribbean communities - have the highest prevalence of chlamydia positivity (13%). Those of mixed ethnicity have a prevalence of 10%, while young Asian people have the lowest (around 5%). The prevalence among White people is about 7%.

3.02 - Chlamydia diagnoses (15-24 year olds)

Key programmes in Islington

Universal services

Health promotion: A wide range of services in Islington work to reduce the transmission of chlamydia and encourage the uptake of testing. They also aim to reduce rates of teenage conception (see indicator 2.4). Primary and secondary schools are supported to deliver Sex and Relationship Education (SRE). Local sexual health (SH) services for young people (e.g. Pulse, Archway, Brook) promote access to SH services. There are outreach sessions in Islington's Integrated Youth Hubs and free condoms are provided in youth centres, hubs and clinics.

Screening: Young people attending open access GUM clinics, e.g. at Archway and Mortimer Market SH services, are offered a chlamydia test as part of a standard sexual health screen. Many GP practices offer chlamydia screening as part of an enhanced SH service. Tests are also offered at some health centres, pharmacies, young people's SH services and antenatal care providers such as the Whittington.

Targeted services: An SRE worker works with the Youth Offending Service to support vulnerable young people. Targeted outreach workers and nurses work with gang prevention teams, detached youth workers, schools and youth providers to target vulnerable young people.

Targets

There are no set targets for this indicator. However, there is a Public Health England recommendation that boroughs should be working towards achieving a chlamydia diagnosis rate of at least 2,300 per 100,000 population (provisional).

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: The number of people aged 15-24 diagnosed with chlamydia.

Denominator: Resident population aged 15-24 as at mid-2010

Further information

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3.3 Population vaccination coverage

Rationale

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

This indicator will cover all vaccination programmes across the life course as previous evidence shows that highlighting vaccination programmes encourages improvements in uptake levels.

Targeted vaccination

- Hepatitis B: vaccination of children aged one and two years old who may have been exposed to Hepatitis B during birth.

Childhood immunisations

- DTaP/IPV/Hib: this protects children against diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b.
- Meningococcal C conjugate vaccine (MenC): this protects children against infection from meningococcal group C bacteria which can cause meningitis and septicaemia.
- Pneumoccocal conjugate vaccine (PCV): this protects children from pneumococcal infections including pneumonia (inflammation of the lungs), septicaemia (a form of blood poisoning) and meningitis (an infection of the membranes around the brain and spinal cord).
- PCV booster: this boosts previous courses of vaccination protection from pneumococcal infections.
- Hib/MenC booster: this boosts the first course of vaccinations which protect children from *Haemophilus influenzae* type b and meningitis C infections.
- MMR: the MMR protects children from measles, mumps and rubella. These conditions are infectious and can lead to meningitis and deafness.

Adolescent immunisations

- Human papilloma virus (HPV): this helps protect young women against cervical cancer.

Adult immunisations

- Pneumococcal polysaccharide vaccine (PPV): this helps protect groups at particular risk of pneumococcal diseases, for example people with bronchitis, pneumonia, and septicaemia.
- Flu vaccination: this protects adults aged 65 and over, and people who are in a clinical risk group (e.g. people with diabetes or asthma) from influenza.

3.03 - Population vaccination coverage - targeted immunisations

3.03i - Hepatitis B vaccination at one year old

Rationale from DH Technical Specification, 2013

Infants born to Hepatitis B virus (HBV) infected mothers are at high risk of acquiring HBV infection themselves. Babies born to infected mothers are given a dose of the Hepatitis B vaccine after they are born. This is followed by another two doses (with a month in between each) and a booster dose 12 months later. Around 20% of people with chronic Hepatitis B will go on to develop scarring of the liver (cirrhosis), which can take 20 years to develop, and around one in 10 people with cirrhosis will develop liver cancer. Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

The Islington picture

In Islington, 71 babies were identified as at risk of acquiring Hepatitis in 2011/12. Of these 47 (66%) received three doses of Hepatitis B by their first birthday. The initial vaccination is given by the hospital where the mother has given birth. It is the GP's responsibility to ensure that the next three doses are given; with three doses due to be completed at one year of age and the fourth dose given by two years of age. According to the data, Islington has performed less well than other comparable areas across England.

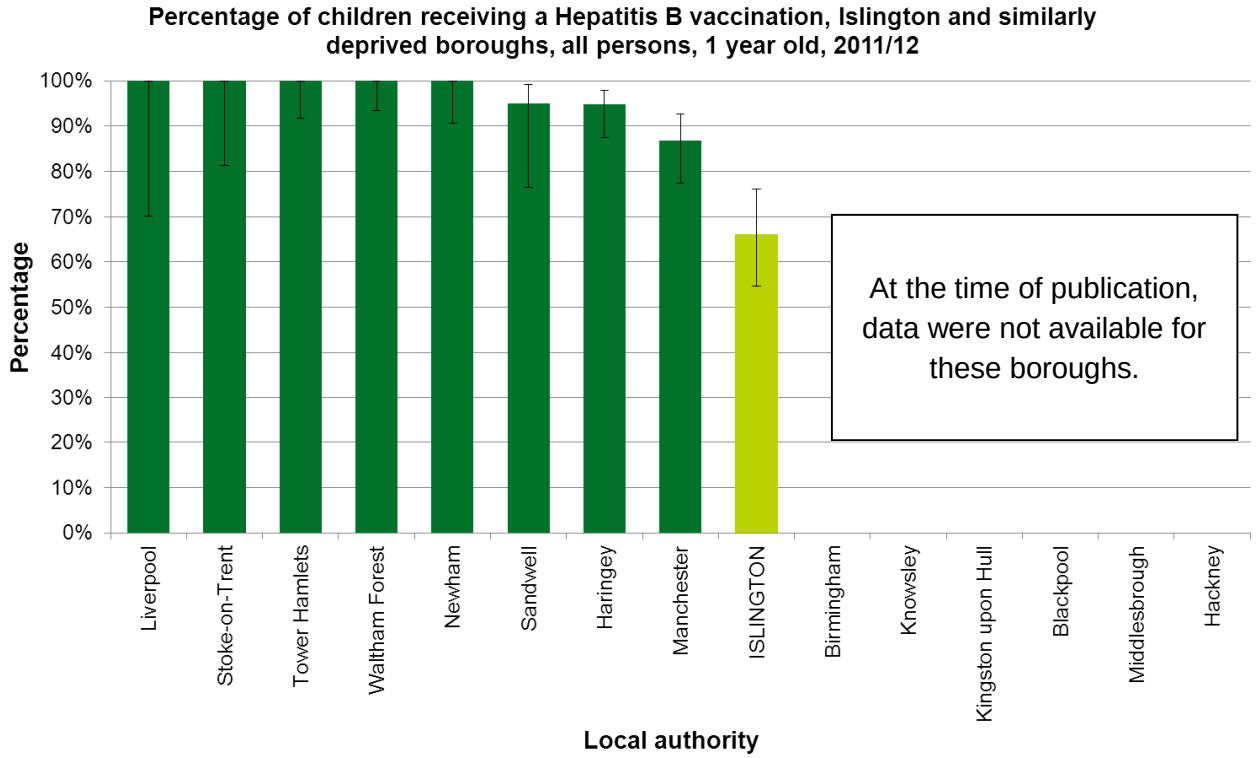
Information received from Public Health England (PHE) does not provide reasons for less than 100% coverage. It could be that the babies have been unwell and therefore immunisations have to be delayed, or they could have not been followed up to be recorded as vaccinated due to mothers moving away from Islington or for other reasons. Parents living in temporary accommodation may transfer out of borough and can be difficult to follow up.

We will only be able to comment on this when we analyse next year's data and look at this group of babies again.

It should also be noted that this data remains experimental - no national or regional data has been published. Therefore it is hard to draw any clear conclusions.

3.03 - Population vaccination coverage - targeted immunisations

3.03i - Hepatitis B vaccination at one year old



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (IC).

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Total number of infants with maternal Hep B positive status who have received three doses of Hepatitis B vaccine before their first birthday. Numerator counts for local authorities are estimated from counts for PCTs.

Denominator: Total number of children reaching their first birthday during the specified evaluation period with maternal Hep B positive status.

3.03 - Population vaccination coverage - targeted immunisations

3.03i - Hepatitis B vaccination at two years old

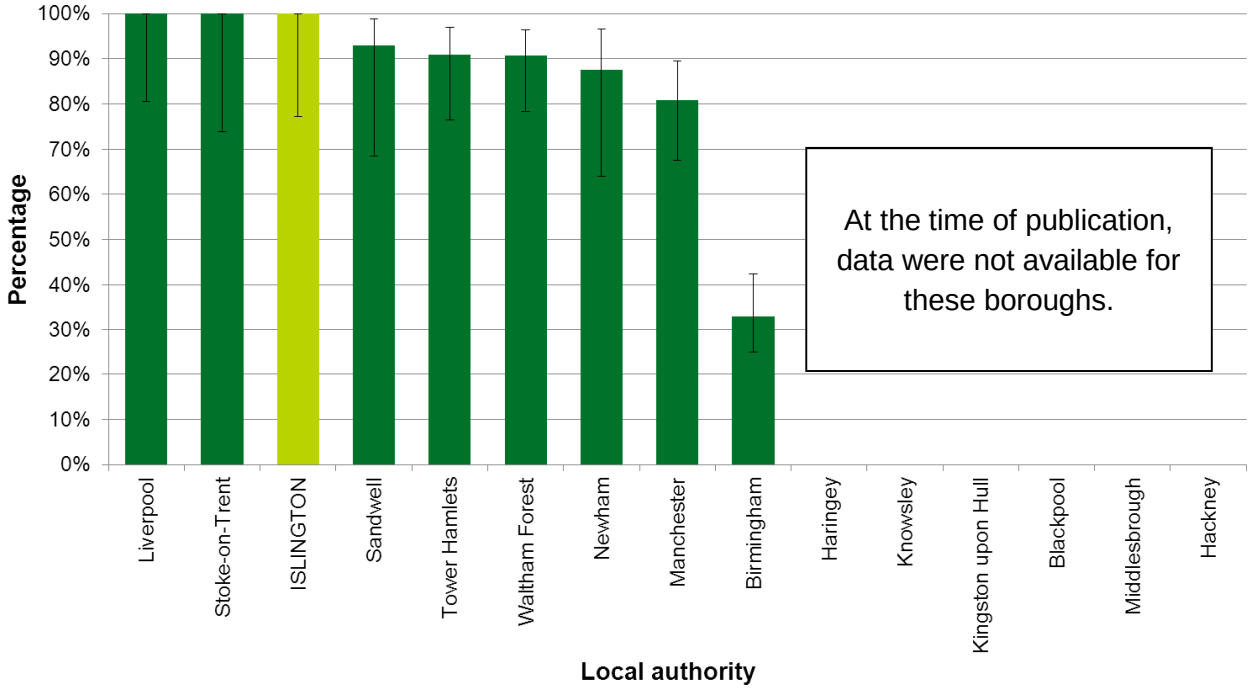
This data shows that all the children identified as being at risk of contracting Hepatitis B because of their mother's positive status received a full course of four immunisations by their second birthday.

The actual numbers are small, with 13 children vaccinated out of 13 identified children. Overall current data shows the prevalence in ante natal women in the UK is around 0.1%. This translates to an approximate average number of four infected Hepatitis B women for Islington per year. Islington has an above average prevalence (13 cases), which is a reflection of the prevalence of the at risk groups resident in the borough.

Islington data for the percentage of children receiving a Hepatitis B vaccination compares favourably with other comparable areas across England, as the graph demonstrates.

However it needs to be stressed that this data is experimental. No national or regional data has to date been published.

Percentage of children receiving a Hepatitis B vaccination, Islington and similarly deprived boroughs, all persons, 2 years old, 2011/12



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (IC).

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Total number of infants with maternal Hep B positive status who have received four doses of Hepatitis B vaccine before their second birthday. Numerator counts for local authorities are estimated from counts for PCTs.

Denominator: Total number of children reaching their second birthday during the specified evaluation period with maternal Hep B positive status.

3.03 - Population vaccination coverage - targeted immunisations

Key programmes in Islington

Universal services

NHS services in Islington routinely offer screening for Hepatitis B during pregnancy, as part of their infectious disease screening programme. Antenatal Hepatitis B screening has been in place since 2000.

The disease can be transmitted to the baby with the risk of chronic disease developing in adult life, for example chronic liver disease.

The initial vaccination is given to the baby in the hospital where the mother has given birth, with the following doses being the responsibility of the GP.

Targeted services

There are no specific targeted services in Islington as screening of all pregnant women takes place during the pregnancy.

Those babies identified at risk are then targeted to receive the appropriate prophylactic interventions.

Equalities and health inequalities

- Hepatitis B infection is more common in areas of the world like South East Asia, Africa, Middle East and Far East, central and southern Europe. Women from these areas are therefore more likely to be at risk and carry the infection.
- The prevalence of Hepatitis B is also higher among injecting drug users.

Targets

There are no set targets for these indicators, but all pregnant women are screened for Hepatitis B, with a protocol in place to immunise all babies whose mothers carry the Hepatitis B infection.

Further information

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3.03 - Population vaccination coverage - childhood immunisations

3.03iii - Dtap/IPV/Hib coverage

Rationale from DH Technical Specification, 2013

The combined DTaP/IPV/Hib is the first in a course of vaccines offered to babies to protect them against diphtheria, pertussis (whooping cough), tetanus, Haemophilus influenzae type b (an important cause of childhood meningitis and pneumonia) and polio (IPV is inactivated polio vaccine). Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

The Islington picture

Islington's rate is similar to comparable boroughs and the England average for DTaP/IPV/Hib vaccination before the age of one and two. The time trend graphs show that there has been steady improvement in the uptake of the DTaP/IPV/Hib vaccine over time.

Islington is just one of five London boroughs with uptake rates at or above 96%. This compares well with London (91%) and England (95%). Islington is above the level to achieve "herd immunity", which is set at 95% (herd immunity confers sufficient immunity in a population to secure protection to the non-immunised).

The overall achievement for 2012/13 for age one was 96% - data supplied by Islington Immunisation Co-ordinator.

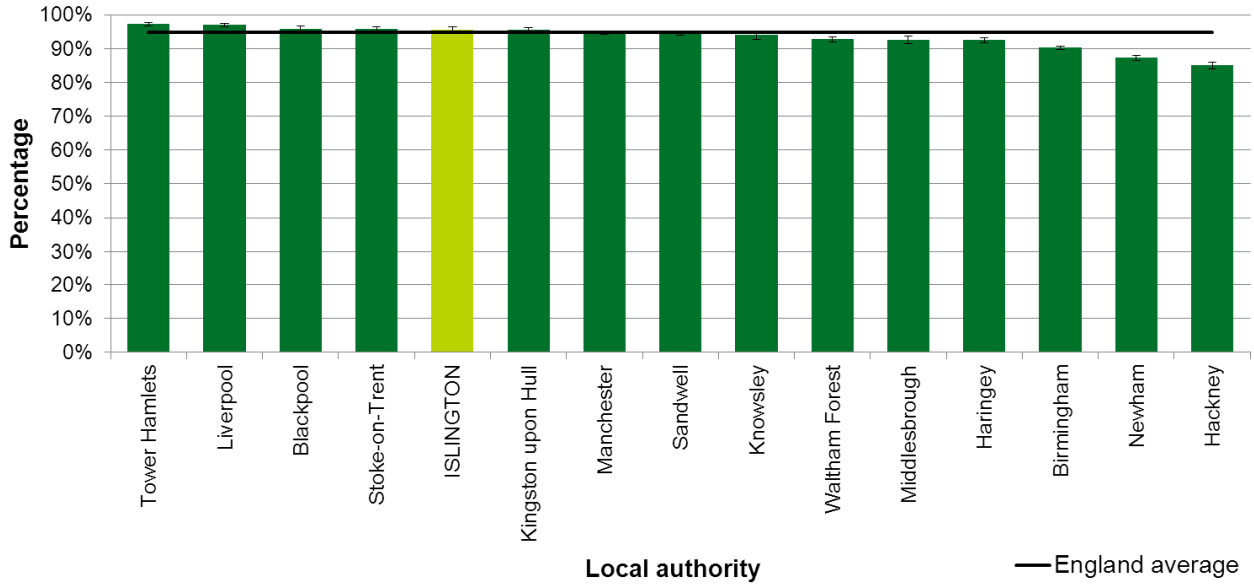
Targets

Local targets have been agreed and set in place. The primary immunisation target has been exceeded in each quarter.

3.03 - Population vaccination coverage - childhood immunisations

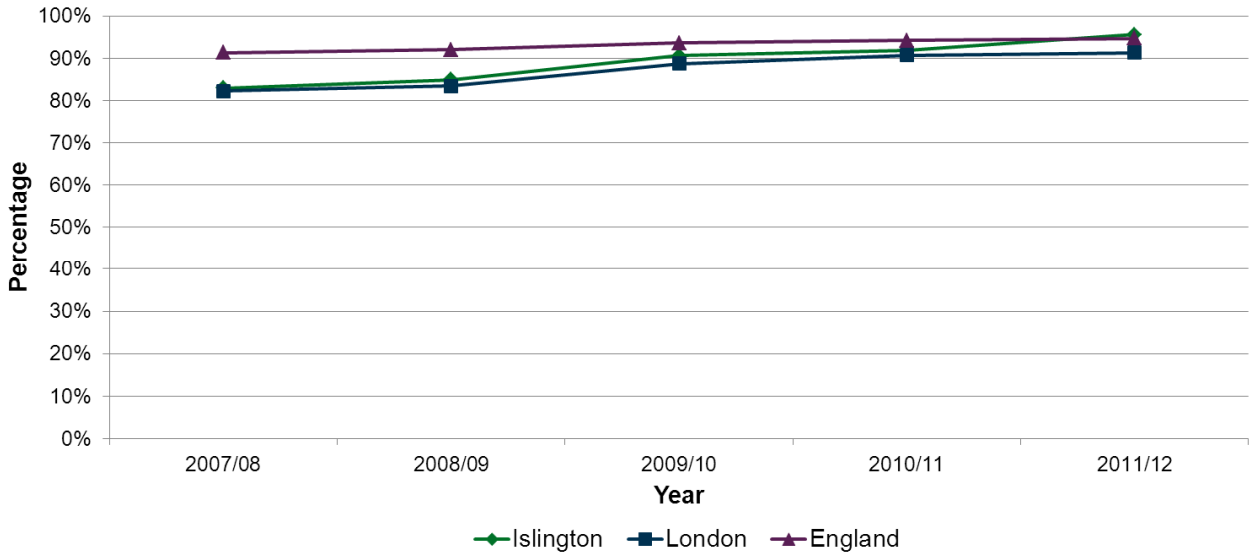
3.03iii - Dtap/IPV/Hib coverage at one year old

Percentage of children receiving a Dtap/IPV/Hib vaccination, Islington and similarly deprived boroughs compared against the England average, all persons, 1 year old, 2011/12



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (IC).

Percentage of children receiving the DTaP/IPV/Hib vaccination by age one, Islington, London and England, 2007/08 to 2011/12



Source: Health and Social Care Information Centre

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

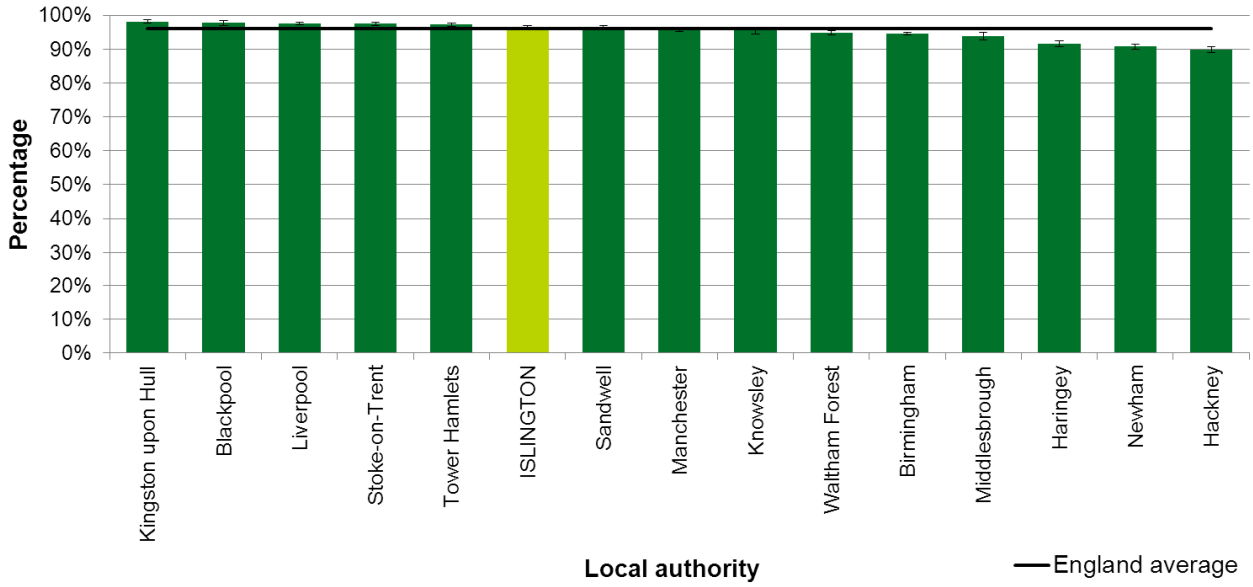
Numerator: Total number of children who received three doses of DTaP/IPV/Hib vaccine by their first birthday. Numerator counts for local authorities are estimated from counts for PCTs.

Denominator: Total number of children whose first birthday falls within the time period. Denominators for local authorities are estimated from denominators for PCTs.

3.03 - Population vaccination coverage - childhood immunisations

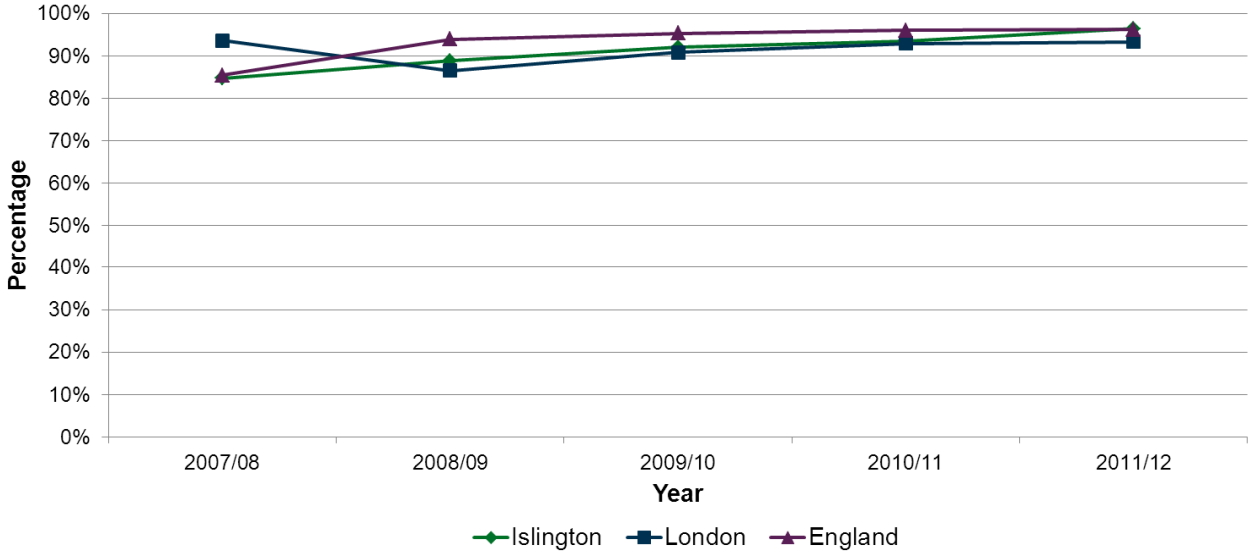
3.03iii - Dtap/IPV/Hib coverage at two years old

Percentage of children receiving a Dtap/IPV/Hib vaccination, Islington and similarly deprived boroughs compared against the England average, all persons, 2 years old, 2011/12



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (IC).

Percentage of children receiving the DTaP/IPV/Hib vaccination by age two, Islington, London and England, 2007/08 to 2011/12



Source: Health and Social Care Information Centre

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Total number of children who received three doses of DTaP/IPV/Hib vaccine by their second birthday. Numerator counts for local authorities are estimated from counts for PCTs.

Denominator: Total number of children whose second birthday falls within the time period. Denominators for local authorities are estimated from denominators for PCTs.

3.03 - Population vaccination coverage - childhood immunisations

3.03iv - Men C coverage at one year old

Rationale from DH Technical Specification, 2013

The meningococcal C conjugate (Men C) vaccine protects against infection by meningococcal group C bacteria, which can cause meningitis and septicaemia. Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

The Islington picture

Islington's uptake is 95%, which is similar to comparable areas and similar to the England average of 94%. In fact Islington has one of the highest rates for this vaccine compared to all the other London boroughs, despite the high levels of deprivation and population mobility.

There are changes to the Men C programme from June 2013, with the second dose of Men C currently given at four months being stopped and instead being given at 13-14 years in adolescence.

Introduction of the adolescent dose is likely to take place in schools from the Spring term of 2014.

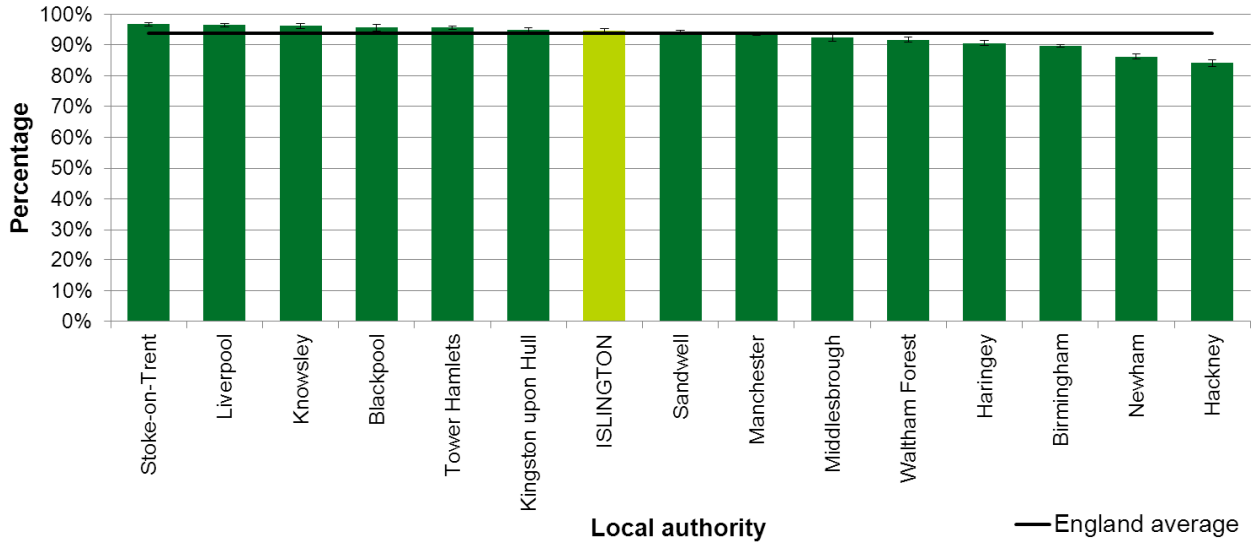
Targets

There is no specific target for Men C although local targets are set for the combined Hib/Men C booster to achieve 95% coverage for herd immunity.

3.03 - Population vaccination coverage - childhood immunisations

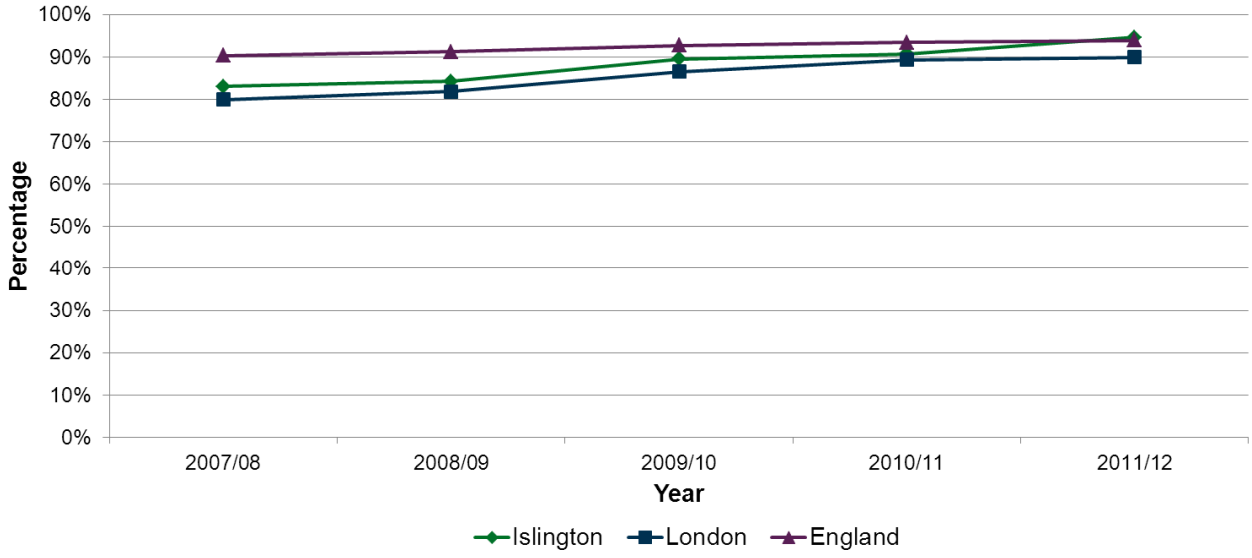
3.03iv - Men C coverage at one year old

Percentage of children receiving a Meningitis C vaccination, Islington and similarly deprived boroughs compared against the England average, all persons, 1 year old, 2011/12



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (IC).

Percentage of children receiving two doses of Meningitis C vaccination by age one, Islington, London and England, 2007/08 to 2011/12



Source: Health and Social Care Information Centre

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Total number of children who received two doses of MenC vaccine at any time by their first birthday. Numerator counts for local authorities are estimated from counts for PCTs.

Denominator: Total number of children whose first birthday falls within the time period. Denominators for local authorities are estimated from denominators for PCTs.

3.03 - Population vaccination coverage - childhood immunisations

3.03v - PCV vaccination coverage

Rationale from DH Technical Specification, 2013

The PCV vaccine protects against pneumococcal infections that can cause pneumonia, septicaemia or meningitis. Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

The Islington picture

Islington achieved 95% coverage for the primary course of PCV at 12 months old, meeting the World Health Organization target. This is significantly higher than both the London (90%) and England (94%) averages.

The PCV booster dose is offered at 12-13 months. Only 88% of Islington children received the booster dose by 24 months old, compared to 91% of children in England who had received the PCV booster at 24 months in 2011/12. When children reach their first birthday it is more challenging to ensure that uptake of vaccination is maintained, as they are less likely to access health services as they become older.

Uptake of the booster has increased over time, in line with increases across London. The gap in uptake has now nearly closed with the England average. Continual efforts are being made to increase the uptake of the PCV booster, to ensure on-going immunity from pneumococcal infections.

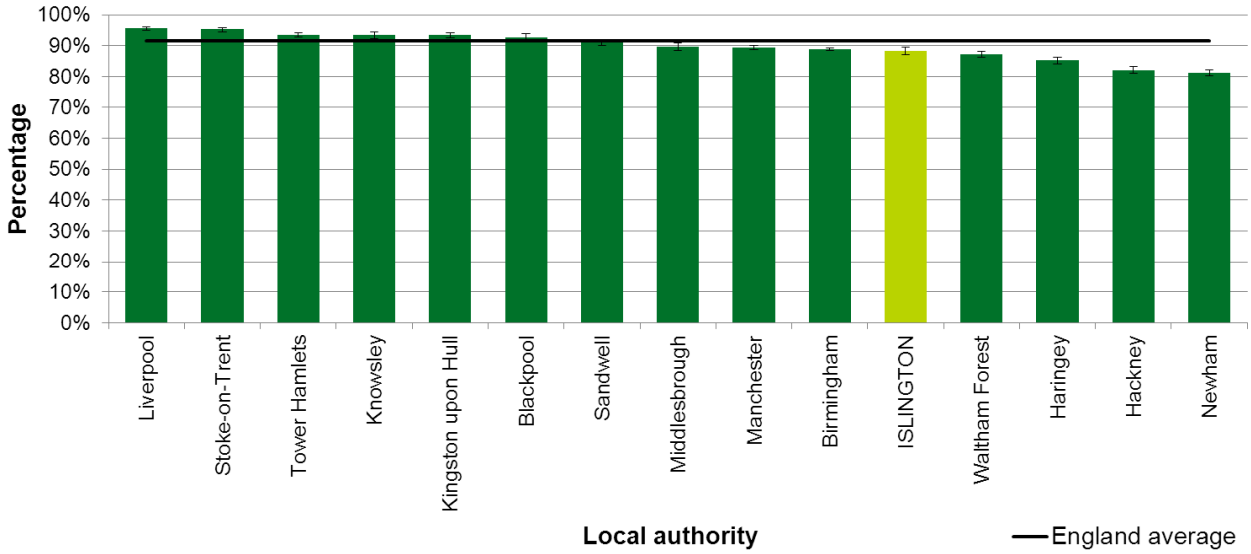
Targets

The national target is set at 95% to achieve herd immunity. There are local targets set on a quarterly basis to ensure that a 95% uptake is achieved by the end of the year. The strategy group may decide to set a fixed target across both Camden and Islington in the future.

3.03 - Population vaccination coverage - childhood immunisations

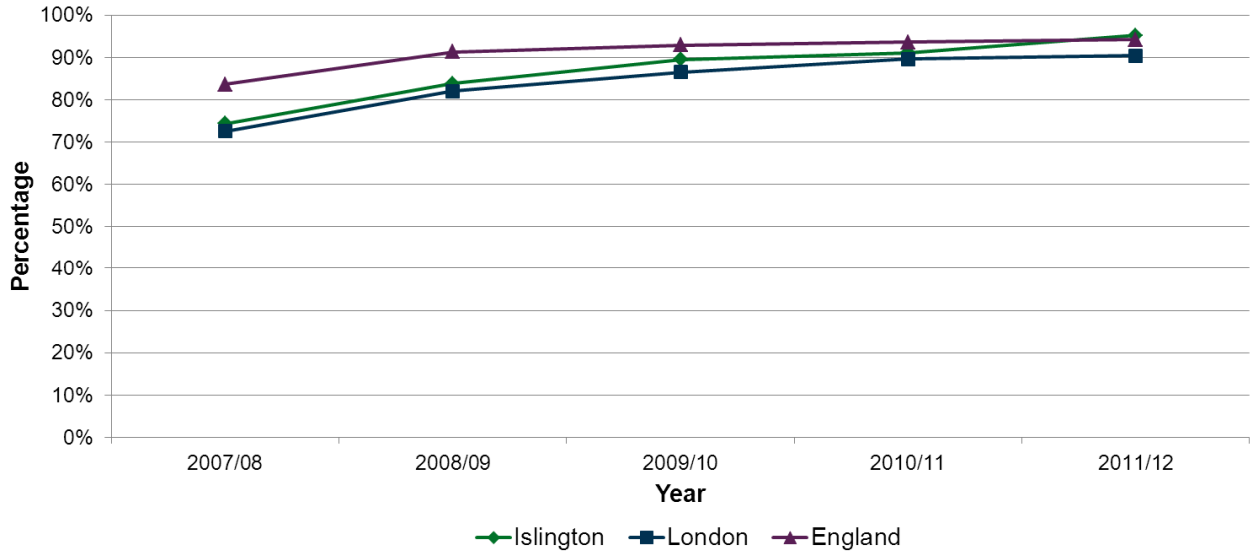
3.03v - PCV vaccination coverage

Percentage of children receiving a PCV booster, Islington and similarly deprived boroughs compared against the England average, all persons, 2 years old, 2011/12



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (IC).

Percentage of children receiving two doses of PCV vaccination by age one, Islington, London and England, 2007/08 to 2011/12



Source: Health and Social Care Information Centre

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Total number of children who received two doses of PCV vaccine at any time by their first birthday. Numerator counts for local authorities are estimated from counts for PCTs.

Denominator: Total number of children whose first birthday falls within the time period. Denominators for local authorities are estimated from denominators for PCTs.

3.03 - Population vaccination coverage - childhood immunisations

3.03 - Hib/Men C booster coverage

Rationale from DH Technical Specification, 2013

In September 2006 a new programme for a combined Hib/Men C booster was introduced. Children are currently offered this between 12-13 months of age

The Hib/Men C booster increases the protection a child gets from the first course of Hib vaccine when they are 8, 12 and 16 weeks old, and the Men C vaccine when they are 12 and 16 weeks. This boosted immunity lasts into adulthood. Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

The Islington picture - Hib/Men C booster (2 and 5 years old)

The rate for Islington from 2011/12 was 87%, however data from the national monitoring programme, Cover of Vaccination Evaluated Rapidly (COVER), for 2012/13 gives an uptake of 92% - a significant improvement. This has been achieved through a concerted effort to reach those children in the second year of life who are less likely to access immunisation services.

This rate is just below the England rate (92%) but is above the London rate (86%).

The gold standard to reach is an uptake of 95% to achieve herd immunity; efforts will be made to continually make improvements with the uptake of this booster vaccine.

For children receiving the booster by the age of five, Islington is below the England average of 89% with a registered uptake of 87%. However Islington compares favourably with the other London boroughs, and is similar to most uptakes achieved in other similarly deprived areas. The London average is 82%.

The time trend graph shows that the uptake for this booster has dropped across England, London and correspondingly in Islington. This concern has been tackled with a proactive response to reach these older children and invite them for the booster dose. Data being collected for 2012/13 are encouraging in that the uptake has increased recently. The challenge will be to ensure that levels are sustained, in order to prevent the outbreak of disease.

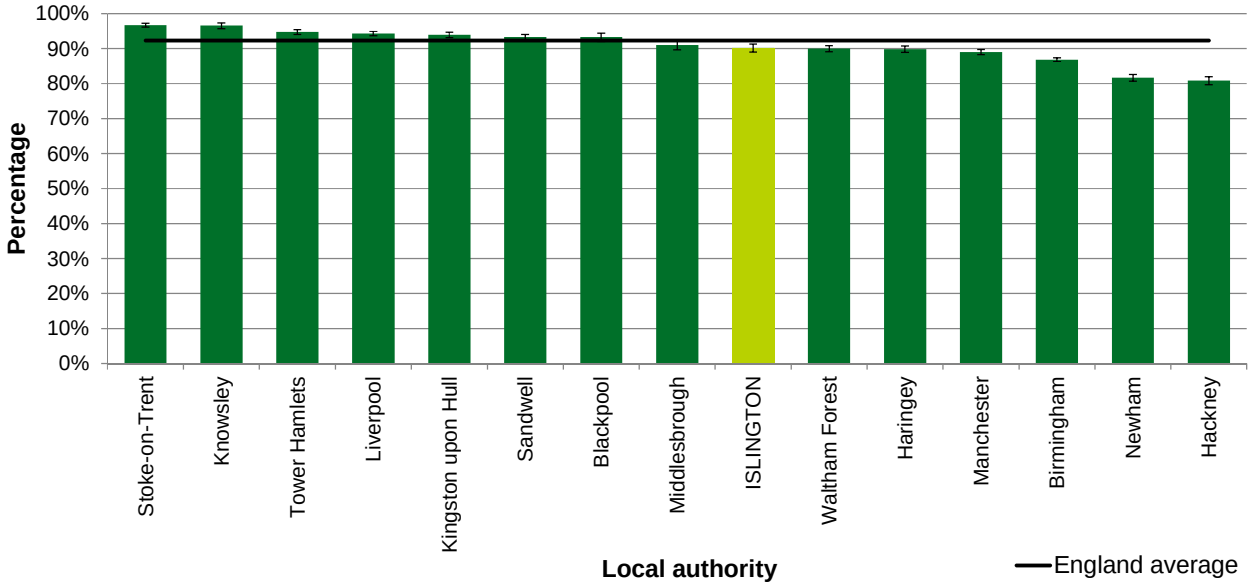
Targets

There are local targets set for the uptake of the Hib/Men C booster doses. In 2011/12 the target for uptake by age two was 89%, and the target by age five was 86%.

3.03 - Population vaccination coverage - childhood immunisations

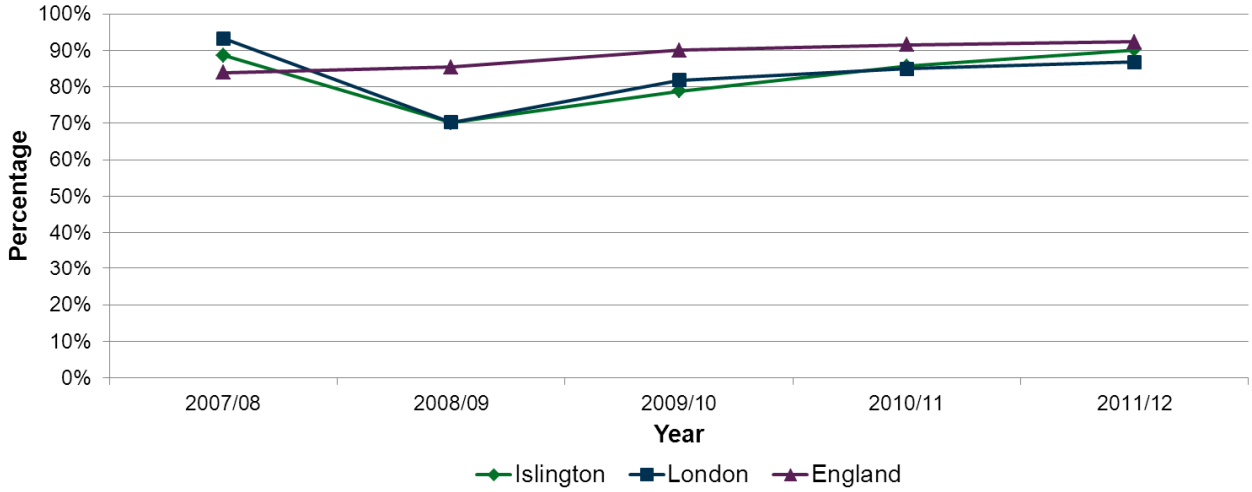
3.03vi - Hib/Men C booster (2 years old)

Percentage of children receiving a Hib/MenC booster by age 2, Islington and similarly deprived boroughs compared against the England average, all persons, 2 years old, 2011/12



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (IC).

Percentage of children receiving the Hib/MenC booster vaccination by age two, Islington, London and England, 2007/08 to 2011/12



Source: Health and Social Care Information Centre

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

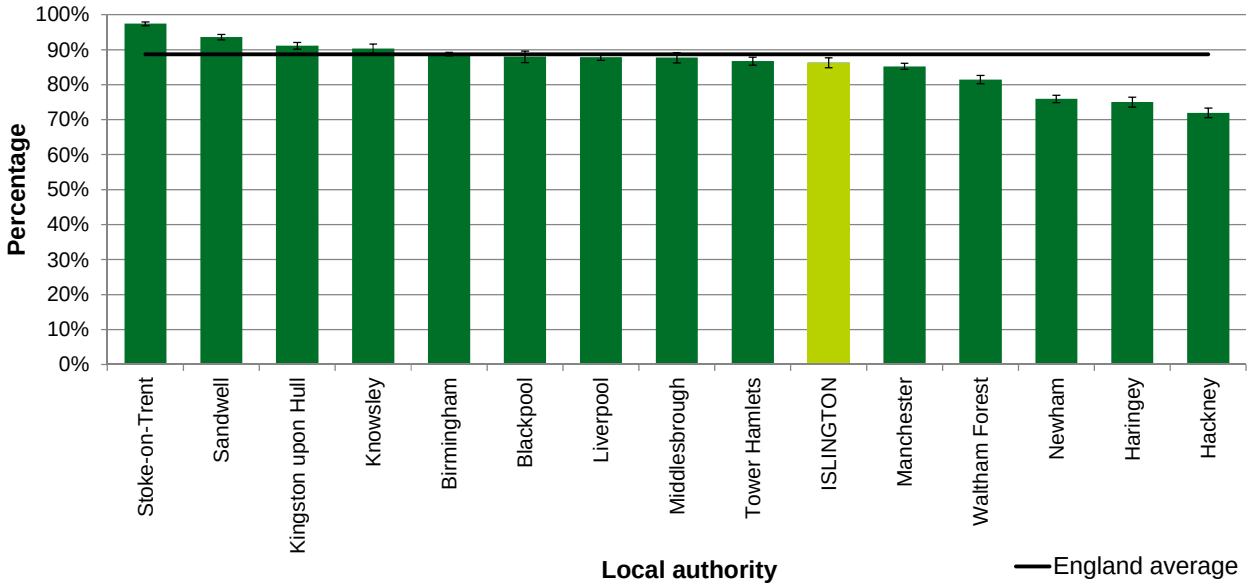
Numerator: Total number of children who received one dose of Hib/MenC booster vaccine on or after their first birthday and at any time up to their second birthday.

Denominator: Number of children whose second birthday falls within the time period.

3.03 - Population vaccination coverage - childhood immunisations

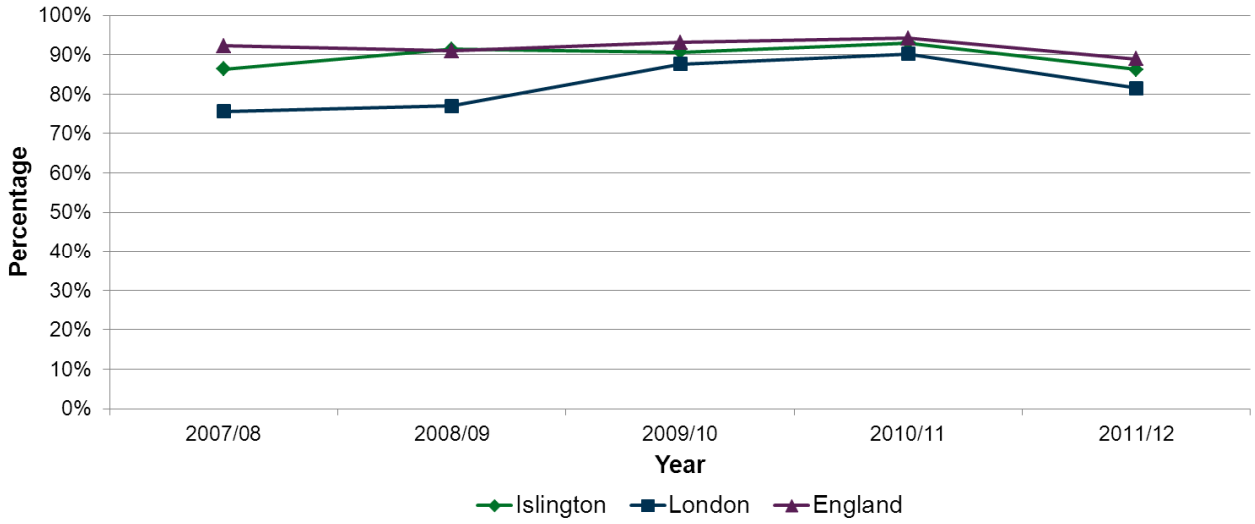
3.03vii - Hib/Men C booster (5 years old)

Percentage of children receiving a Hib/Men C booster by age 5, Islington and similarly deprived boroughs compared against the England average, all persons, 5 years old, 2011/12



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (IC).

Percentage of children receiving a Hib or Hib/Men C vaccination by age five, Islington, London and England, 2007/08 to 2011/12



Source: Health and Social Care Information Centre
Note: The 2011/12 data represents the first experimental data published for the Hib/Men C booster, which was introduced for five year olds in 2006.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Total number of children who received one dose of Hib/MenC booster vaccine on or after their first birthday and at any time up to their fifth birthday.

Denominator: Number of children whose fifth birthday falls within the time period.

3.03 - Population vaccination coverage - childhood immunisations

3.03 - MMR vaccination coverage

Rationale from DH Technical Specification, 2013

MMR is the combined vaccine that protects against measles, mumps and rubella. Measles, mumps and rubella are highly infectious, common conditions that can have serious complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby and can lead to miscarriage. Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

The Islington picture - MMR vaccination coverage

Islington achieved a take up of 87% of MMR among two year olds, in 2011/12. This rate is not statistically different to the England average or to boroughs with similar levels of deprivation. The England average is now 91%; this is the first time that uptake has exceeded 90% since 1997/8.

The uptake dropped dramatically at this time due to negative publicity concerning a possible link between MMR vaccination and autism. This has been fully discredited.

The Islington Immunisation Action Plan adopts a proactive approach, targeting those children who are less likely to attend for immunisations.

The time trend graph shows that the uptake has increased year on year and appears to have stabilised at just below 90%. Efforts will be made to make further improvements on uptake, as “herd immunity” is only achieved at 95%.

For children receiving one dose by the age of five, Islington’s position is similar to other comparable boroughs and the England average. The percentage of those children who have received one dose of MMR by the time they reach their fifth birthday in England is 93%, London 90%, and Islington 93%. There has been a steady, continuous improvement in the uptake of the MMR vaccine by the age of five since 2007/08, as the second graph illustrates.

The picture is slightly worse for children receiving two doses by the age of five - Islington’s position (82%) is below the England average of 86% in 2011/12, but is above the London average of 80%. Islington has done less well than several other boroughs with comparable deprivation. It is recognised that the older cohort of children are harder to reach than the younger children who are more likely to access health services frequently, particularly in a borough like Islington which has high population turnover.

The time trend graph demonstrates an improvement over time. There needs to be an on-going strategy to increase uptake as the gold standard is 95% uptake to achieve “herd immunity”.

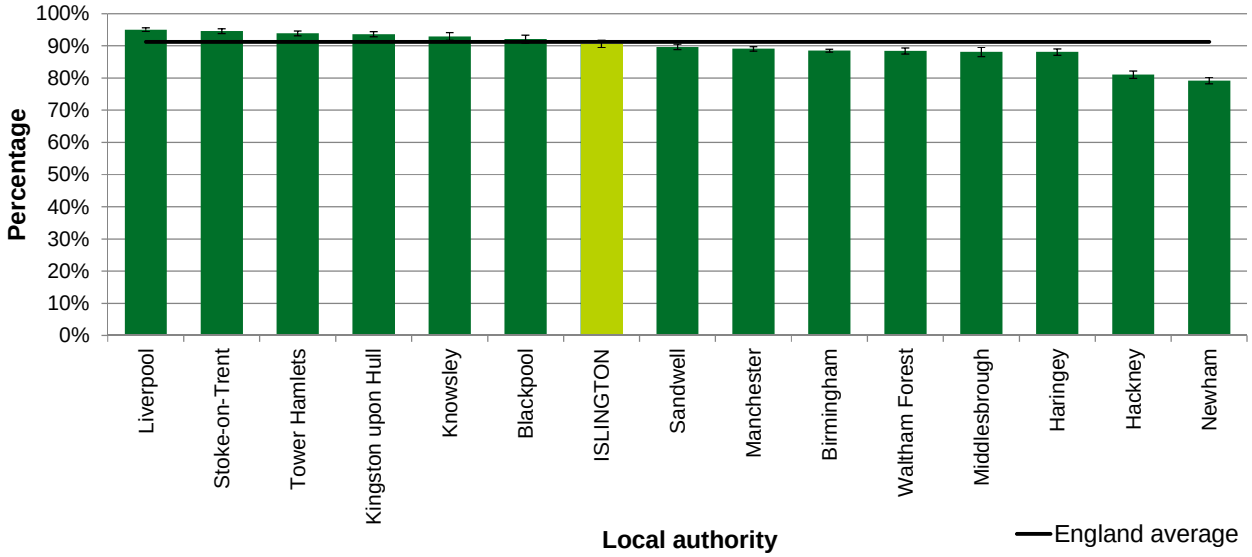
Targets

The national target is set at 95% to achieve herd immunity. There are local targets set on a quarterly basis to ensure that a 95% uptake is achieved by the end of the year. The strategy group may decide to set a fixed target across both Camden and Islington in the future.

3.03 - Population vaccination coverage - childhood immunisations

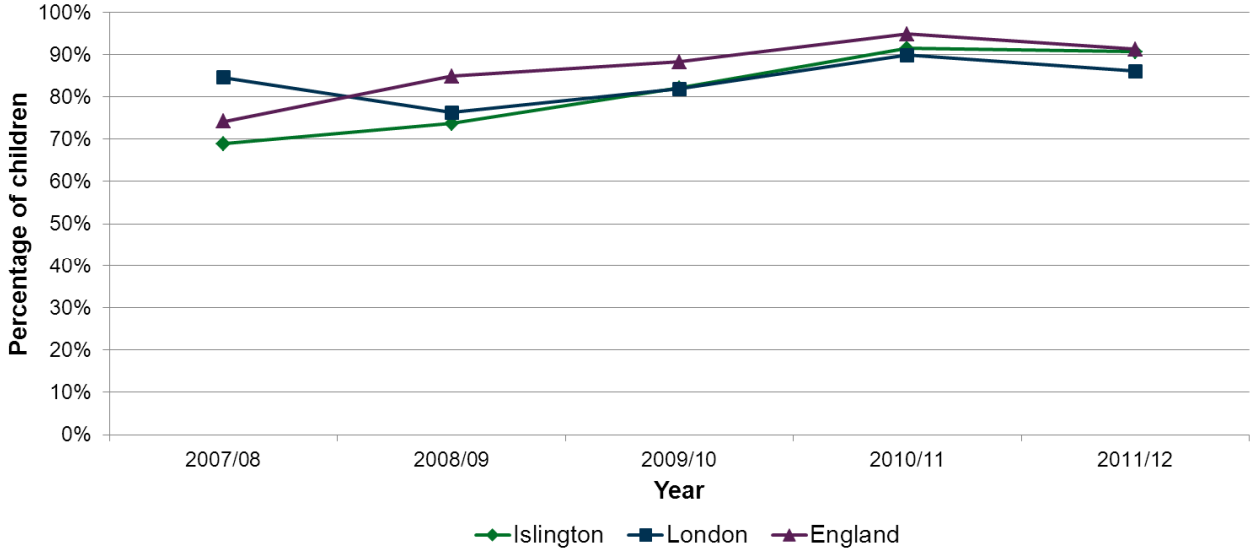
3.03viii The Islington picture - MMR vaccinations by two years of age

Percentage of children receiving one dose of MMR by age 2, Islington and similarly deprived boroughs compared against the England average, all persons, 2 years old, 2011/12



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (IC).

Percentage of children receiving the MMR booster vaccination at age two, Islington, London and England, 2007/08 to 2011/12



Source: Health and Social Care Information Centre

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

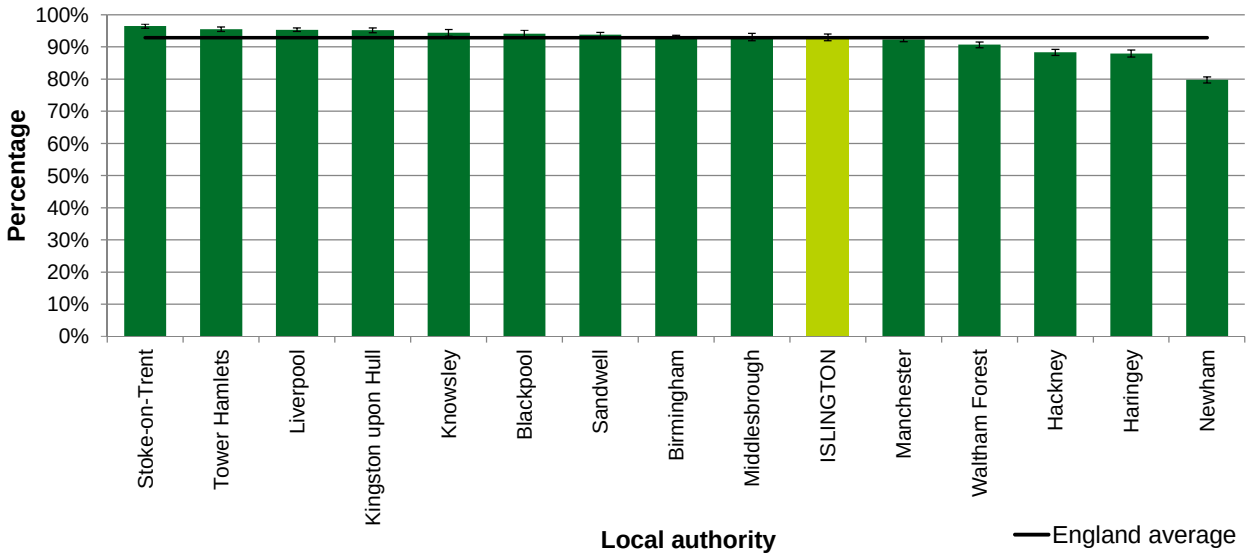
Numerator: Total number of children who received one dose of MMR vaccine on or after their first birthday and at any time up to their second birthday. Numerator counts for local authorities are estimated from counts for PCTs.

Denominator: Total number of children whose second birthday falls within the time period. Denominators for local authorities are estimated from denominators for PCTs.

3.03 - Population vaccination coverage - childhood immunisations

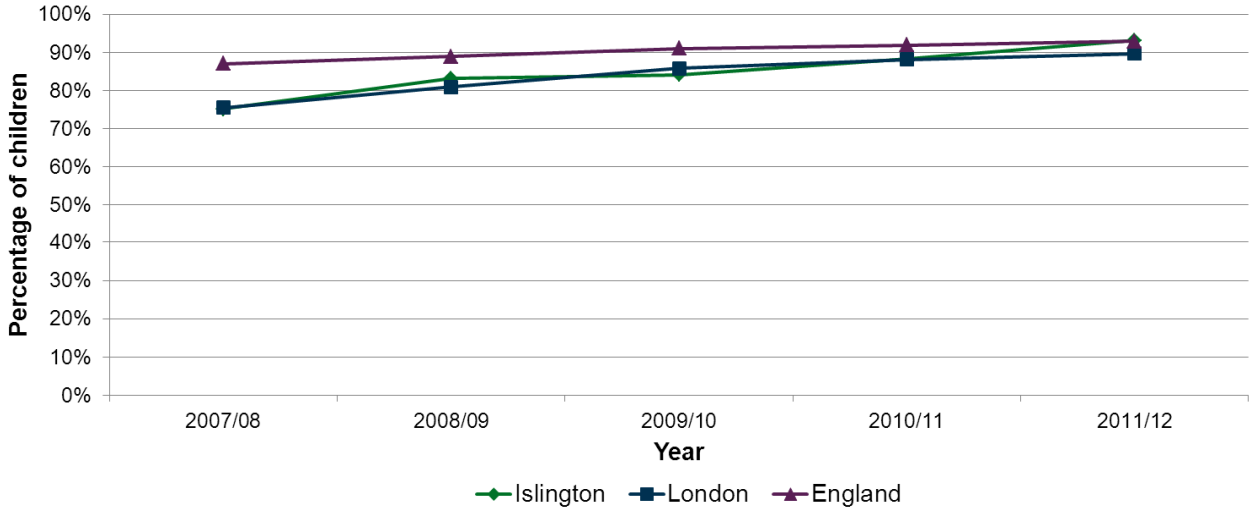
3.03ix The Islington picture - MMR, one dose by five years of age

Percentage of children receiving one dose of MMR by age 5, Islington and similarly deprived boroughs compared against the England average, all persons, 5 years old, 2011/12



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (IC).

Percentage of children receiving one dose of MMR vaccination at age five, Islington, London and England, 2007/08 to 2011/12



Source: Health and Social Care Information Centre

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

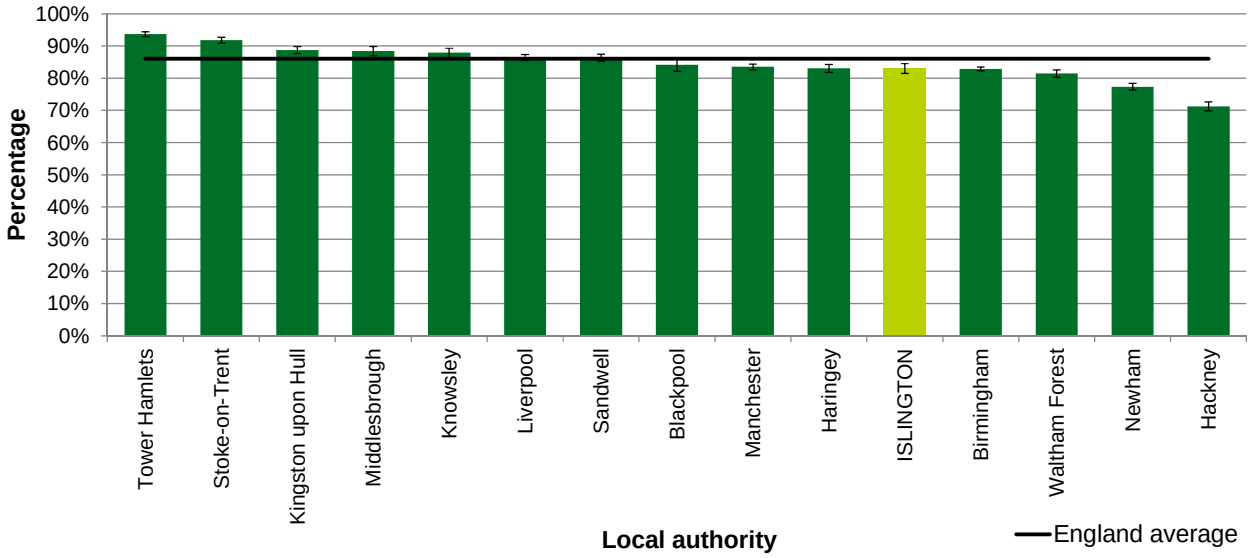
Numerator: Total number of children who received one dose of MMR on or after their first birthday and at any time up to their fifth birthday. Numerator counts for local authorities are estimated from counts for PCTs.

Denominator: Total number of children whose fifth birthday falls within the time period. Denominators for local authorities are estimated from denominators for PCTs.

3.03 - Population vaccination coverage - childhood immunisations

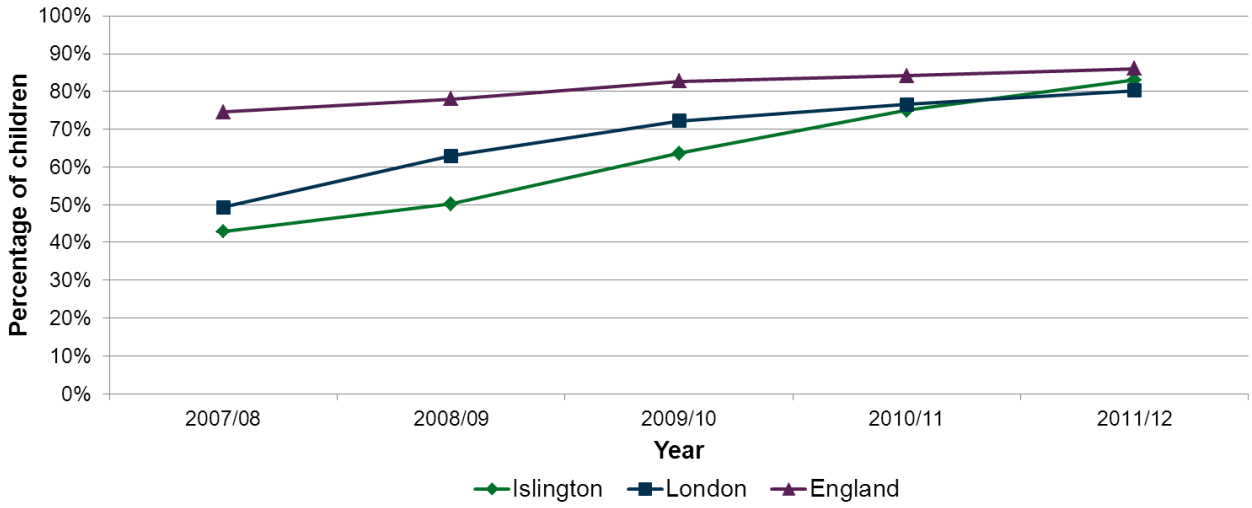
3.03x The Islington picture - MMR, two doses by five years of age

Percentage of children receiving two doses of MMR, Islington and similarly deprived boroughs compared against the England average, all persons, 5 years old, 2011/12



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (IC).

Percentage of children receiving two doses of MMR vaccination at age five, Islington, London and England, 2007/08 to 2011/12



Source: Health and Social Care Information Centre

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Total number of children who received two doses of MMR on or after their first birthday and at any time up to their fifth birthday. Numerator counts for local authorities are estimated from counts for PCTs.

Denominator: Total number of children whose fifth birthday falls within the time period. Denominators for local authorities are estimated from denominators for PCTs.

3.03 - Population vaccination coverage - childhood immunisations

Equalities and health inequalities

- National evidence suggests that more deprived populations have lower uptake rates of immunisation.
- Some communities such as the Somali community have particular concerns about vaccines so uptakes are lower.
- Older children are less likely to be immunised than younger children. This may well be due to the fact that younger children are seen more frequently by healthcare professionals.
- Other more vulnerable groups where immunisation uptake may be lower are families seeking asylum, non-English speaking families and some minority ethnic groups such as the Somali community.
- A childhood immunisation equity audit in Islington was published in November 2012, and is available on the Evidence Hub.

Key programmes in Islington

Universal services

All children under the age of one are invited for the full course of primary immunisations.

Children are invited for subsequent vaccinations and boosters as they become eligible.

Targeted services

Families whose children are less likely to attend are specifically targeted and invited to immunisation sessions. Uptake of immunisations decreases with age, which likely reflects the amount of contact they have with health services.

Health visitors and the immunisation team work proactively with vulnerable groups to improve the uptake.

Groups where uptake may be lower include:

- Looked after children
- Children with disabilities
- Children of lone parents
- Asylum seekers

Further information

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3.03 - Population vaccination coverage - adolescent immunisations

3.03xii - HPV vaccination coverage

Rationale from DH Technical Specification, 2013

The Human Papillomavirus (HPV) vaccine protects against the two high-risk HPV types – 16 and 18 – that cause over 70% of cervical cancers. Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

The Islington picture

HPV vaccination involves the administration of three doses of vaccine over a six month period. This is given in schools by the school nurses to girls aged 12-13 years.

Islington has performed less well (at 82%) than most other comparable areas and is below the England average of 87%.

The HPV programme was only recently introduced (2008) and, at present, is only given to girls. Girls in Year 8 are invited to be immunised in school following parental consent to participate.

Girls not in education will be contacted by the local NHS or their GP practice.

As the programme is new there is little data to demonstrate uptake over time. The second graph shows the direct standardised mortality rate from cervical cancer over time, but it isn't possible to make any conclusions about the impact that uptake of HPV is having on cervical cancer rates until long term trends are available.

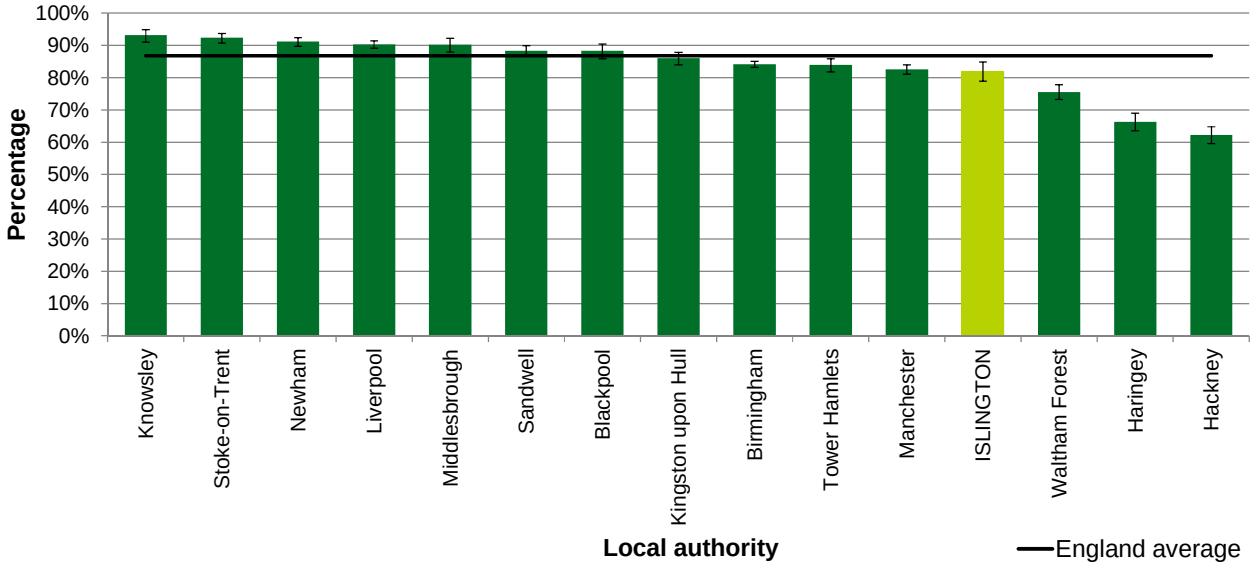
Targets

The national target is 95%. Local targets are set which change according to the on-going trajectory.

3.03 - Population vaccination coverage - adolescent immunisations

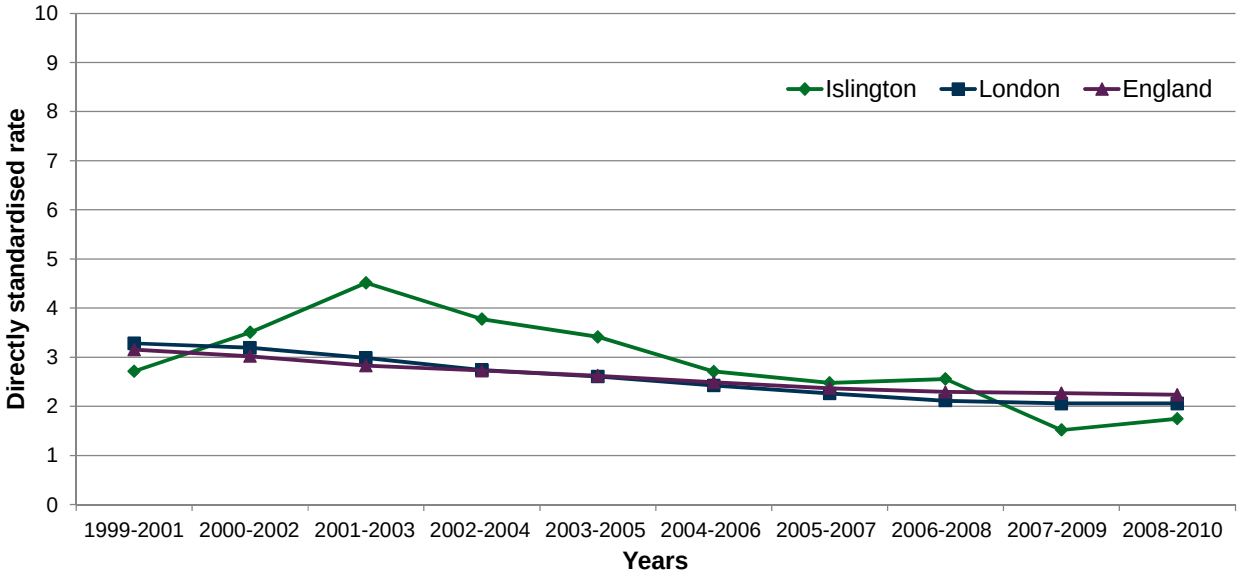
3.03xii - HPV vaccination coverage

Percentage of people receiving an HPV vaccination, Islington and similarly deprived boroughs compared against the England average, girls, aged 12-13 years, 2011/12



Source: Department of Health (DH)

Directly standardised rate of mortality from cervical cancer, Islington, London, and England, per 100,000 people, women, 1999-2001 to 2008-10 (three year rolling average)



Source: NCHOD, 2012

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of Year 8 schoolgirls (aged 12 to 13 years) who have received all three doses of the HPV vaccine.

Denominator: Number of Year 8 schoolgirls (aged 12 to 13 years).

3.03 - Population vaccination coverage - adolescent immunisations

Equalities and health inequalities

- Understanding variations in uptake of childhood immunisations between different population groups and the reasons underlying these variations and then taking appropriate actions to reduce these inequalities is the approach that underpins the Islington Immunisation Action Plan.
- Despite efforts to address inequalities, they do persist, for example older children are less likely to be immunised than younger children. This may well be due to the fact that younger children are seen more frequently by healthcare professionals.
- Unregistered children who do not attend GP services, can be difficult to trace and ensure that they are offered the vaccination schedule.
- A childhood immunisation equity audit in Islington was published in November 2012, and is available on the Evidence Hub.

Key programmes in Islington

Universal services

All girls aged between 12-13 years are offered three doses of HPV over a six month period.

Targeted services

Adolescent girls who are harder to reach are targeted - the groups less likely to access vaccinations include:

- Girls excluded from school
- Girls attending pupil referral units
- Girls in families who move frequently
- Girls with high absenteeism

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3.03 - Population vaccination coverage - adult immunisations

3.03xiii - PPV vaccination coverage

Rationale from DH Technical Specification, 2013

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Achieving high population coverage is closely associated with significant reductions in disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise. Pneumococcal disease is a significant cause of morbidity and mortality. Certain groups are at risk for severe pneumococcal disease, these include young children, the elderly and people who are in clinical risk groups. Pneumococcal infections can be non-invasive such as bronchitis, otitis media or invasive such as septicaemia, pneumonia, meningitis. Cases of invasive pneumococcal infection usually peak in the winter during December and January. The PPV protects against 23 types of Streptococcus pneumoniae bacterium. It is thought that the PPV is around 50-70% effective at preventing more serious types of invasive pneumococcal infection. Since 1992, PPV has been recommended for people in clinical risk groups and since 2003, for all those aged 65 years and over in England.

The Islington picture

In 2011/12, 63% of the Islington population aged 65 and over received a PPV vaccine. This is significantly lower than the England average of 68%, and slightly below average when compared to the similarly deprived boroughs. This equated to 6,381 over 65s not receiving the PPV vaccination.

Compared with winter flu vaccine which needs to be administered every year PPV vaccine only needs to be given once to those aged over 65 years.

Coverage of PPV is monitored among over 65s, but it is also important to ensure those with a weakened immune system and those in clinical risk groups aged under 65 are also offered PPV to protect them from the infection.

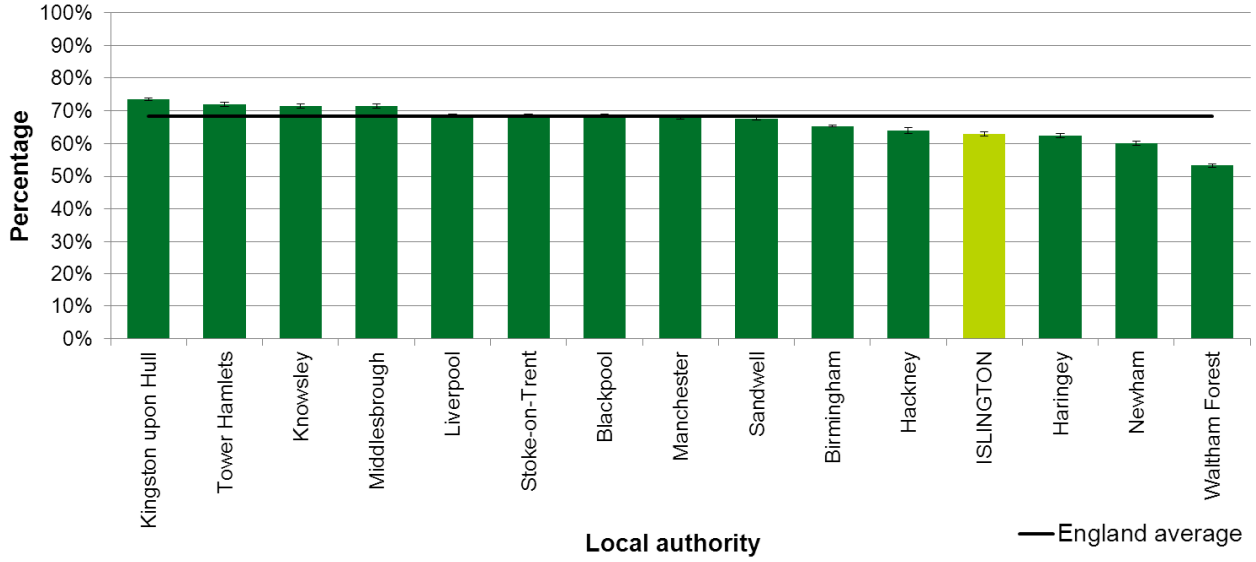
Targets

The national target is 95%. Local targets are set which change according to the on-going trajectory.

3.03 - Population vaccination coverage - adult immunisations

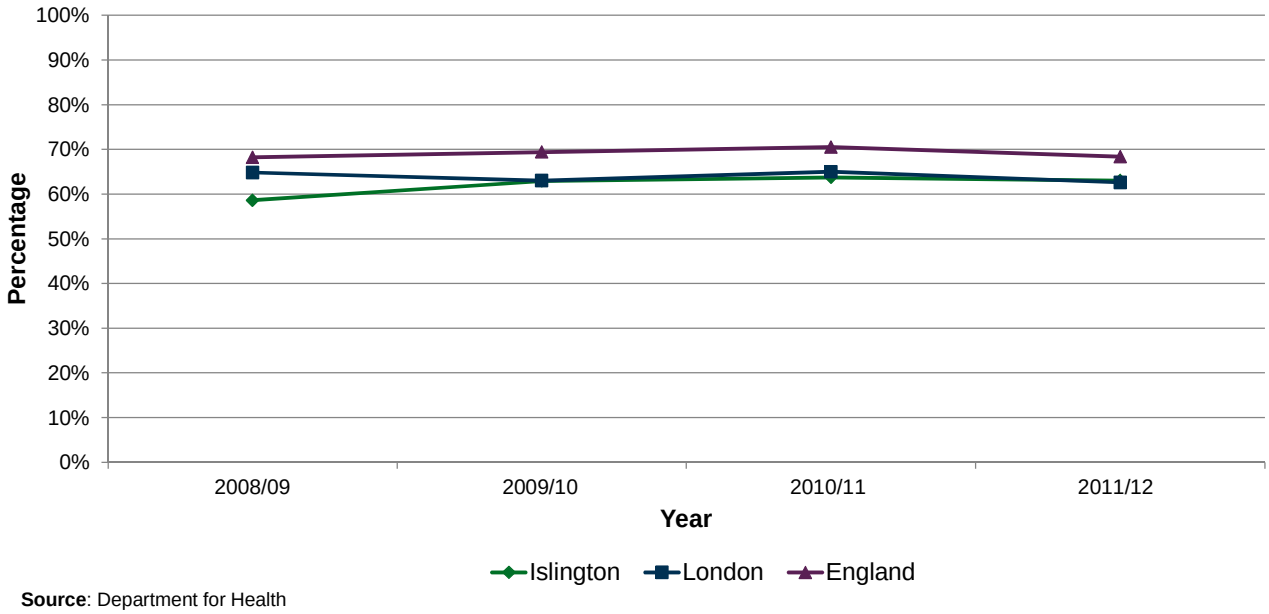
3.03xiii - PPV vaccination coverage

Percentage of people receiving a PPV vaccination, Islington and similarly deprived boroughs compared against the England average, all persons, 65 years old and over, 2011/12



Source: Department of Health (DH) and Health Protection Agency (HPA)

Percentage of people who have received a single dose of the PPV, aged 65 and over, Islington, London and England, 2008/09 to 2011/12



Source: Department for Health

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of adults aged 65 years and over who have received one dose of PPV.

Denominator: Number of adults aged 65 years and over.

3.03 - Population vaccination coverage - adult immunisations

3.03 - Flu vaccination coverage

Rationale from DH Technical Specification, 2013

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Achieving high population coverage is closely associated with significant reductions in disease. Flu (also known as influenza) is a highly infectious illness caused by the flu virus. It spreads rapidly through small droplets coughed or sneezed into the air by an infected person. Studies have shown that flu vaccines provide effective protection against the flu. The flu vaccination is offered to people in at-risk groups such as pregnant women, people with medical conditions and elderly people. These people are at greater risk of developing serious complications, such as bronchitis and pneumonia if they catch flu.

The Islington picture

In 2012/13, 74% of Islington's over 65s received the flu vaccination, leaving 5,182 unvaccinated and susceptible to flu, just below the Department of Health's target for 75% vaccination uptake. Between 2004/05 and 2012/13, flu vaccination uptake for those aged 65 and over in Islington increased by about 10%. Uptake in Islington is now similar to the England average.

The winter of 2011/12 saw some of the lowest GP consultation rates for flu like illness on record, but influenza remains highly unpredictable and warrants continuing efforts to increase flu vaccine uptake.

While uptake rates have been increasing, In 2012/13, 53% of people aged under 65 who had a clinical risk (e.g. asthma) were vaccinated against flu in Islington, which was below the national target of 60%. However, uptake exceeded the England average of 52%. A further 9,696 people aged under 65 with a clinical risk did not receive vaccination that year.

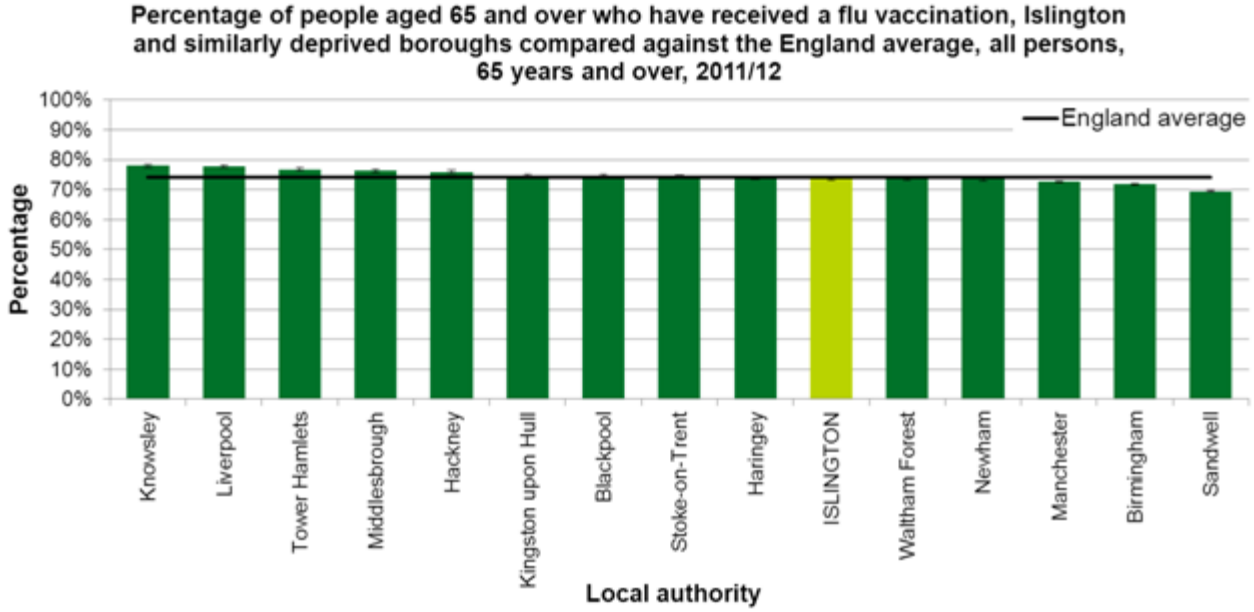
Targets

For those 65 years of age and over, the Department of Health's target is to achieve 75% uptake of flu vaccine.

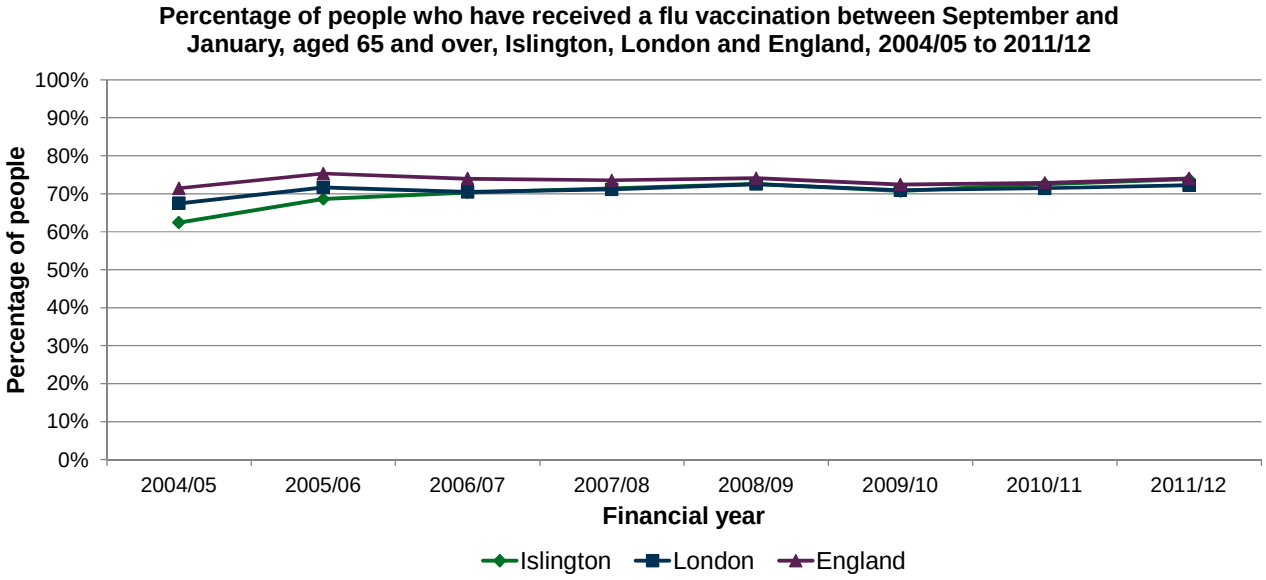
For those at risk between the ages of 6 months and 64 years, the Department of Health's target is a 60% uptake of flu vaccine.

3.03 - Population vaccination coverage - adult immunisations

3.03xiv The Islington picture - Flu vaccination coverage (aged 65+)



Source: Department of Health (DH) and Health Protection Agency (HPA)



Source: Department for Health

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

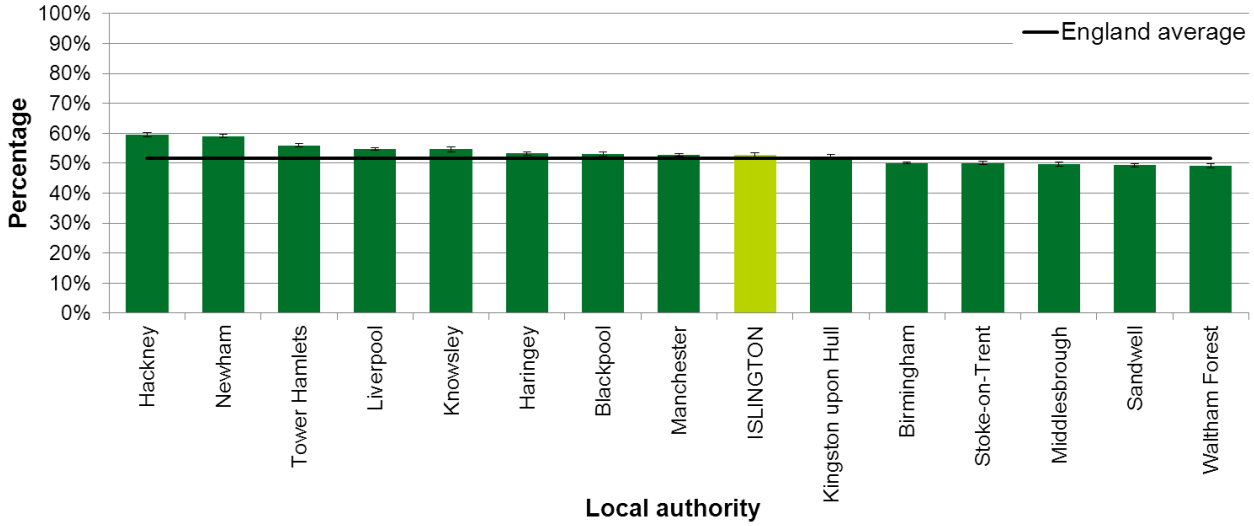
Numerator: Number of adults aged 65 years and over vaccinated between 1st September 2011 and 31st January 2012 of the financial year. Numerator counts for local authorities are estimated from counts for PCTs.

Denominator: Number of adults aged 65 years and over. Denominators for local authorities are estimated from denominators for PCTs.

3.03 - Population vaccination coverage - adult immunisations

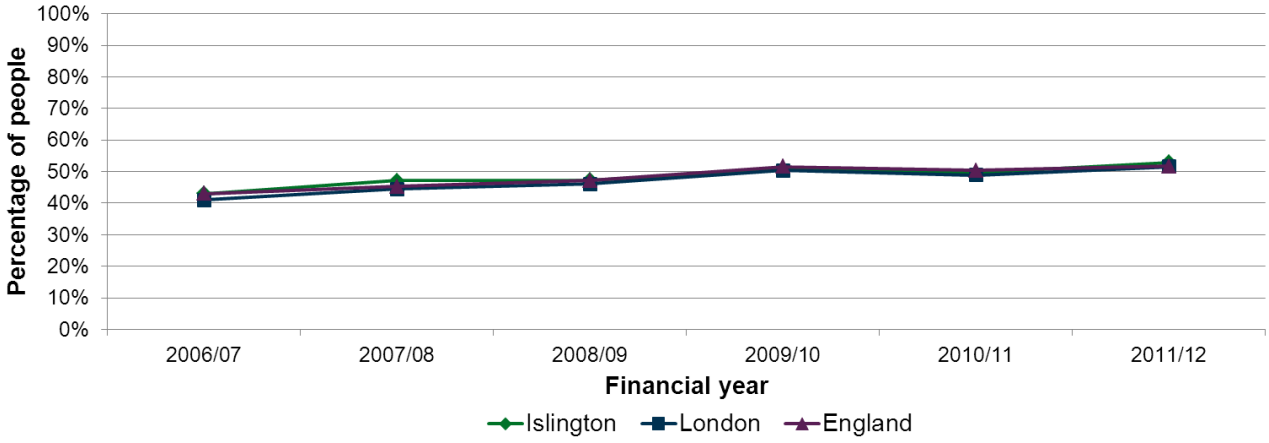
3.03xv - Flu vaccination coverage - people at risk

Percentage of at risk people who have received a flu vaccination, Islington and similarly deprived boroughs compared against the England average, all persons, 6 months-64 years, 2011/12



Source: Department of Health (DH) and Health Protection Agency (HPA)

Percentage of at risk people who have received a flu vaccination between September and January, aged 6 months to 64 years, Islington, London and England, 2006/07 to 2011/12



Source: Department for Health

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of individuals aged between six months and 65 years who are in a clinical risk group vaccinated between 1st September 2011 and 31st January 2012 of the financial year.

Denominator: Number of individuals aged between six months and 65 years who are in a clinical risk group. Denominators for local authorities are estimated from denominators for PCTs.

3.03 - Population vaccination coverage - adult immunisations

Equalities and health inequalities

The elderly are at lower risk of contracting flu as they may have been exposed to the virus earlier in life, however they have a greater risk of the severe complications of flu infection such as pneumonia, because they often have underlying diseases, which reduce their resistance to infection. The immune response may also be less effective in older people.

The groups at greater risk of complications include individuals who have existing respiratory, cardiac, renal, liver, neurological disease, who are insulin dependent diabetics or whose immune systems make them more vulnerable to flu and more likely to suffer severe illness.

Vaccination is also recommended for those living in long-stay residential homes or other long-stay facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality.

Variation by ethnicity: over 60% of the ‘unknown’ ethnicity category were unvaccinated for flu; this is higher than other ethnic groups, and the Islington total.

Analysis by long term condition showed that those with serious mental illness were significantly less likely to have had a flu vaccination than patients with other conditions. There was minimal variation between other conditions.

Key programmes in Islington

The local NHS proactively runs a flu vaccination campaign every year between October and March, when the vaccination becomes available, to offer flu jabs to people aged over 65 years and those in risk groups (which include people with particular long term condition, e.g. asthma, and their carers). All GP practices in Islington invite those aged over 65 years to have a flu vaccination at the surgery and they will proactively contact people who do not initially take up the offer of a jab. For patients who are housebound or who live in care homes, district nurses from Whittington Health are commissioned to visit them and provide flu vaccinations in their home.

To help support local areas to increase the uptake of the flu jab, the Department of Health will often run a national campaign to encourage people to get the flu jab. The flu virus changes from year to year and so, in contrast to other vaccines, the vaccination needs to be administered every year as the vaccine changes every year.

Pneumococcal disease is more prevalent in winter than at other times of year. PPV vaccine should be given once to those aged over 65 and to those at clinical risk. It is safe to administer the PPV vaccine at the same time as the annual influenza jab.

Further information

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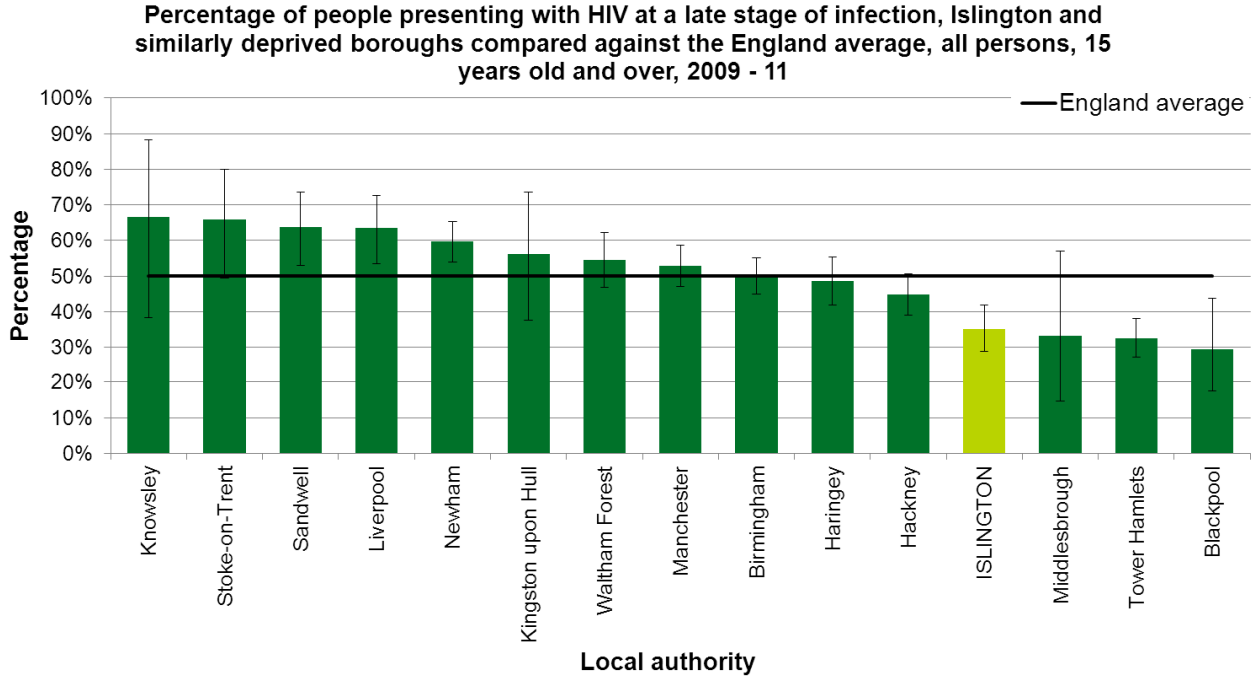
3.04 - People presenting with HIV at a late stage of infection

Rationale from DH Technical Specification, 2013

The late HIV diagnosis indicator is essential to evaluate and promote public health and prevention efforts to tackle the impact of HIV infection. Over half of patients newly diagnosed in the UK are diagnosed late and 90% of deaths among HIV positive individuals within one year of diagnosis are among those diagnosed late. Inclusion of this indicator in the Public Health Outcomes Framework will focus efforts to expand HIV testing and to reduce late HIV diagnoses in the UK. Without a reduction in late HIV diagnosis, consequences may include: continued high levels of short-term mortality in those diagnosed late, poor prognosis for individuals diagnosed late, onward transmission of HIV and higher healthcare costs.

The Islington picture



Source: HIV & STI Department, Centre for Infectious Disease Surveillance & Control, Health Protection Agency

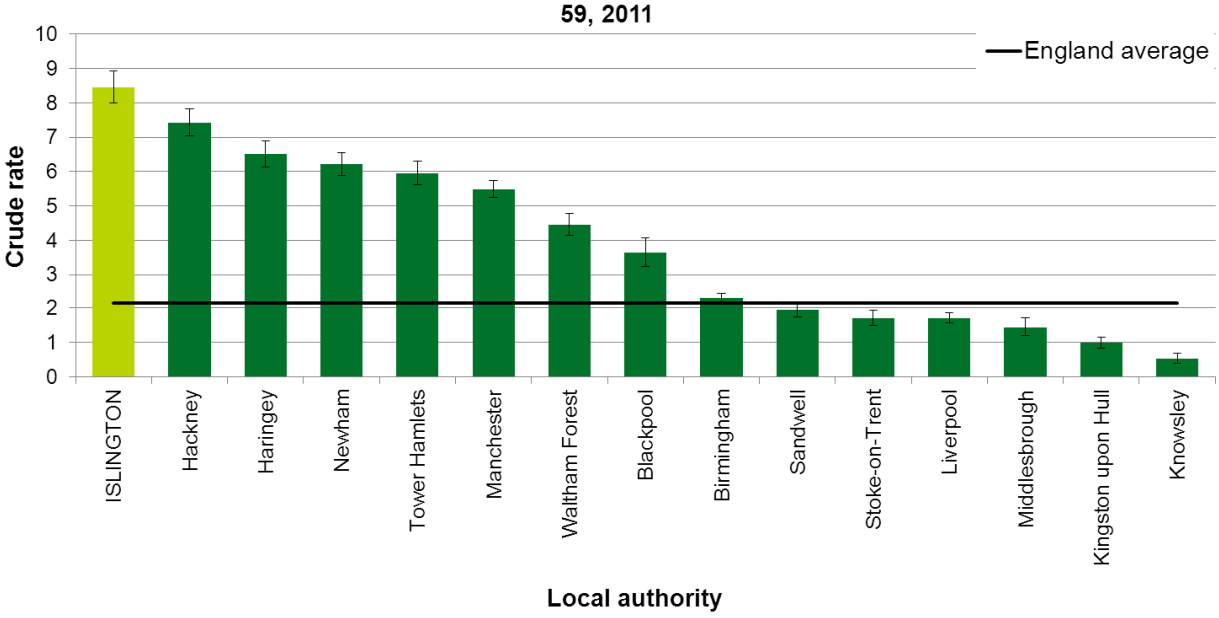
During 2009-11, 35% of Islington residents diagnosed with HIV, were diagnosed late in the course of their infection (measured by an important indicator of immune function; CD4 <350 cells/ mm^3 within three months of diagnosis). Earlier diagnosis is associated with improved outcomes and helps to prevent onward HIV transmission. The Islington rate is significantly lower than the England average (50%). Although not statistically significantly different, when compared to similar London boroughs, Tower Hamlets has a lower proportion (32%), whilst Hackney and Haringey have a higher proportion (45% and 49%, respectively) of residents diagnosed at a late stage of infection. Waltham Forest and Newham have statistically significantly higher rates than Islington.

Overall, Islington had the 4th lowest proportion of late diagnosis in London. In 2011, Islington had the seventh highest rate of HIV infection in London. This equates to 1,266 people (aged 15-59 years) living with diagnosed HIV infection and a diagnosed prevalence of 8.45 per 1,000 population.

3.04 - People presenting with HIV at a late stage of infection

There are likely to be several reasons for this: i) better treatment has dramatically improved survival, so people are living for much longer; ii) increases in HIV testing have meant that more of those infected with HIV are diagnosed (and in turn less are living with undiagnosed HIV infection); iii) there are continuing high rates of HIV transmission among men who have sex with men (MSM) in the UK resulting in new HIV infections; iv) the UK has strong historical links with parts of the world which have generalised HIV epidemics (e.g. sub-Saharan Africa) or increasing rates (e.g. Caribbean), with HIV prevalence among African and Caribbean communities in the UK reflecting these links. There is also evidence of increasing transmission among black African communities within the UK.

Crude rate of people accessing care for HIV infection, Islington and similarly deprived boroughs compared against the England average, per 1,000 residents, people aged 15-59, 2011



Source: SOPHID

Equalities and health inequalities

National level findings can help to understand general patterns. The highest rates of HIV prevalence are reported among MSM and the black African community. There is continued MSM transmission, with recent evidence of an increase in new infections.

Exposure group: In 2011, 64% of heterosexual men and 56% of women (likely to have greater engagement with health services, e.g. antenatal services offering routine HIV testing) were diagnosed late compared to 35% of MSM. Fifty-two percent of people who inject with drugs received a late HIV diagnosis, although this group now accounts for a relatively low proportion of new diagnoses.

Nearly a quarter (24%) of people living with HIV in the UK in 2011 were unaware of their infection. Amongst non-African born heterosexuals, is it estimated that nearly a third of those with an HIV infection may be undiagnosed.

Over half of the heterosexual men and women diagnosed in 2011 probably acquired their HIV infection in the UK, compared to 27% in 2002.

3.04 - People presenting with HIV at a late stage of infection

Key programmes in Islington

Islington is part of the pan-London HIV prevention programme which runs a number of different initiatives to reduce transmission of HIV and to encourage people who may be at risk of infection to have an HIV test, as well as commissioning local services. There is a specific focus on black African and MSM communities as they are most affected by HIV in Islington and London. Initiatives include:

- Raising awareness of HIV and the need for safe sex through media campaigns
- Providing information and advice to people about HIV
- Condom distribution
- Encouraging and supporting people to go for voluntary, confidential HIV testing
- Training people to be sexual health trainers and developing community organisations to promote good sexual health.

The NHS also provides services to help diagnose HIV infections earlier through: provision of open access, confidential, genito-urinary medicine (GUM) services so that people can be tested easily in a clinic of their choice, and which promote HIV testing; offering routine testing for HIV among pregnant women at time of antenatal booking, which will also mean that steps can be put in place to reduce mother-to-child transmission at birth.

Targets

There are no set targets for this indicator.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of adults (aged 15 years or more) newly diagnosed with HIV infection between 2009 and 2011 with CD4 counts available within 91 days and indicating a count of less than 350 cells per mm3

Denominator: Number of adults (aged 15 years or more) newly diagnosed with HIV infection between 2009 and 2011 with CD4 counts available within 91 days.

Further information

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3.05 - Treatment completion for TB

Rationale from DH Technical Specification, 2013

TB re-emerged as a serious public health problem in the UK over the last three decades, with TB incidence rising above the European average. Timely and fully completed treatment for TB is key to saving lives and preventing long-term ill health, as well as reducing the number of new infections and development of drug resistance. Dropping out of treatment before it is completed can contribute to drug-resistant TB, and preventing the development of drug resistant TB is particularly important as it has more severe health consequences and is considerably more difficult and expensive to treat.

The Islington picture - Treatment completion for tuberculosis

Islington's proportion of those in treatment who complete treatment of 83% compares well with the England rate of 84%.

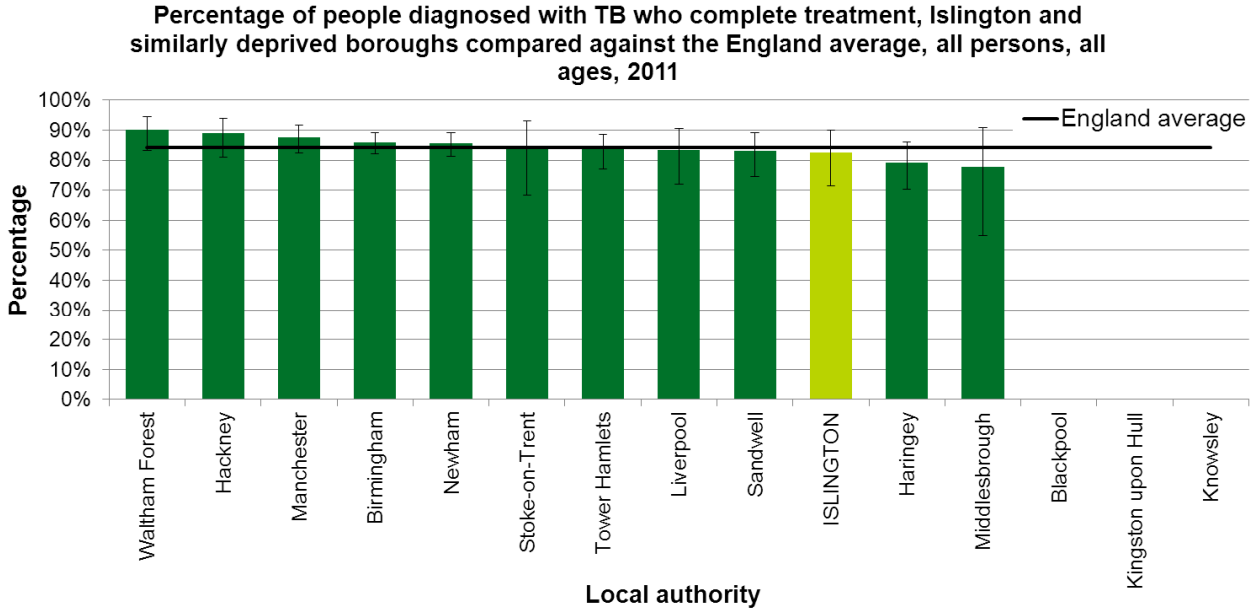
Treatment for TB involves taking more than one antibiotic for a period of six months. Ensuring adherence and completion of the treatment has a number of challenges. Often people do not feel unwell while treatment is continuing and it may be difficult to motivate them to complete their treatment programme. Some patients have difficult and sometimes chaotic lifestyles. They may be moved from place to place for housing, or as a prisoner, and miss appointments and be difficult to find for follow up.

Equalities and health inequalities

- TB rates are higher in some BME communities.
- Nationally, there are much higher rates of TB in prisoners. The two prisons in Islington both have active case finding programmes. Prisoners are often moved form prison to prison after court hearings and it can be difficult to follow them up and ensure that treatment is continued. If they are released during treatment it may be difficult to motivate them to complete treatment or to find them to ensure follow-up.
- The risk of developing TB is increased in people with HIV infection.
- There are higher rates of TB in those who are in overcrowded housing or who are homeless. People with TB who are homeless are often offered DOT [directly observed treatment] so that they can be supported through treatment and adherence can be monitored
- Injecting drug use and chaotic lifestyles are also associated with increased rates of TB, these patients are also supported by DOT.

3.05i - Treatment completion for TB

The Islington picture - Treatment completion for tuberculosis



Source: Health Protection Agency (HPA)

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: The number of people completing treatment for tuberculosis within 12 months of case notification. Count data for local authority areas is not public to prevent patient identification.

Denominator: The number of people with TB whose case was notified the previous year.

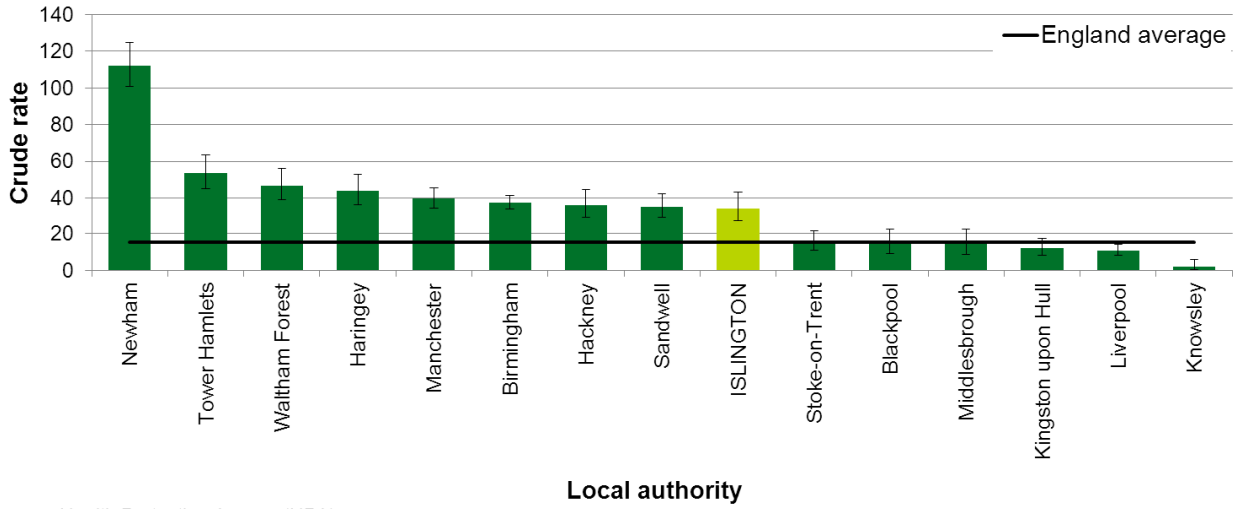
3.05ii - Treatment completion for TB - TB incidence

The Islington picture - TB incidence

The incidence (new cases) of TB in Islington is 34.4 per 100,000 total population, significantly above the values for England of 15.1, but below the London average. The incidence has reduced over the last ten years, particularly since 2007 when a new service was introduced.

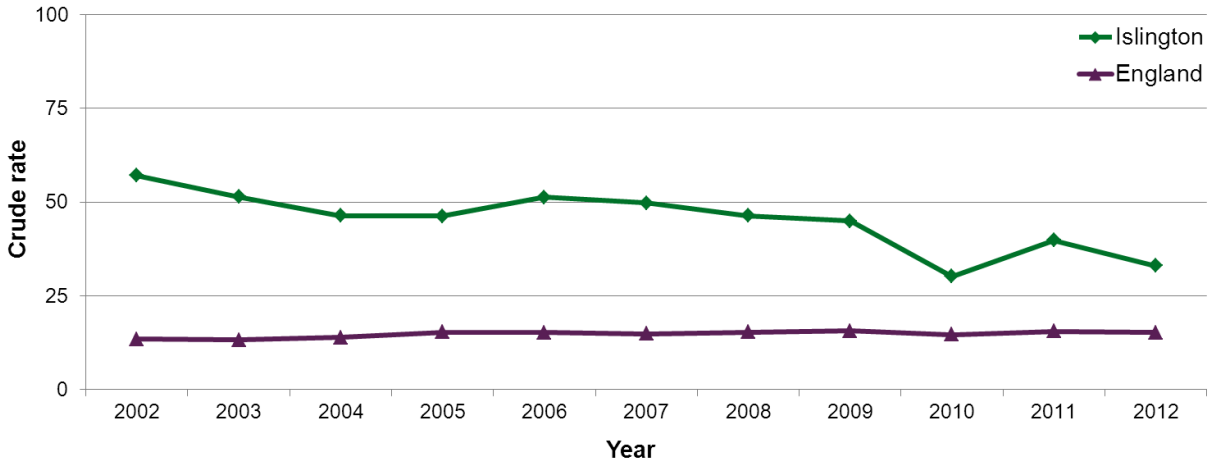
Reasons for higher rates of TB in Islington include the ethnic mix of the population, the two prisons, and other risk factors in the population including higher levels of HIV infection, deprivation, homelessness, and problem drug use.

Crude rate of TB incidence, Islington and similarly deprived boroughs compared against the England average, all persons, all ages, 2010-12



Source: Health Protection Agency (HPA)

Crude rate of tuberculosis incidence, per 100,000 people, Islington and England, 2002-2012



Source: HPA, 2013

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of new cases of TB - three-year rolling average

Denominator: Office for National Statistics mid-year population estimate for the middle year of the three-year rolling average period

3.05 - Treatment completion for TB

Key programmes in Islington

To prevent the spread of TB, the Public Health England infection control team actively follows up the contacts of anyone who has been diagnosed with TB to determine whether they have been infected or not. Babies born to “high risk” mothers (those from areas where TB is very prevalent, e.g. some Asian countries) are also given BCG vaccination to help protect them from being infected with TB.

Most Islington residents with TB are treated at the TB services at the Whittington and UCL Hospitals.

Directly Observed Therapy (DOT): DOT is used for TB patients who have been assessed as likely to default on their treatment and require additional support, or after commencing treatment have found difficulty adhering to it.

TB social care team: This team is part of the multi-disciplinary TB team providing care to vulnerable people with complex health and social care needs, such as homelessness, drug and alcohol dependence, mental health or people who are refugees or asylum seekers. For the homeless this can include ensuring access to stable housing during treatment leading to longer term sustained housing and re-engagement with other services. For hostel dwellers the social care support team ensures TB patients are accessing the full range of available services. The team also helps TB patients with ‘no recourse to public funds’ out of hospital into hostel or Bed and Breakfast accommodation for the duration of their TB treatment and care.

Targets

There are no national or local targets

Further information

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Domain 4: Healthcare public health and preventing premature mortality

Objective: Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

Indicators (indicators which are still being finalised nationally are in italics)

4.01 *Infant mortality*
4.02 *Tooth decay in children aged five*
4.03 Mortality from causes considered preventable
4.04 Mortality from all cardiovascular diseases
4.05 Mortality from cancer
4.06 Mortality from liver disease
4.07 Mortality from respiratory diseases
4.08 Mortality from communicable diseases
4.09 Excess under 75 mortality in adults with serious mental illness
4.10 Suicide
4.11 Emergency readmissions within 30 days of discharge from hospital
4.12 Preventable sight loss
4.13 *Health-related quality of life for older people*
4.14 Hip fractures in over 65s
4.15 *Excess winter deaths*

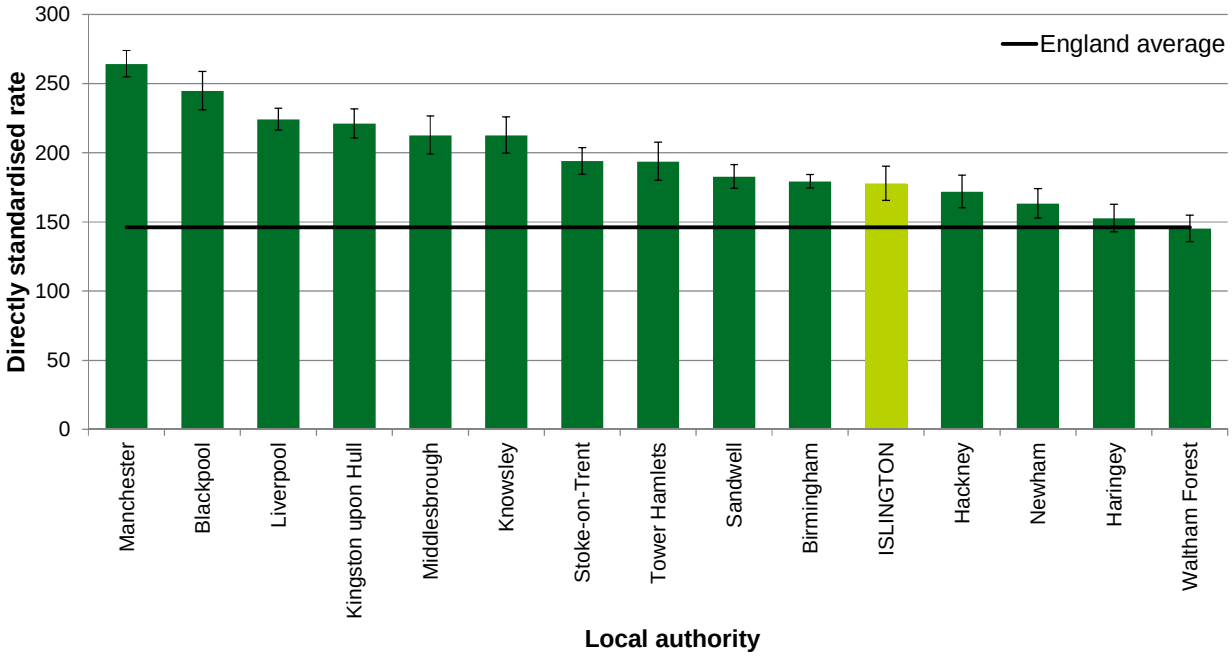
4.03 - Mortality rate from causes considered preventable (provisional)

Rationale from DH Technical Specification, 2013

The basic concept of preventable mortality is that deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense. Preventable mortality overlaps with, but is not the same as 'amenable' mortality, which includes causes of deaths which could potentially be avoided through good quality healthcare. Preventable mortality and amenable mortality are the two components of 'avoidable' mortality, as defined by the Office for National Statistics in April 2012.

The Islington picture

Directly standardised rate of mortality rate from causes considered preventable (provisional), Islington and similarly deprived boroughs compared against the England average, all persons, all ages, 2009 - 11



Source: EMPHO (based on ONS source data)

In Islington, the directly standardised mortality rate from causes considered preventable is 178 per 100,000 people (2009-2011). This is significantly higher than the rate in England (146 per 100,000) but lower than a number of other similarly deprived boroughs from across the country and comparable to other London boroughs that experience similar levels of deprivation.

Mortality from causes considered preventable includes deaths from cardiovascular diseases, respiratory diseases, liver disease, some infectious diseases and some cancers. (For more detail see indicators 4.04, 4.05, 4.06 and 4.07).

Such deaths could be prevented by the adoption of healthy lifestyles, for example, reducing tobacco consumption, alcohol and substance misuse and overweight and obesity; and increasing physical activity, vaccination and screening uptake.

4.03 - Mortality rate from causes considered preventable (provisional)

In Islington, tobacco consumption is the leading cause of deaths considered to be preventable, contributing to 16% of early deaths (under 75) due to long term conditions such as cardiovascular diseases, cancers and respiratory diseases. In 2011, 25% of adults registered with a GP in Islington were smokers.

Overweight and obesity is a risk factor for a number of conditions such as diabetes and high blood pressure, which can lead to early death. Obesity in Islington is thought to contribute to 36% of long term conditions and one in ten early deaths. According to the Islington GP dataset (2012) 28% of adults in Islington are overweight and a further 17% are obese.

Alcohol misuse is also a significant contributor to preventable death. Drinking too much alcohol can lead to a number of long-term conditions, as well as increasing the risk of death from accidents and violent behaviour. Islington has the 6th highest proportion of binge drinkers in London and in 2011/12 there were 1,311 hospital admissions wholly due to alcohol.

Equalities and health inequalities

- Smoking is more prevalent in areas of higher deprivation (28% in the most deprived quintile compared to 20% in least deprived quintile), and therefore deprivation is associated with higher rates of respiratory diseases, cardiovascular diseases and lung cancer.
- As more men smoke than women (30% vs 20%), there are more early deaths due to smoking-related causes in men than in women.
- In 2008-2010 Islington had the highest rate of alcohol-specific deaths among men in London.
- People living in the most deprived areas of Islington (bottom three deprivation quintiles) are 30% more likely to have an alcohol-related hospital admission than those living in more affluent areas (top two deprivation quintiles).
- Obesity is more common in people who live in the most deprived areas of Islington compared to those who live in less deprived parts of the borough. When age is taken into account the rate of obese people in Holloway is 30% higher than the Islington average while the rate in Highbury East is 13% lower than the average.
- Asian and black people are 60% more likely to be obese than the general Islington population. People with learning disabilities are 1.6 times more likely to be obese compared to the Islington average.
- Uptake of the three national cancer screening programmes, which can prevent and detect cancer at an earlier stage, is also lower in people living in the more deprived areas of Islington and lower among some BME groups. Younger women (aged between 25-34) in Islington are significantly less likely to attend their cervical cancer screening appointment than older women.

Targets

There are no set targets for this indicator however preventing and managing long term conditions has been identified as a priority area for the Islington Health and Wellbeing Board. For targets relating to this indicator please see indicators 4.04, 4.05, 4.06 and 4.07 for further details.

4.03 - Mortality rate from causes considered preventable (provisional)

Key programmes in Islington

Universal services

Supporting people to lead healthy lives, and diagnosing long term conditions earlier, will reduce the number of people dying from causes considered preventable.

NHS Stop Smoking Services (SSS) offer support to people wanting to quit smoking. The service is available free of charge in a wide variety of settings. In 2011/12 there were 2,460 quits in Islington and the SSS achieved the second highest quit rate in London.

The NHS Health Checks programme aims to prevent heart disease, stroke, diabetes and kidney disease by identifying those who are at risk of developing these conditions and providing support and advice to help reduce this risk. Health checks are available free, through GPs or in a community setting, to Islington residents aged between 35-74 years who have not been previously diagnosed with one of the conditions. 69% of people who are offered a health check in Islington have one, above the London and England average.

National screening and vaccination programmes aim to protect people from infectious diseases and diagnose conditions, such as cancer, at an early, more treatable stage.

Targeted services

Work is being carried out to reduce the gap between the recorded and expected prevalence of long term conditions. This involves GP practices proactively identifying patients who are at a greater risk of certain conditions, such as cardiovascular diseases. These patients are then followed-up and managed in primary care and referred to lifestyle services as appropriate.

There is a range of services aimed at reducing the harm caused by alcohol. Islington offers online Identification and Brief Advice, supported by alcohol health promotion in the community. There is a single point of access to the Islington Community Alcohol Service, and services are easily accessible by drop-in or referral.

A free weight management programme for people aged 18+ with a BMI ≥30 (or ≥27.5 for South Asian people), and BMI ≥25 with a co-morbidity, aims to support patients to lose 5-10% of their weight over 12 weeks, and maintain this weight loss. A structured exercise on referral scheme is also available to support people with certain conditions to increase their physical activity.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of deaths that are considered preventable (classified by underlying cause of death) registered in the respective calendar years, aggregated into quinary age bands.

Denominator: Population-years (ONS mid-year population estimates for 2011 multiplied by 3 - see Caveats in DH Technical Spec) for people of all ages, aggregated into quinary age bands.

Further information

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4.04 - Under 75 mortality from cardiovascular diseases (provisional)

Rationale from DH Technical Specification, 2013

Cardiovascular disease (CVD) is one of the major causes of death in under 75s in England. There have been huge gains over the past decades in terms of better treatment for CVD and improvements in lifestyle, but to ensure that there continues to be a reduction in the rate of premature mortality from CVD, there needs to be concerted action in both prevention and treatment.

The Islington picture - under 75 mortality from all cardiovascular diseases

CVD is the second major cause of early death (death before the age of 75) in Islington after cancer. There were 120 early deaths from CVD each year in Islington (2009-11). The early CVD death rate in Islington is similar to other boroughs with comparable deprivation levels.

Most of the early deaths from CVD in Islington are due to coronary heart disease (CHD), followed by stroke and heart failure. An audit of early CVD deaths by Islington GP practices in 2007 showed that at that time, 43% of people who died from CVD before age 75 had not been previously diagnosed by their GP. This highlights the importance of finding people with undiagnosed CVD so that they can be given appropriate treatment and support to change their lifestyle to reduce their risk of early death.

The early CVD death rate in general has been falling during the last few decades, both in England as a whole and in Islington. Between 1999-2001 and 2007-2009, the Islington early death rate was not reduced much as the rest of England. This means the inequalities gap in CVD mortality between Islington and England has widen.

However, since 2007-2009, the Islington CVD early death rate 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.

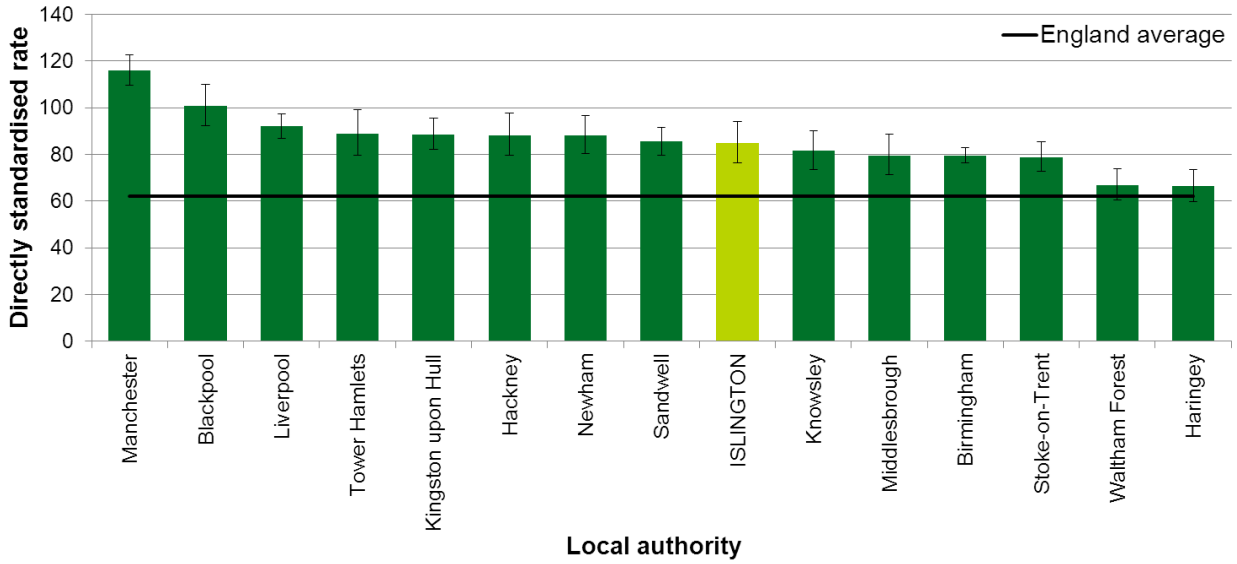
Equalities and health inequalities

- Both Islington men and women have higher early death rates from CVD compared to the regional and national average, however, the rate is higher in men with substantially more men dying young from CVD.
- As would be expected, the early death rate from CVD increases with age, with a large number of ‘excess’ deaths in men aged 65-75 years compared to patterns of death in England.
- Ethnicity data are not collected on death certificates, but analysis by country of birth suggests that among Islington’s population, people born in Cyprus, Ireland, Jamaica, and Bangladesh have higher than average crude early death rates from CVD.
- Early CVD death rates are higher in more deprived populations, which reflects a number of different lifestyle factors including for example, higher rates of smoking amongst more deprived people, as well as other factors.

4.04i - Under 75 mortality rate from all cardiovascular diseases (provisional)

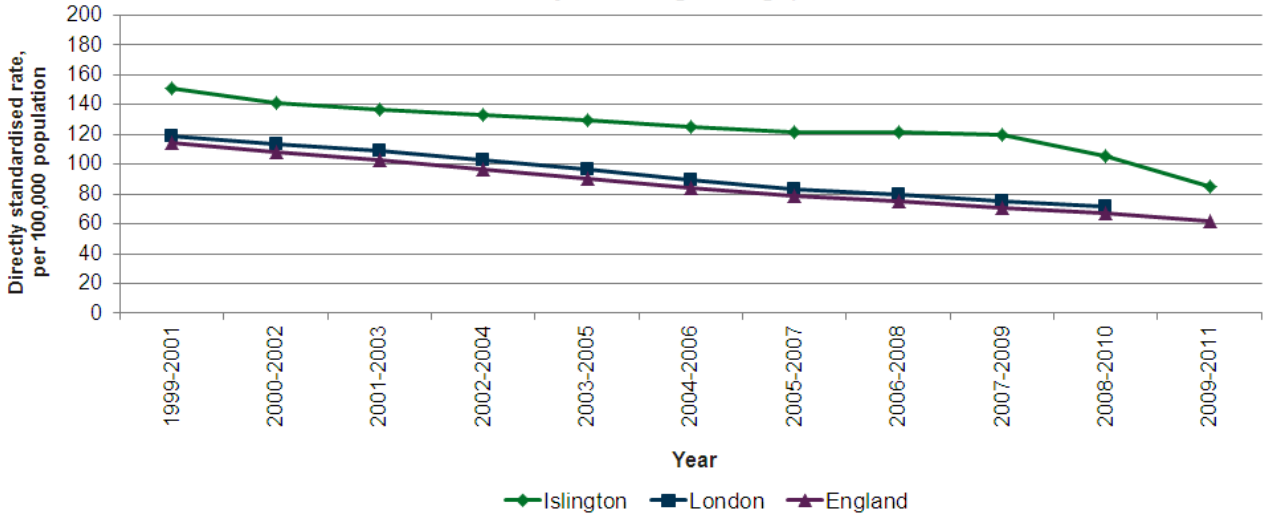
The Islington picture - under 75 mortality from all cardiovascular diseases

Directly standardised rate of under 75 mortality from all cardiovascular diseases (provisional), Islington and similarly deprived boroughs compared against the England average, all persons, under 75 years old, 2009 - 11



Source: EMPHO (based on ONS source data)

Age-standardised rate of mortality from cardiovascular diseases per 100,000 population in under 75s, Islington, London and England, 1999-2001 to 2009-11 (three year rolling average)



Source: NCHOD, 2012; EMPHO, 2013 (for 2009-11 data).

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of deaths from all cardiovascular diseases registered in the respective calendar years, in people aged under 75, aggregated into quinary age bands (0-4, 5-9,…, 70-74).

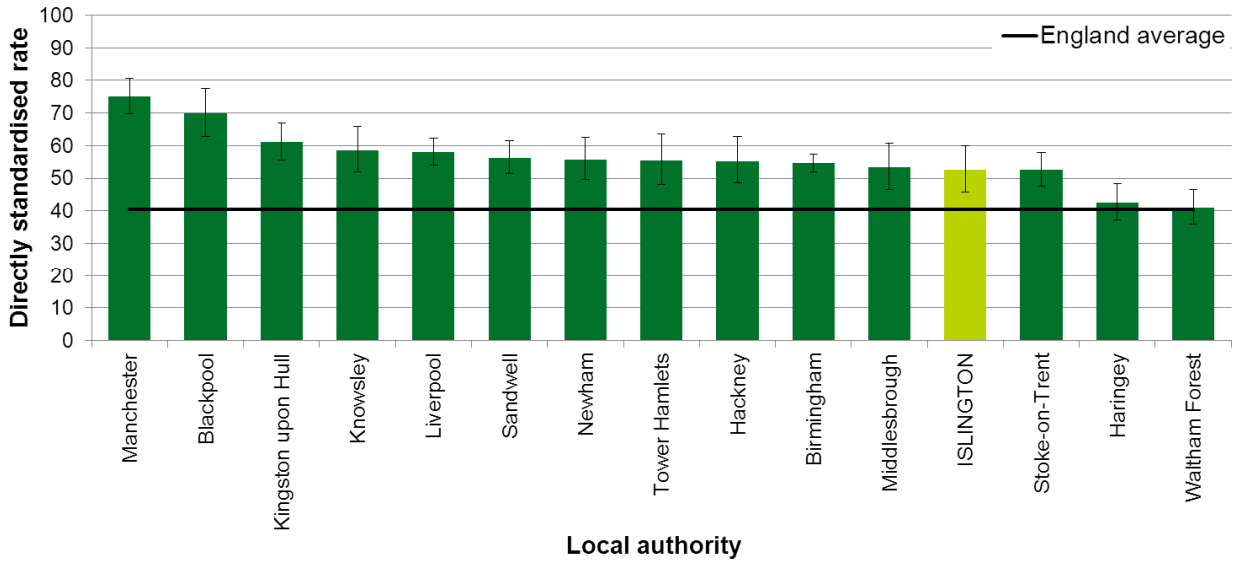
Denominator: Population-years (ONS mid-year population estimates for 2011 multiplied by 3 - see Caveats in DH Technical Spec) for people aged under 75, aggregated into quinary age bands (0-4, 5-9,…, 70-74).

4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (provisional)

The Islington picture - under 75 mortality from preventable CVD

Preventable mortality and amenable mortality are the two components of 'avoidable' mortality, as defined by the Office for National Statistics in April 2012. Preventable mortality from all cardiovascular diseases in those under 75 could potentially be avoided by public health interventions. NHS Health Checks is a national programme that aims to identify people at risk of cardiovascular disease and takes steps to prevent them suffering a heart attack or stroke. The graph below shows Islington and most of the deprived boroughs' early death rates from cardiovascular disease are above the England average. This may be linked to high levels of deprivation and a number of lifestyle factors such as lack of exercise, poor diet, obesity and smoking.

Directly standardised rate of under 75 mortality from cardiovascular diseases considered preventable (provisional), Islington and similarly deprived boroughs compared against the England average, all persons, under 75 years old, 2009 - 11



Source: EMPHO (based on ONS source data)

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of deaths that are considered preventable from all cardiovascular diseases registered in the respective calendar years, in people aged under 75, aggregated into quinary age bands (0-4, 5-9,…, 70-74).

Denominator: Population-years (ONS mid-year population estimates for 2011 multiplied by 3 - see Caveats in DH Technical Spec) for people aged under 75, aggregated into quinary age bands (0-4, 5-9,…, 70-74).

4.04 - Under 75 mortality from cardiovascular diseases (provisional)

Key programmes in Islington

Risk reduction in the general population

Lifestyle factors such as smoking, unhealthy diet and physical inactivity, and the consequences of these (obesity, high cholesterol, high blood pressure and diabetes) are all major risk factors for CVD. Supporting people to adopt healthier behaviours, is key to preventing early CVD deaths in the future. There is continued investment in smoking cessation services, particularly focusing on supporting people from key groups to quit, such as those living with long term conditions and people from deprived communities with high levels of smoking (including Bangladeshi, Somali, and Turkish communities).

Primary prevention and early diagnosis in those at high risk of CVD

The NHS Health Checks programme is raising awareness and encouraging diagnosis of vascular conditions such as heart disease, stroke and diabetes in GPs and pharmacies.

There is also a Weight Management Pathway which GPs use to support adults identified as over weight or obese (a key risk factor for diabetes and CVD).

Treatment of those already diagnosed with CVD or an associated condition

GPs can refer people with a range of underlying health conditions, including high blood pressure, to the Exercise on Referral programme. There is support for those who already have long term conditions to better self manage through programmes such as Cardiac Rehabilitation and the Diabetes Education and Self Management or Ongoing and Newly Diagnosed (DESMOND) (diabetes is a key risk factor for CVD).

Emergencies

Specialist heart attack centres at the Royal Free Hospital and University College London Hospital (UCLH) and a hyper-acute stroke unit at UCLH provide specialist emergency care, supported by 24 stroke recovery units at the Royal Free Hospital and National Hospital for Neurology and Neurosurgery. These have noticeably improved health outcomes for people with CVD.

Targets

There are no local or national targets for these indicators.

Further information

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4.05 - Under 75 mortality from cancer (provisional)

Rationale from DH Technical Specification, 2013

Cancer is the highest cause of death in England in under 75s. To ensure that there continues to be a reduction in the rate of premature mortality from cancer, there needs to be concerted action in both prevention and treatment.

The basic concept of preventable mortality is that deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense. Preventable mortality overlaps with, but is not the same as 'amenable' mortality, which includes causes of deaths which could potentially be avoided through good quality healthcare. Preventable mortality and amenable mortality are the two components of 'avoidable' mortality, as defined by the Office for National Statistics in April 2012.

The Islington picture

Cancer is the leading cause of early death (deaths in people under 75 years) in Islington. On average, there were 172 early cancer deaths in Islington each year between 2009-11. The directly standardised premature mortality rate from cancer in Islington is 124 per 100,000 people. This is significantly higher than the rate in England (108 per 100,000 people).

Islington has one of the highest early death rates from cancer in London, but a similar rate to other deprived areas. Most of the early deaths from cancer are due to lung cancer, (there were 26 early deaths per year in men and 17 per year in women in 2008-10 in the borough), followed by bowel cancer (11 early deaths per year in men and four per year in women), then breast cancer (14 early deaths per year in women). Data from 2008-10 are the most recent data available when looking at the numbers of people dying early from different cancer types.

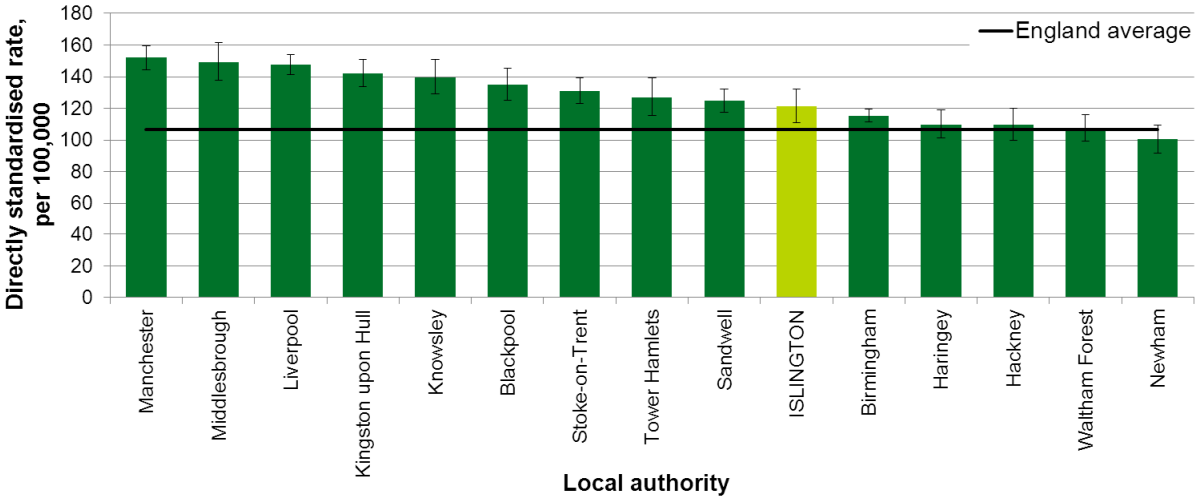
Equalities and health inequalities

- Both Islington men and women have higher premature death rates from cancer compared to London and England averages, however, the rate is higher in men with substantially more men dying young from cancer.
- As would be expected, the premature death rate from cancer increases with age, with a large number of 'excess' deaths in men aged 65-75 years.
- Ethnicity data are not collected on death certificates, but analysis by country of birth suggests that among Islington's population, people born in Ireland have a higher than average crude premature death rate from cancer.

4.05i - Under 75 mortality rate from cancer (provisional)

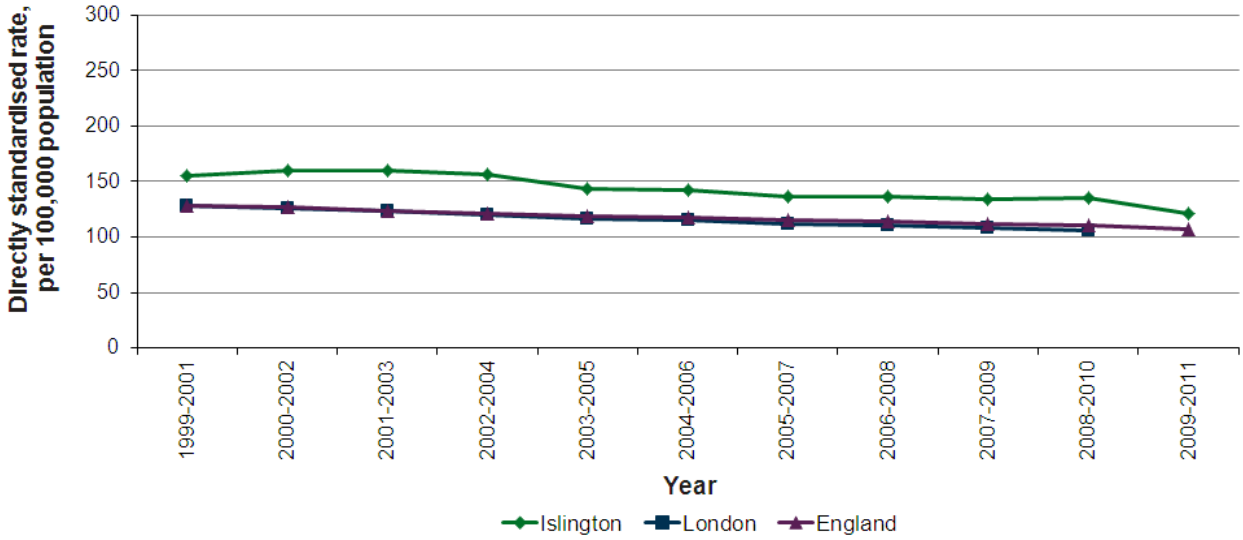
The Islington picture - under 75 mortality from cancer

Directly standardised rate of under 75 mortality from cancer (provisional), Islington and similarly deprived boroughs compared against the England average, all persons, under 75 years, 2009 - 11



Source: EMPHO (based on ONS source data)

Age-standardised rate of mortality from cancer per 100,000 population in under 75s, Islington, London and England, 1999-2001 to 2009-11 (three year rolling average)



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.

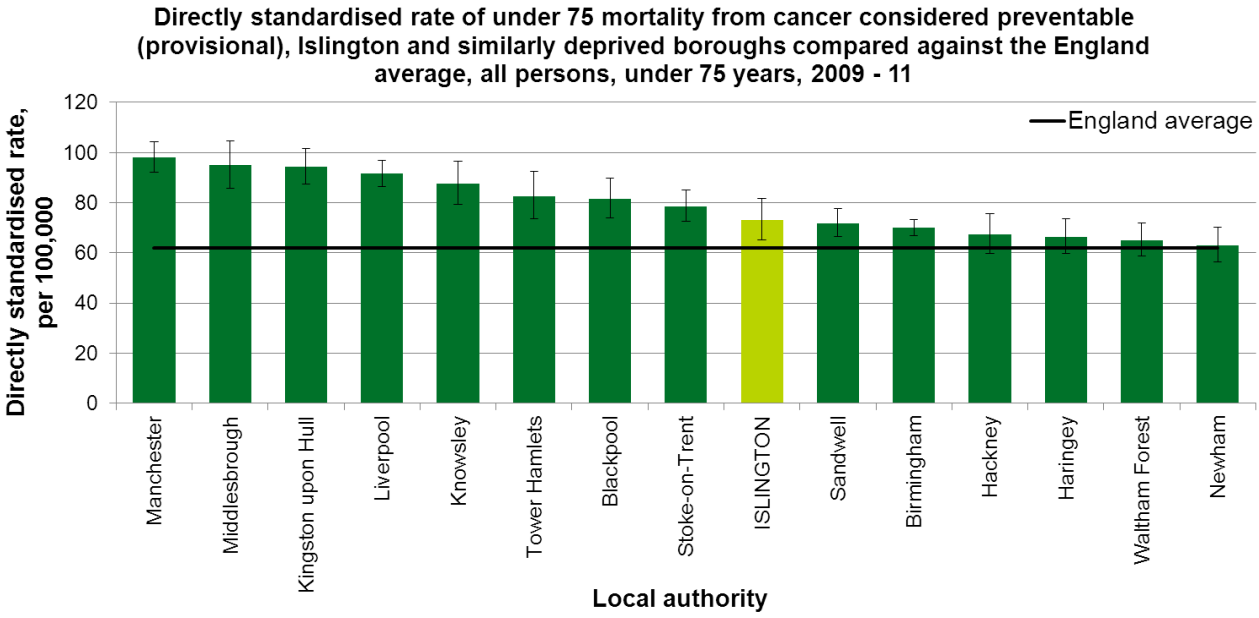
Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of deaths from all cancers (classified by underlying cause of death recorded as ICD codes C00-C97) registered in the respective calendar years, in people aged under 75, aggregated into quinary age bands (0-4, 5-9,…, 70-74).

Denominator: Population-years (ONS mid-year population estimates for 2011 multiplied by 3 - see Caveats in DH Technical Spec) for people aged under 75, aggregated into quinary age bands (0-4, 5-9,…, 70-74).

4.05ii - Under 75 mortality rate from cancer considered preventable (provisional)

The Islington picture - under 75 mortality from preventable cancers



Source: EMPHO (based on ONS source data)

More than four in ten cases of cancer could be prevented by lifestyle changes, such as not smoking, keeping a healthy body weight, cutting back on alcohol, eating a healthy, balanced diet, keeping active, and staying safe in the sun.

The rate of premature mortality from preventable cancers in Islington is 73 per 100,000 people. This is significantly higher than the rate in England which is 62 per 100,000 people. However, Islington has a similar rate of premature preventable mortality from cancer as other similarly deprived boroughs. Mortality from cancers considered preventable includes deaths from cancers of the lung, bowel, breast, skin, stomach and mouth.

Smoking is the largest single cause of cancer. Smoking increases the risk of many cancers, but particularly lung cancer, where the chance of developing cancer is 20 times greater in smokers than non-smokers. The percentage of the adult population that smoke in Islington is 21%.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of deaths that are considered preventable from all cancers registered in the respective calendar years, in people aged under 75, aggregated into quinary age bands (0-4, 5-9, …, 70-74).

Denominator: Population-years (ONS mid-year population estimates for 2011 multiplied by 3 - see Caveats in DH Technical Spec) for people aged under 75, aggregated into quinary age bands (0-4, 5-9,…, 70-74).

4.05ii - Under 75 mortality rate from cancer considered preventable (provisional)

Key programmes in Islington

Risk reduction in the general population

Supporting people to adopt healthier behaviours, particularly to stop smoking, is key to preventing future early cancer deaths. Smoking cessation services are offered in a wide range of settings in Islington (see indicator 2.14). In addition, encouraging people to eat more healthily, reduce their alcohol intake and take more exercise is important for preventing early death from cancer.

Diagnosing people earlier

The earlier cancer is diagnosed the higher the chance of survival. A number of campaigns have taken place in Islington to raise awareness of cancer signs and symptoms and encourage local residents to go to their doctor quickly if they notice a symptom of cancer. This includes the 'Get to know cancer' campaign which ran market stalls in various locations across the borough to raise awareness of cancer and signpost people to their GP if necessary.

A programme of work is also taking place with GPs to increase early cancer referrals in primary care. This two year project involves providing support, information and recourses to practices in order to optimise clinical practice and increase earlier diagnosis.

Cancer screening

Some early deaths from cancer can be prevented through screening programmes. Islington offers screening for breast, bowel and cervical cancers (all national cancer screening programmes), but uptake of screening invitations is lower compared to some other areas, particularly for bowel cancer. An enhanced service is being commissioned from GP practices in Islington to increase bowel cancer screening uptake through the promotion of bowel screening and following up with patients who have not been screened. For more information on other cancer screening initiatives please see indicators 2.20i and 2.20ii.

Targets

There are a number of targets relating to this indicator in the NHS Outcomes Framework:

Reducing premature mortality from the major causes of death; Under 75 mortality from cancer; one and five year survival from all cancers; and one and five year survival from breast, lung and colorectal cancer.

Additionally, the national strategy Improving Outcomes: A strategy for cancer (2011) sets out an aim to save 5000 lives from cancer in the UK each year by 2015.

Further information

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4.06 - Under 75 mortality from liver disease

Rationale from DH Technical Specification, 2013

Liver disease is one of the top causes of death in England and people are dying from it at younger ages. Most liver disease is preventable and much is influenced by alcohol consumption and obesity prevalence, which are both amenable to public health interventions.

The basic concept of preventable mortality is that deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense. Preventable mortality overlaps with, but is not the same as 'amenable' mortality, which includes causes of deaths which could potentially be avoided through good quality healthcare. Preventable mortality and amenable mortality are the two components of 'avoidable' mortality, as defined by the Office for National Statistics in April 2012.

The Islington picture - under 75 mortality from liver disease

In 2009-2011, there were on average 97 under 75s early deaths in Islington attributable to chronic liver disease, equivalent to a directly standardised mortality rate of 22 per 100,000 population in Islington. This figure is significantly higher compared against the England average.

Since 2001-2003, the death rate from liver disease in Islington has remained consistently higher than both London and England.

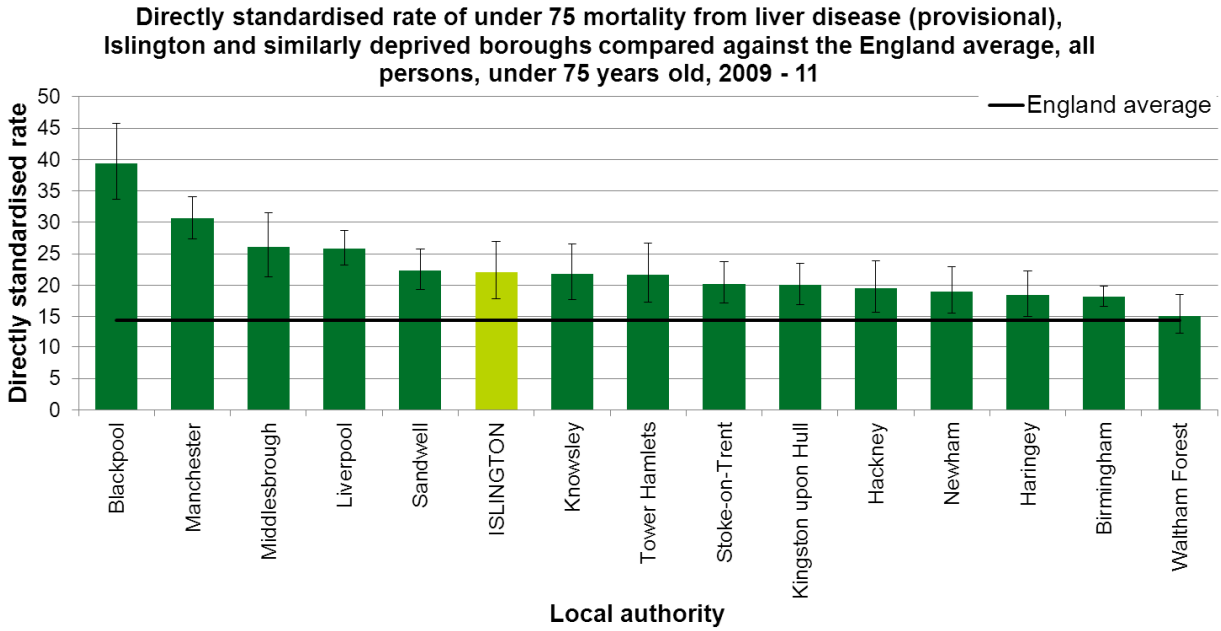
Harmful alcohol consumption (drinking over the recommended levels on a weekly basis, and experiencing harm as a result) contributes to the risk of developing liver disease. Both men and women who are drinking alcohol over the recommended limits are 13 times at increased risk of developing liver disease. Liver mortality is closely associated with an increase consumption of alcohol by individuals. In 2009 there were 6,584 deaths in England related to alcohol consumption. Of these alcohol-related deaths, 63% (4,154) died from alcohol related liver disease.

Hepatitis is a group of blood-borne viruses and persistent infection can lead to chronic liver disease. Hepatitis C is the most prevalent form of the virus. Islington has the second highest estimated prevalence of Hepatitis C (after Camden) and significantly higher than London.

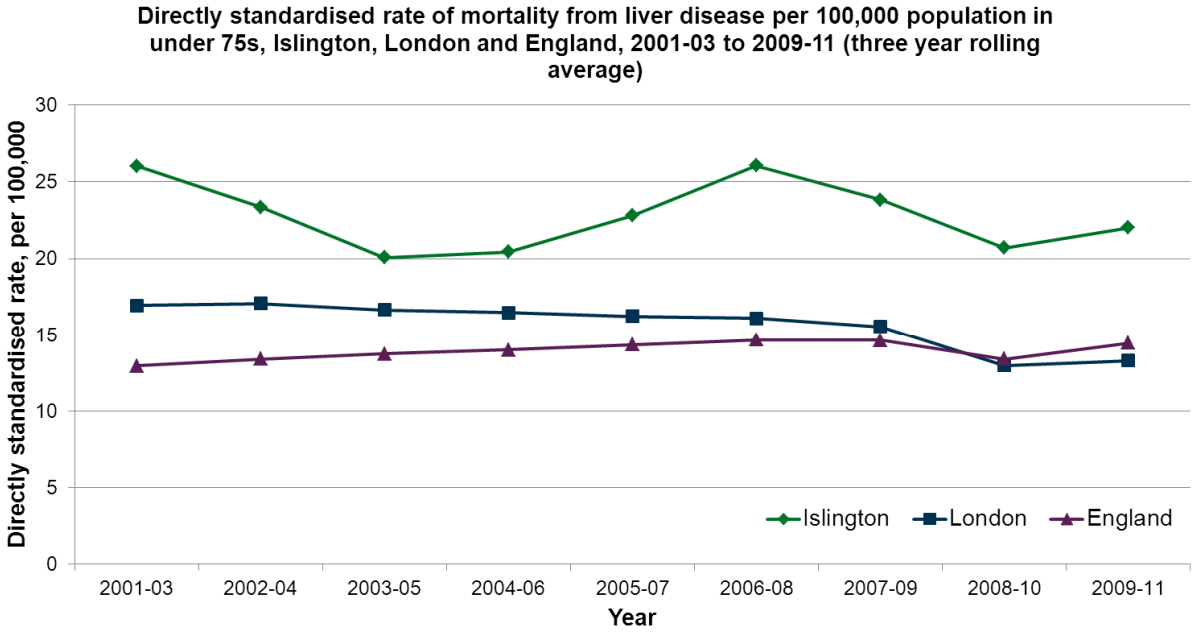
Obesity is also closely related to liver disease and its associated condition of high blood pressure. 67,300 adults registered with Islington GPs are classified as overweight or obese.

4.06i - Under 75 mortality rate from liver disease (provisional)

The Islington picture - under 75 mortality from liver disease



Source: EMPHO (based on ONS source data)



Source: ONS, 2012

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of deaths from liver disease registered in the respective calendar years, in people aged under 75, aggregated into quinary age bands (0-4, 5-9,…, 70-74).

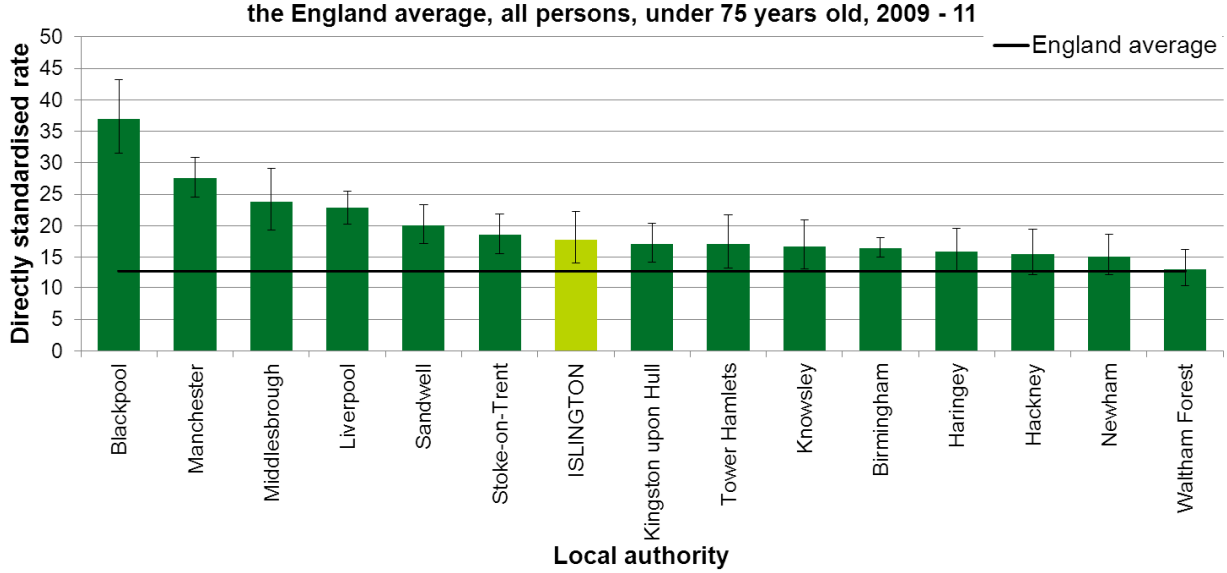
Denominator: Population-years (ONS mid-year population estimates for 2011 multiplied by 3 - see Caveats in DH Technical Spec) for people aged under 75, aggregated into quinary age bands (0-4, 5-9,…, 70-74).

4.06ii - Under 75 mortality rate from liver disease considered preventable (provisional)

The Islington picture - under 75 mortality from liver disease, preventable

In 2009-2011 there were 51 early deaths from liver in Islington which are considered to be preventable. This figure is higher than the England average. Compared to other deprived boroughs, Islington's rate of preventable early deaths from liver disease is significant lower than Blackpool and Manchester.

Directly standardised rate of under 75 mortality from liver disease considered preventable (provisional), Islington and similarly deprived boroughs compared against the England average, all persons, under 75 years old, 2009 - 11



Source: EMPHO (based on ONS source data)

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of deaths that are considered preventable from liver disease registered in the respective calendar years, in people aged under 75, aggregated into quinary age bands (0-4, 5-9, …, 70-74).

Denominator: Population-years (ONS mid-year population estimates for 2011 multiplied by 3 - see Caveats in DH Technical Spec) for people aged under 75, aggregated into quinary age bands (0-4, 5-9,…, 70-74).

Equalities and health inequalities

- Liver mortality rates is higher for men in Islington. This may be due to the higher alcohol prevalence observed in men. This figure is highest when compared to London boroughs and significantly worse than England
- Both men and women have similar percentages of hospital admission due to alcohol liver disease (this equates to a total of 13%)
- There are no local ethnicity data for Hepatitis. However, people from high prevalence countries (such as Brazil, China, Ghana and Nigeria) are at high risk of Hepatitis C.
- Also, there is a very high prevalence of chronic liver disease (probably due to infection in childhood of Hepatitis B), among Asian communities.

4.06 - Under 75 mortality rate from liver disease (provisional)

Key programmes in Islington

Lifestyle and prevention

Supporting people to adopt healthy behaviours, particularly to reduce the levels of alcohol, is key to preventing future liver diseases and deaths. Islington Community Alcohol Service offers a range of services to individuals, families and friends concerned about their own or another's level of drinking.

In addition, encouraging people to eat more healthily is important in reducing the risk of liver disease in the population. Services and support offered in a wide range of settings in Islington by heath professionals, dieticians and community services.

A new adult weight management service offers a 12 week programme of physical activity and educational sessions. It aims to support patients to lose 5-10% of their body weight over 12 weeks and maintain this weight loss for 12 months, post programme. The programme is designed for those age 18+ with a body mas index (BMI) ≥30 (or ≤27.5 for South Asian people), and BMI ≥25 with a co-morbidity such as Type 2 diabetes, hypertension and cardio vascular disease (CVD).

Diagnosis and management

People with suspected liver disease can be tested in primary care and referred for specialist treatment and management.

Hepatitis testing in Islington currently takes place in drug and alcohol treatment centres, sexual health clinics and GP practices. People from countries with high prevalence are particularly encouraged to be tested. Patients who test positive for Hepatitis are cared for by hospital specialists or GPs or some cases drug and alcohol services.

New guidance is being developed (2013) which may include new awareness campaigns on the dangers of Hepatitis, improved monitoring of the number of infections and proactive testing of patients in high-risk groups.

Targets

There are no targets for this indicator.

Further information

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4.07 - Under 75 mortality from respiratory disease

Rationale from DH Technical Specification, 2013

Respiratory disease is one of the top causes of death in England in under 75s and smoking is the major cause of chronic obstructive pulmonary disease (COPD), one of the major respiratory diseases. This indicator will focus public health attention on the prevention of smoking and other environmental factors that contribute to people getting respiratory disease.

The basic concept of preventable mortality is that deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense.

The Islington picture - under 75 mortality from respiratory disease

In Islington, respiratory diseases are the third largest cause of death, after cardiovascular disease and cancer.

The early death rate from respiratory disease in Islington in under 75s during 2009-2011 is not statistically different from the England rate (23 per 100,000). Compared to other boroughs with high levels of deprivation, Islington has one of the lowest early death rates from respiratory disease (25 per 100,000).

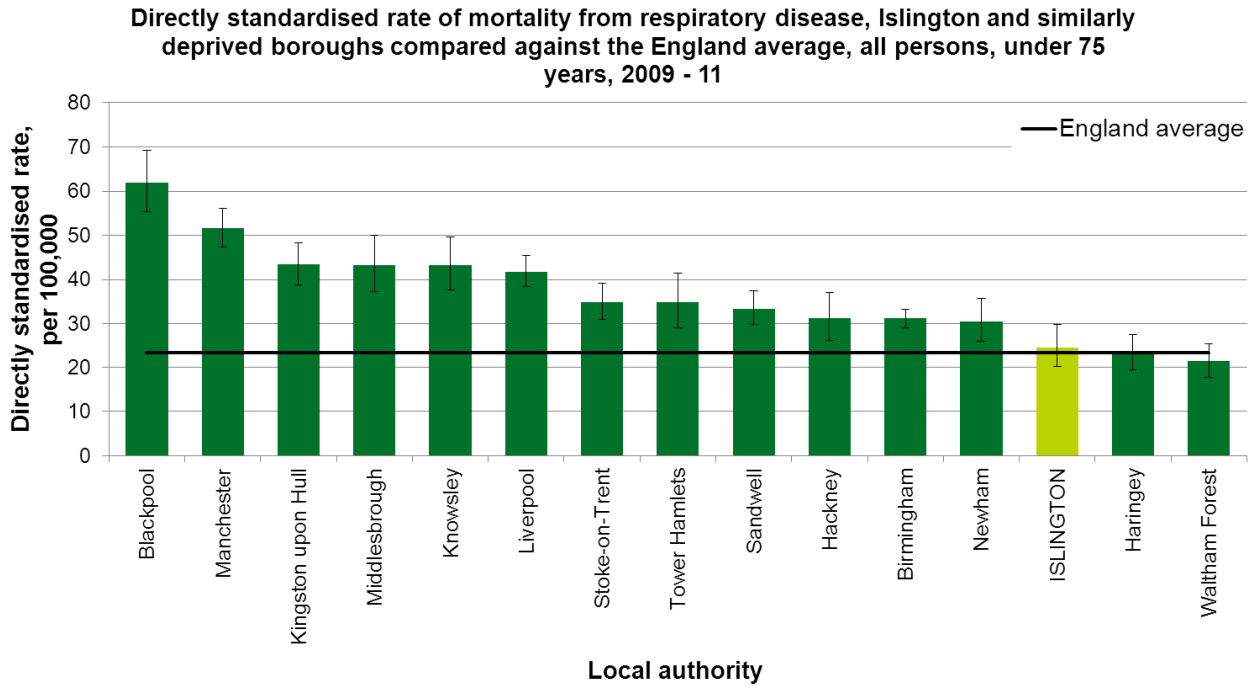
Between 2008-2010, there were 139 early deaths rates from respiratory disease (9% of deaths in those under 75 years). Smoking is considered the leading risk factor and a significant contributor to these deaths. Other causes of respiratory disease deaths include bronchopneumonia and there are a small number of deaths due to asthma.

Among respiratory diseases, chronic obstructive pulmonary disease (COPD) is the leading cause of early death. Compared to England and London, COPD early death rates in under 75s has fallen over the years from 50% in 1995 to 28% in 2010 but with some fluctuations over the time period.

A number of interventions are in place to reduce the prevalence of COPD risk factors i.e. Stop Smoking Services, Smoke Free homes; earlier identification and assessment of patients at risk of COPD; improved medical and lifestyle support for COPD and people with established disease.

4.07i - Under 75 mortality rate from respiratory disease (provisional)

The Islington picture - under 75 mortality from respiratory disease



Source: EMPHO (based on ONS source data)

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of deaths from respiratory diseases (classified by underlying cause of death recorded as ICD codes J00-J99) registered in the respective calendar years, in people aged under 75, aggregated into quinary age bands (0-4, 5-9,…, 70-74).

Denominator: Population-years (ONS mid-year population estimates for 2011 multiplied by 3 - see Caveats) for people aged under 75, aggregated into quinary age bands (0-4, 5-9,…, 70-74).

Equalities and health inequalities

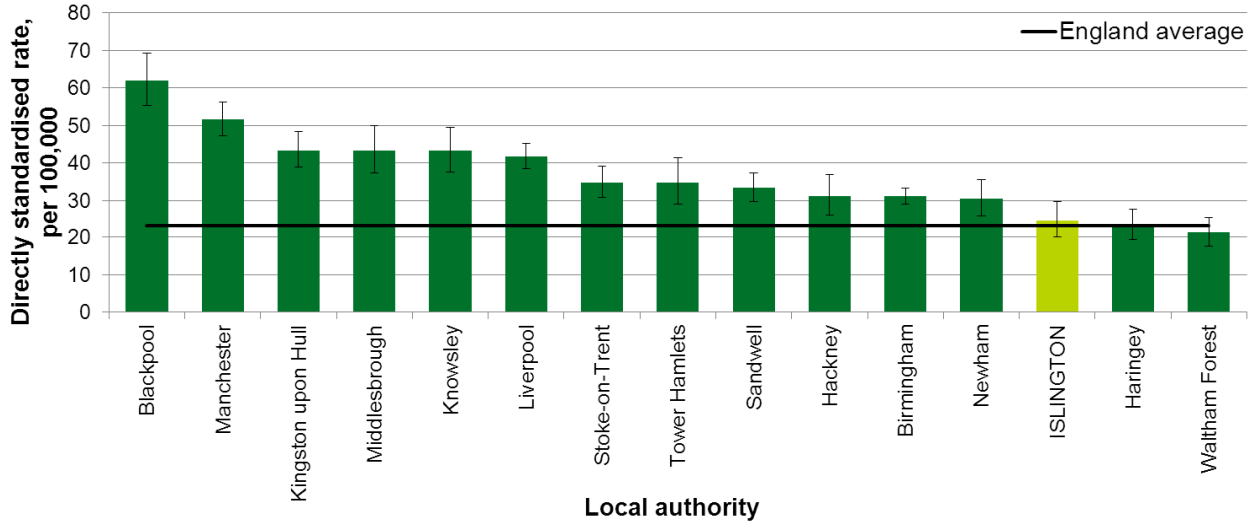
- More early deaths due to respiratory disease are in men (63 % of early deaths) because local figures show that more men smoke.
- As would be expected, the premature death rate from respiratory disease increases with age, with the largest number of ‘excess’ deaths in people aged 65-74 years.
- In Islington, 91% of diagnosed COPD cases are in people from white communities. This is partly due to a higher proportion of people from white communities in older age groups compared to Islington’s general population and to higher rates of smoking in these communities.
- Smoking prevalence is higher in more deprived areas, and so deprivation is associated with higher rates of COPD and respiratory disease.
- Higher levels of air pollution in inner city areas like Islington will also have an impact on respiratory disease deaths.

4.07ii - Under 75 mortality rate from respiratory disease considered preventable (provisional)

The Islington picture - under 75 mortality, preventable respiratory diseases

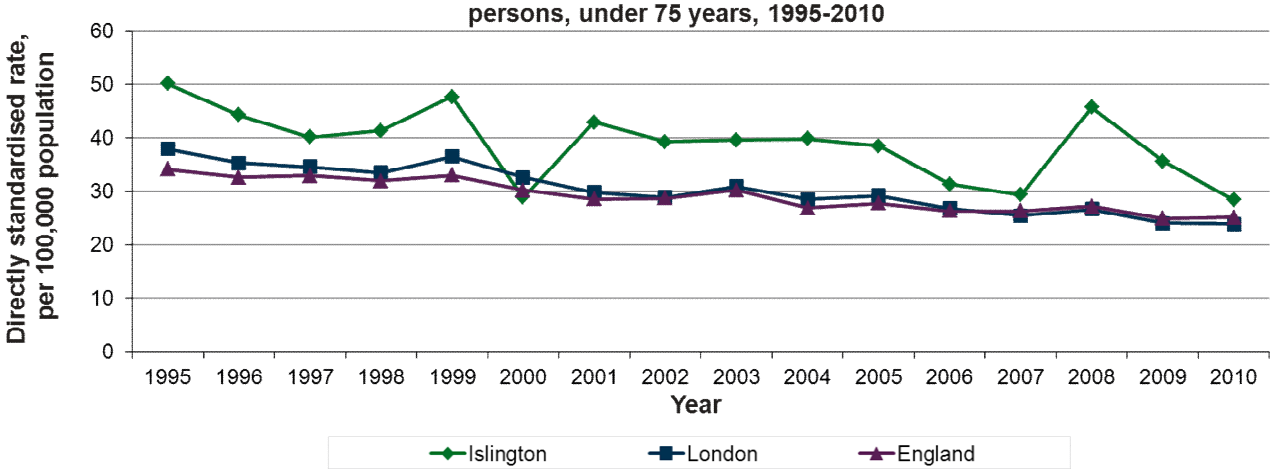
Islington has a relatively low rate of early death from respiratory diseases among comparable boroughs. Approximately half of early deaths from respiratory diseases are considered preventable. As with all deaths from respiratory diseases, Islington has one of the lowest rates of preventable early deaths from respiratory diseases.

Directly standardised rate of mortality from respiratory disease, Islington and similarly deprived boroughs compared against the England average, all persons, under 75 years, 2009 - 11



Source: EMPHO (based on ONS source data)

Directly standardised rate of under 75 mortality from bronchitis, emphysema, and other chronic obstructive pulmonary disorders, Islington, London, and England, all persons, under 75 years, 1995-2010



Source: NHS Indicator Portal, 2012
Note: Time trend data for all respiratory disorders considered preventable is not available from Public Health England at this time.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of deaths that are considered preventable from respiratory disease (classified by underlying cause of death) registered in the respective calendar years, in people aged under 75, aggregated into quinary age bands (0-4, 5-9,…, 70-74).

Denominator: Population-years (ONS mid-year population estimates for 2011 multiplied by 3 - see Caveats) for people aged under 75, aggregated into quinary age bands (0-4, 5-9,…, 70-74).

4.07 - Under 75 mortality rate from respiratory disease (provisional)

Key programmes in Islington

Public Health Awareness initiatives and services

There have been a number of health awareness campaigns to promote knowledge of the signs and symptoms of respiratory diseases (i.e. Get it off your Chest campaign).

Supporting people to stop smoking, particularly those already diagnosed with respiratory diseases, is key to preventing early respiratory deaths in the future. Stop Smoking Services (SSS) are provided within general practices and by a community service.

Flu and pneumococcal vaccinations are offered to people aged over 65 each winter, as are younger people who have conditions like asthma. Pneumococcal vaccination is given to people aged over 65. Both vaccinations help to prevent people developing serious respiratory infections.

Air pollution

Islington Council will soon to have in place an Air Quality Strategy (2013-2016) and some initiatives include:

- Raising awareness of air pollution so that residents can modify their behaviours to reduce their risks of exposure e.g. AirTEXT service which will inform people with respiratory problems when levels of air pollution are high;
- Reducing the concentration of particulate matter and emissions across the borough e.g. reducing the amount of idling of vehicles to reduce exhaust fumes;
- Determining the impacts of new developments on air quality.

Improving early diagnosis and management

The Local enhanced service delivered by GPs aims to improve the diagnosis and management of COPD in Islington. The service promotes evidence based prescribing and care for people, and aims to reduce the rate of emergency admissions caused by exacerbations of the disease.

A pulmonary rehabilitation (PR) programme run by the Islington COPD community team provides patients with supervised exercise and educational advice in managing their condition.

Self-management is an important component of COPD care. Expert Patient Programme courses for COPD patients are offered in Islington, including a new self-management programme being developed to complement existing programmes.

Recent developments in secondary care include the development of a COPD discharge bundle, as a means of ensuring COPD patients systematically receive a package of key interventions to support and improve the management of their condition.

Targets

There are no set targets for this indicator.

Further information

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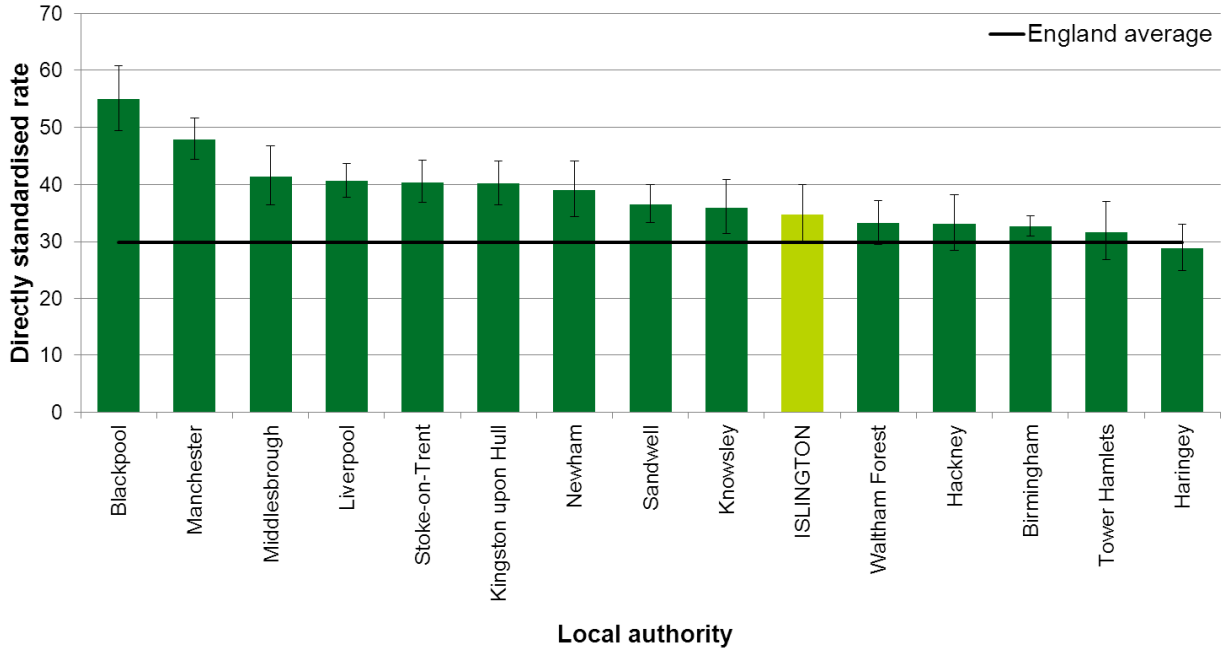
4.08 - Mortality from communicable diseases (provisional)

Rationale from DH Technical Specification, 2013

Prevention of the spread of communicable diseases is an important issue for Public Health. There is evidence that rapid identification, treatment and prevention of spread can reduce mortality, as well as immunisation and other preventative actions to prevent or reduce the risk of infection.

The Islington picture

Directly standardised rate of mortality from communicable diseases (provisional), Islington and similarly deprived boroughs compared against the England average, all persons, all ages, 2009 - 11



Source: EMPHO (based on ONS source data).

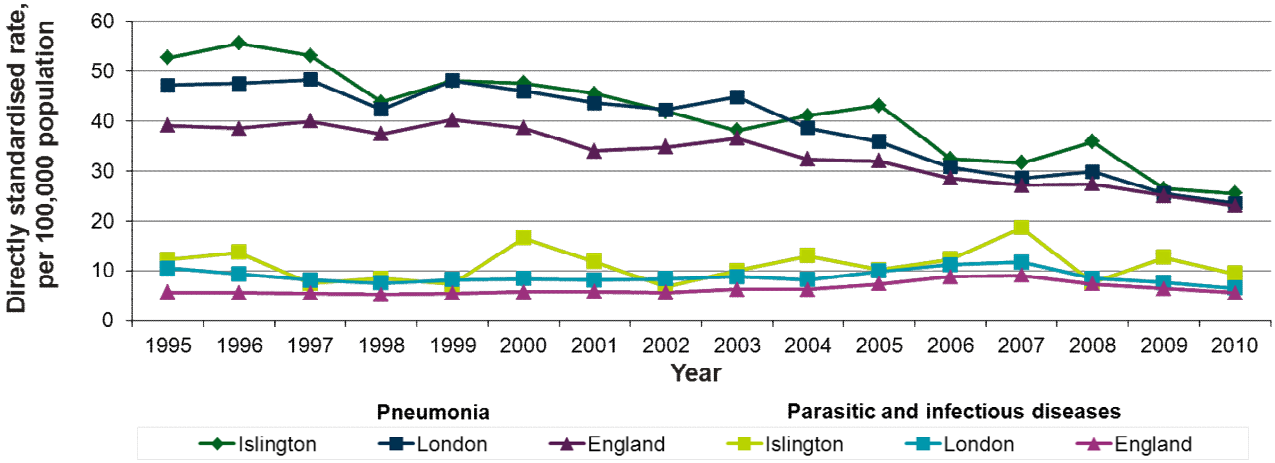
Islington has a significantly higher rate of deaths from infectious diseases than the England average with an average of 67 deaths per year for the last three years (a total of 201).

These figures include all infectious diseases, including TB, HIV as well as influenza and pneumonia. The majority of the deaths, on average 53 of the 67 deaths annually, are due to bronchopneumonia.

4.08 - Mortality from communicable diseases (provisional)

The figure below shows that mortality linked to infectious diseases in people under 75 has reduced overall, with the reduction in pneumonia related deaths showing a downward trend similar to the London and national trends. By 2010, deaths due to pneumonia in Islington were similar to the London and national positions. In the community, steps to further improve flu and pneumococcal immunisation among older people and vulnerable groups may help to reduce rates further. The rate of mortality linked to other infectious and parasitic diseases is substantially lower than the mortality rate due to pneumonia but, as with London and England, has remained broadly similar over the past 15 years, with some year-on-year variation.

Directly standardised rate of under 75 mortality rate from infectious or parasitic diseases and pneumonia, Islington, London, and England, all persons, under 75 years, 1995-2010



Source: NHS Indicator Portal, 2012

Equalities and health inequalities

- High childhood immunisation rates mean that nationally deaths due to vaccine-preventable diseases, such as measles, have become very rare. Local health equity audit found that coverage of immunisations was equitable across ethnic groups in Islington. Feedback from local community links show that some groups have different concerns and beliefs about immunisation, for example the Somali community, which may affect uptake.
- Infectious diseases may affect anyone, but different types of infectious disease, and the risks of serious complications and death caused by those infections, may affect groups differently. For example:
- The very young and the old are at increased risk of mortality caused by bronchopneumonia.
- People who are immuno-compromised due to illness or treatment are at higher risk of death or serious illness due to infectious diseases.
- Mortality from HIV has dramatically reduced due to advances in treatment and care for people with HIV and improvements in earlier diagnosis, but HIV infections disproportionately affect gay and bisexual men and men and women from some Black African communities.

4.08 - Mortality from communicable diseases (provisional)

Key programmes in Islington

Universal services

Patients with infections will be diagnosed and managed by both primary and secondary health care services. Environmental Health services play an important role in protecting the public from infection, for example through promotion and enforcement of food hygiene and outbreak investigations.

Prevention of infection includes a number of approaches:

- immunisation against vaccine-preventable diseases, e.g. flu or measles
- ensuring good hygiene practices and standards
- limiting contact with those who are infected, particularly for those at the extremes of age or those with other vulnerabilities
- following up those who may have been in contact with infectious diseases to offer screening and treatment to prevent further spread, e.g. partner notification.

Targeted services

There are a range of services that support the prevention, diagnosis and management of infectious diseases, e.g. local GUM services, the North Central London TB Service, etc.

Targets

There are no national or local targets for this indicator.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of deaths from certain infectious and parasitic diseases registered in the respective calendar years, aggregated into quinary age bands (0-4, 5-9, ..., 80-84, 85+).

Denominator: Population-years (ONS mid-year population estimates for 2011 multiplied by 3 - see caveats in the DH technical Spec) for people of all ages, aggregated into quinary age bands (0-4, 5-9, ..., 80-84, 85+).

Further information

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4.09. Excess under 75 mortality in adults with serious mental illness

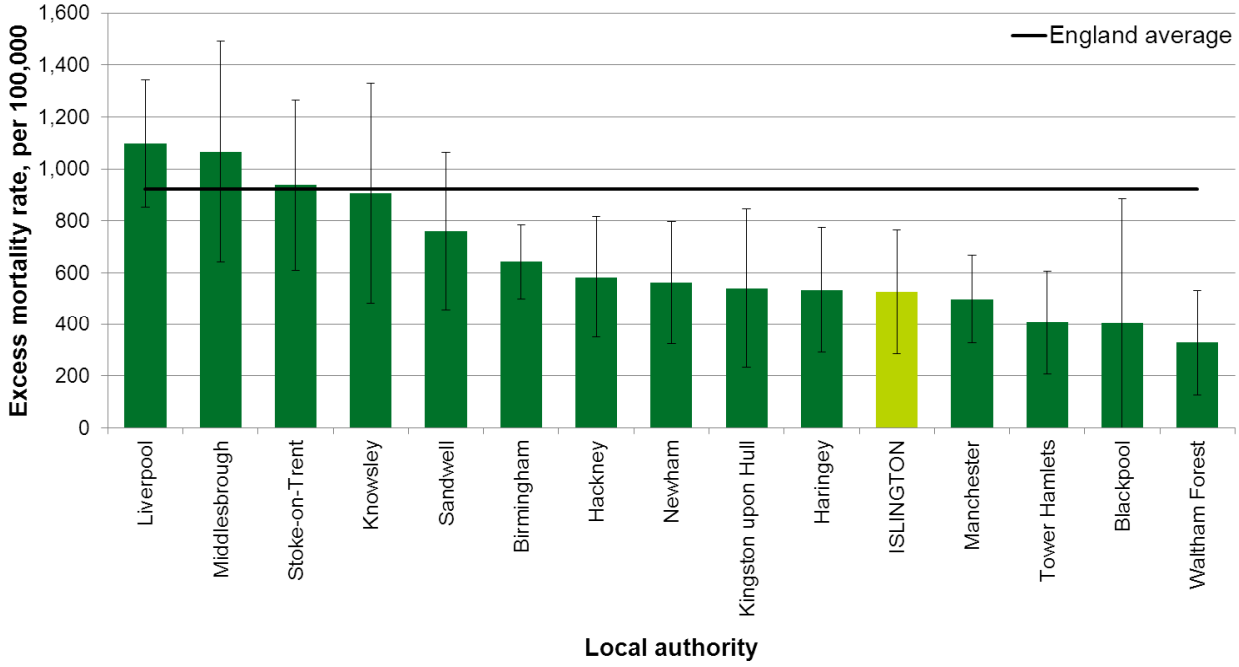
Rationale from DH Technical Specification, 2013

People with serious mental illness on average die much earlier than others. The Disability Rights Commission has highlighted the serious inequalities in life expectancy experienced by people with severe mental illness. Increased risk of suicide is important, however deaths due to physical health conditions account for a much greater proportion of early, preventable deaths. For example, people with serious mental illness are twice as likely to die from coronary heart disease and four times as likely to die from respiratory disease as the general population.

This is a shared indicator with the NHS Outcomes Framework which reflects the importance of joined up action between public health and health and social care services to make change.

The Islington picture

Excess mortality rate among people with a serious mental illness, per 100,000 population, Islington and similarly deprived boroughs compared against the England average, all persons aged 18 to 74, 2010/11



Sources: Mental Health Minimum Data Set; ONS Mortality Data and mid-2010 Population Estimates

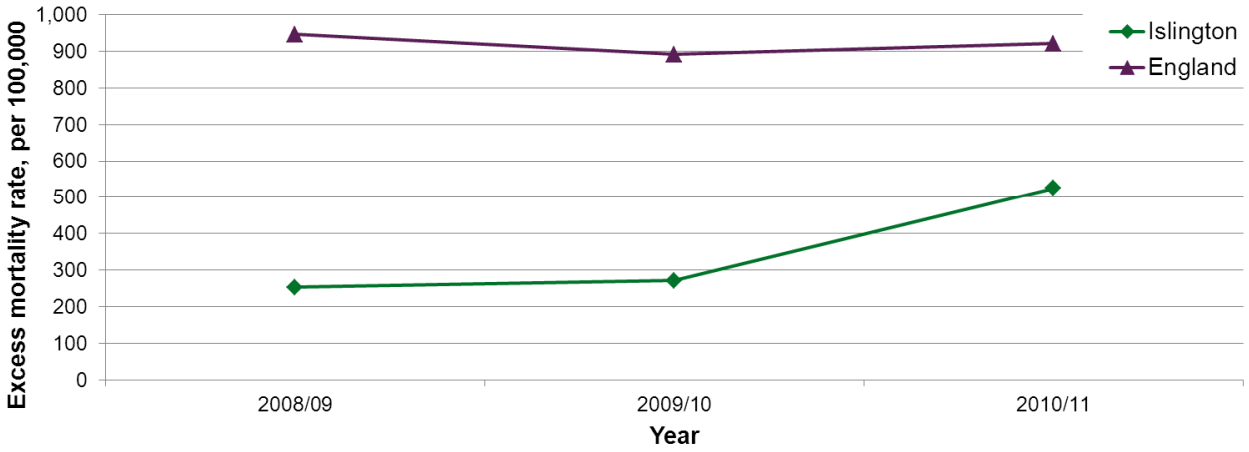
This indicator looks at the excess mortality among people with a serious mental illness (defined as people in contact with a specialist secondary mental health care service). The excess mortality rate is the difference between the directly standardised under 75 mortality rate among people with a serious mental illness and the directly standardised under 75 mortality rate in the general population.

In Islington the rate is significantly lower than the England rate and is lower (although not significantly so) than many boroughs with similar levels of deprivation. However this remains a significant inequality as the premature (under 75) death rate amongst people with a serious mental illness (821 deaths per 100,000) is approaching three times that of the general population in Islington (296 per 100,000).

4.09. Excess under 75 mortality in adults with serious mental illness

Data for this indicator is only available for the last three years. The data shows that the excess rate has varied over the period between 250 and over 500 per 100,000 over the three years, however this is likely to be a fluctuation around a trend rather than indicative of a more recent increase. A longer time period of data will be needed to assess whether the inequalities gap is narrowing or widening as the premature mortality rate in Islington improves. Additionally, it should be borne in mind that a significant proportion of people with serious mental illness are managed through primary care rather than secondary care services, and will share many of the same risk factors. Therefore, the true excess mortality (in terms of numbers of people) is likely to be higher.

Trend in excess mortality rate among people with a serious mental illness, per 100,000 population, Islington compared against the England average, all persons aged 18 to 74, 2008/10 to 2010/11



Sources: Mental Health Minimum Data Set; ONS Mortality Data and mid-2010 Population Estimates

Equalities and health inequalities

People with mental illness have reduced life expectancy and poorer physical health than the general population. On average, people with mental illness die five to ten years younger than the general population, and there is extensive published evidence that people with a severe mental illness such as schizophrenia die between 15 and 25 years earlier than the average for the general population.

These early deaths are largely due to physical health conditions such as diabetes, circulatory diseases, and respiratory diseases, and are largely preventable. There is evidence for raised risk of some diseases (e.g. diabetes), and poorer outcomes for others (e.g. cardiovascular disease).

The reasons for this inequality are complex and involve a combination of lifestyle, social, economic and service delivery issues. These include:

- Very high smoking rates, low levels of physical activity and higher rates of obesity
- 'Diagnostic over-shadowing' leading to poor physical healthcare and access to services
- Poorer levels of self-management of illness
- Higher levels of deaths due to suicide and undetermined injuries
- Significantly higher levels of poverty, deprivation and social exclusion
- Side effects of medication

4.09. Excess under 75 mortality in adults with serious mental illness

Key programmes in Islington

Universal services

Many of the factors that contribute to inequalities in life expectancy amongst the general population are over-represented in those with a diagnosis of serious mental illness, and often underpinned by long term poor mental health. These include being male, poverty, unemployment, poor housing and low levels of education as well as high prevalence of smoking, high levels of obesity, poor diet and low levels of physical activity. Additionally, serious mental illness as a diagnosis can delay or overshadow the diagnosis and treatment of other conditions by health services.

Universal screening and lifestyle services aimed at reducing premature mortality are available to, although not necessarily widely accessed by people with serious mental illness. These include screening and early detection and primary and secondary prevention for cancer and cardiovascular disease, NHS health checks and flu immunisations, as well as smoking cessation, weight management and physical activity programmes.

Targeted services

A local CQUIN supports improved physical care within the local Mental Health Trust, supported by a primary/secondary care interface agreement between the Trust and local GPs. Local integrated care services for people with long term conditions are developed by the CCG and Adult Social Services to include people with serious mental illness and support for mental health needs. The recently formed physical health group in Camden & Islington Foundation Trust supports strategic decisions related to the physical health of the Trust's service users. National and local primary care indicators support the provision of smoking cessation support, health checks and breast cervical screening in people with serious mental illness.

Targets

There are no national or local targets for this indicator.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of deaths from any condition, among people known to mental health services and aged between 18 and 74 (inclusive), based on the year of registration.

Denominator: Population-years (ONS mid-year population estimates for 2010 for people aged 18 to 74, aggregated into quinary age bands (18-24, 25-29,…, 70-74).

Further information

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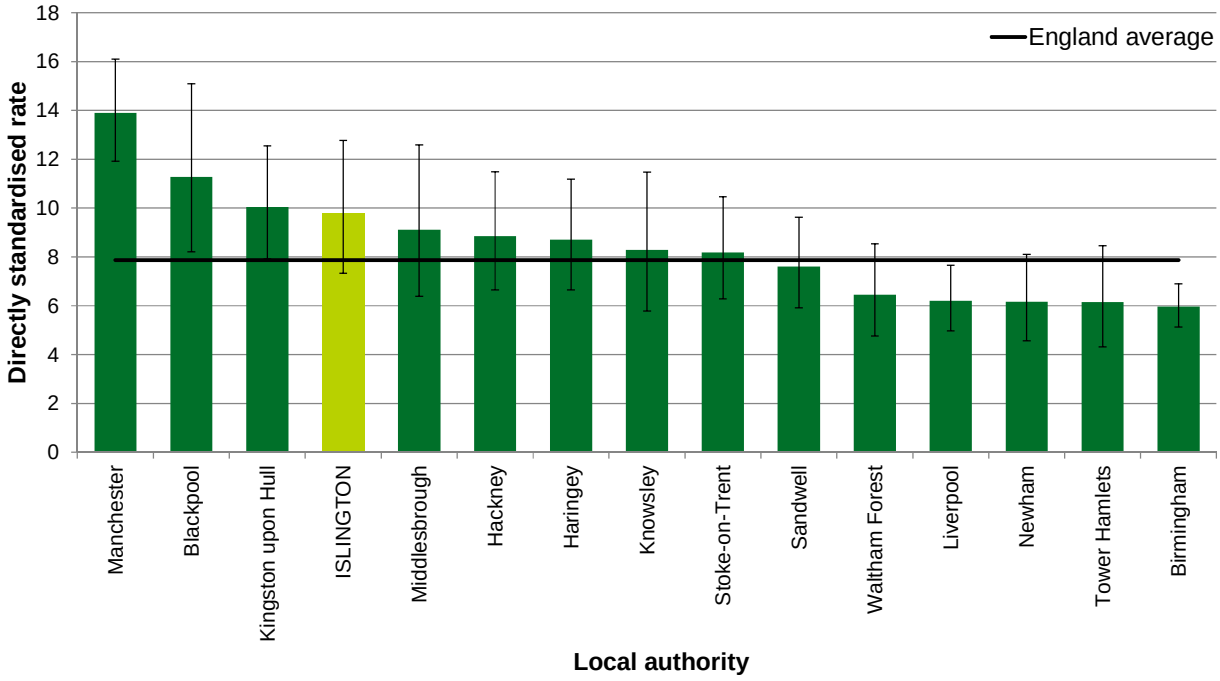
4.10 - Suicide rate (provisional)

Rationale from DH Technical Specification, 2013

Suicide is a significant of cause of preventable death particularly in young and middle-aged adults, and is seen as an indicator of underlying rates of mental ill-health.

The Islington picture

Directly standardised rate of suicides (provisional), Islington and similarly deprived boroughs compared against the England average, all persons, all ages, 2009 - 11



Source: EMPHO (based on ONS source data)

Between 2009-11 there were a total of 60 suicides in Islington, an average of 20 suicides a year. This gives a directly standardised rate of 9.8 suicides per 100,000 people. This is a reduction on the previous three year average rate of 12 per 100,000. The rate is higher, but not significantly different from the England rate for 2009-2011, or from authorities matched by socio-economic decile (see above). However, the rate is the highest of the London boroughs.

Local analysis has shown that the majority of suicides are by people not known to secondary mental health services and occur at home or close to home. There are places of risk in the borough such as prisons and a bridge, but these have not in themselves accounted for the higher rate of suicide in Islington. In recent years, Islington has seen a number of suicides take place around local transport hubs.

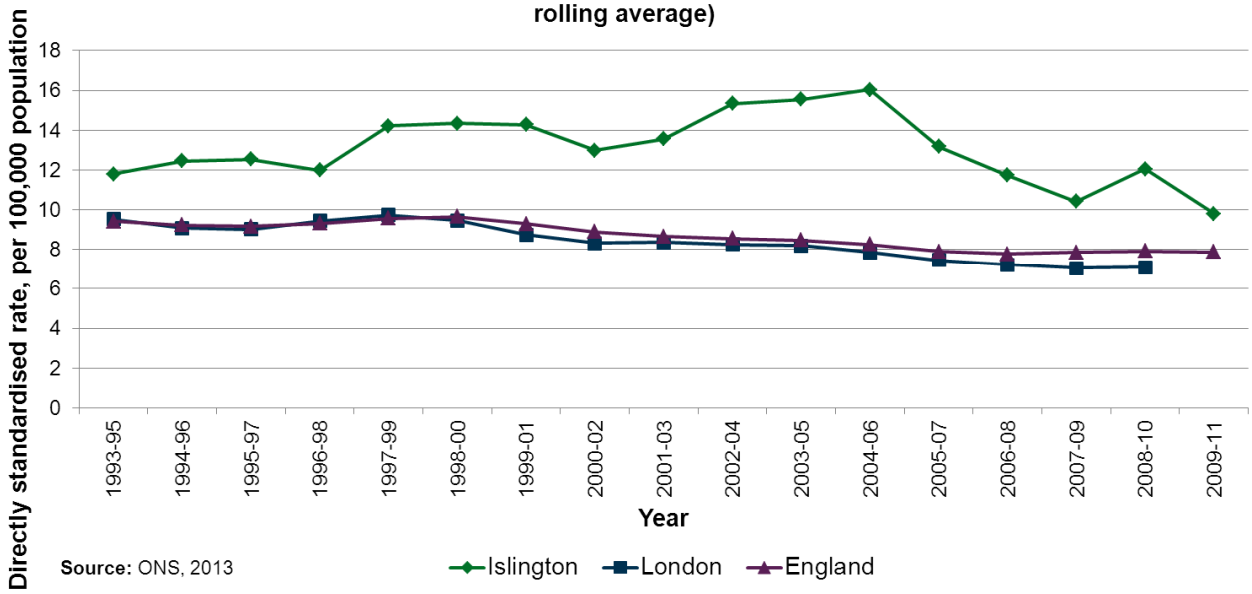
4.10 - Suicide rate (provisional)

As well as the direct loss of life associated with suicide, suicides have a significant and often devastating impact on family and friends and affected others.

The suicide rate in Islington has fluctuated over the past 15 years, but has remained higher than that of London or England. The past five years show a consistent downward trend, narrowing the gap between Islington and the rest of London and England.

Economic downturn, and in particular unemployment are known factors in increasing rates of suicide, especially amongst men. In the current climate, and given that these figures are for the period to 2011, suicide remains an area of risk and concern.

Age-standardised rate of mortality from suicide or injury of undetermined intent per 100,000 population, Islington, London and England, 1993-95 to 2009-11 (three year rolling average)



Source: ONS, 2013

Equalities and health inequalities

- Islington's local audit identified no clear patterns in the people most as risk of suicide as there is wide distribution by sex, age, ethnicity and geographical location.
- National evidence suggests that men in lower socio-economic groups are more vulnerable to suicide, particularly in times of economic hardship.
- An increased risk of suicide is also seen in people both with a lower level of educational attainment and with very high attainment.
- Problem drug users and people with a concurrent mental disorder, particularly a psychotic disorder, are at greater risk of suicide.
- Alcohol use increases risk and is associated with more than half of all suicides.
- People bereaved by suicide are at increased risk of suicide.

4.10 - Suicide rate (provisional)

Key programmes in Islington

Universal services

For any one individual the factors that lead to their suicide will be complex and unique. Achieving lower numbers of suicides requires strong, inclusive and healthy communities and individuals and action at many levels. Many of the universal services that improve economic prospects, education, social welfare and health will contribute to fewer suicides. We also know that improving mental wellbeing as well as mental health, with better and more timely access to improved services can lead to fewer suicides. Services can be targeted at those more at risk and reducing access to the means for suicide can also reduce deaths.

Targeted services

There are a number of more targeted initiatives within the borough which support this:

- Mental Health First Aid (a mental health awareness training) is delivered across the borough, specifically targeting more marginalised communities
- The Direct Action Project works with teenagers and young adults to raise awareness of mental health issues and sources of support, with suicide and self-harm a focus
- Mental Health Champions develops skilled champions and advocates of mental health within specific communities in the borough
- A new initiative will improve mental health awareness in schools in the autumn, and will include sessions on self-harm and suicide for staff and pupils
- Effective crisis services (currently under review) can prevent suicide

Targets

There are no set targets for this indicator

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Number of deaths from suicide and injury of undetermined intent classified by underlying cause of death, registered in the respective calendar years, aggregated into quinary age bands (0-4, 5-9,…, 80-84, 85+).

Denominator: Population-years (ONS mid-year population estimates for 2011 multiplied by 3 - see Caveats) for people of all ages, aggregated into quinary age bands (0-4, 5-9,…, 80-84, 85+).

Further information

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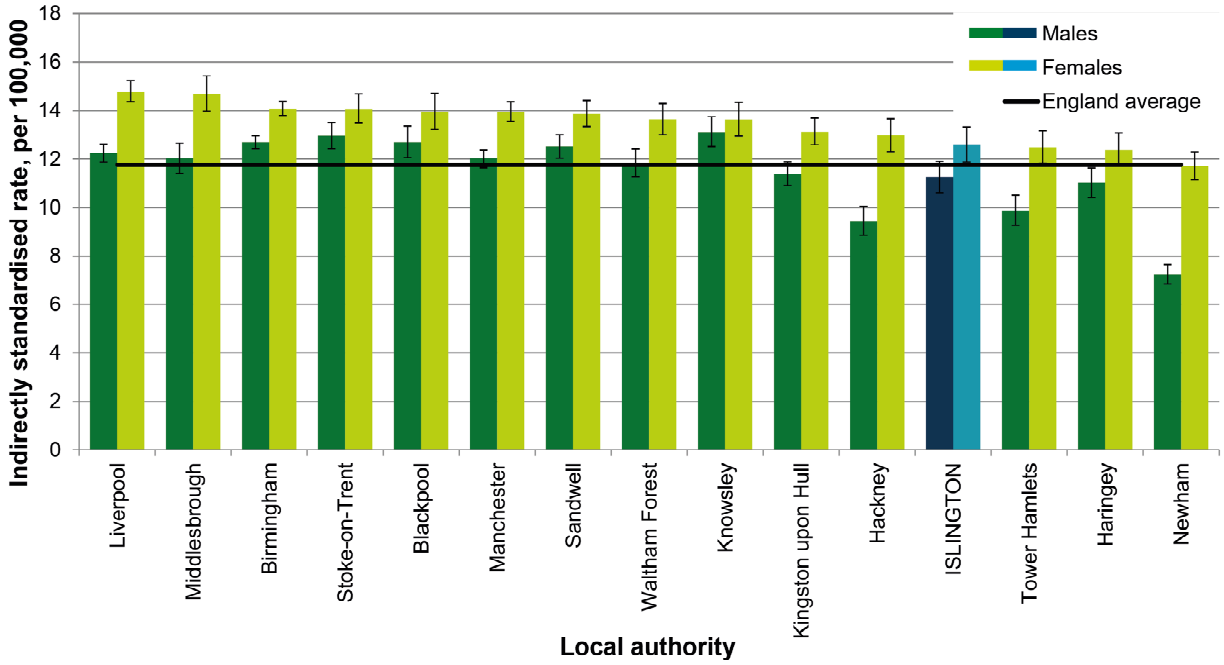
4.11 - Emergency readmissions within 30 days of discharge from hospital

Rationale from DH Technical Specification, 2013

This indicator will follow individuals discharged from hospital to monitor success in avoiding emergency admissions. Health interventions and social care will play significant roles in putting in place the right re-ablement, rehabilitation and intermediate care services to support individuals to return home or regain their independence, so avoiding crisis in the short term.

The Islington picture

Indirectly standardised rate of emergency readmissions within 30 days of discharge from hospital, Islington and similarly deprived boroughs compared against the England average, males and females, all ages, 2010/11



Source: Hospital Episode Statistics (HES)

Islington's rate of emergency readmissions within 30 days is similar to other boroughs in the comparator group, and follows a similar position in terms of a lower rate for males than females. This probably reflects the increased proportion of older adults that are women.

The Islington value of 12 per 100,000 people (for all people) is not significantly different from the England average of 11 per 100,000.

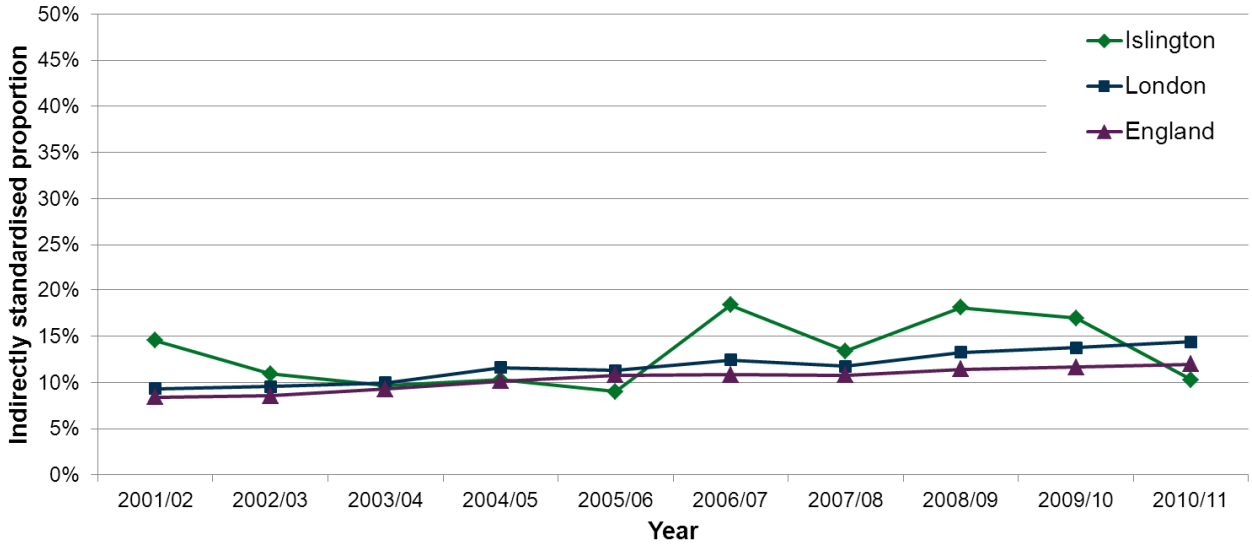
4.11 - Emergency readmissions within 30 days of discharge from hospital

As shown below, Islington's readmission rate has declined over recent years to its position in 2010/11 of being below the national average.

Islington Clinical Commissioning Group (CCG) and Islington Council have worked with UCLH and Whittington Hospitals to conduct a detailed audit of readmissions in 2012 as required under NHS Payment By Results guidance. The audit identified that 53% of the sample had one or more admission within the previous six months, some patients had up to nine readmissions within the previous six months. All age groups were represented within the audit sample, however 40% of the sample was 70 years or over.

In 2011/12 there were 6,053 emergency admissions from 3,366 people aged 65+ in Islington. The majority of these were to the Whittington (51%) and UCL Hospital (33%).

Indirectly age-standardised proportion of emergency readmissions to hospital within 30 days, Islington, London and England, all ages, 2001/02 to 2010/11



Source: NHS Indicators, 2012

Equalities and health inequalities

- Local audits of readmissions have indicated a number of factors that seem to increase the chance of experiencing a readmission, including the person's age, number of previous readmissions and whether they were admitted from a care home
- National research from the Nuffield Trust on PARR-30 (Patients at Risk of Rehospitalisation in 30 days algorithm) suggests further relationships between readmission risk and deprivation, and between previous hospital use and readmission
- This research also highlighted several conditions that increase risk of readmission, including heart failure, vascular disease, dementia, chronic pulmonary disease, cancer, liver disease, diabetes, paralysis of one side of the body, and renal disease

4.11 - Emergency readmissions within 30 days of discharge from hospital

Key programmes in Islington

Targeted services

Providing services to prevent readmission to hospital requires an integrated approach. Islington has created an Intermediate Care pooled budget, funded by Islington CCG, the London Borough of Islington and Whittington Health. This helps us work together to fund services to help people recover from a hospital admission.

Islington Council and Whittington Health support people at home with help from occupational therapists, physiotherapists, social workers and home carers, as well as providing specialist inpatient support at hospitals and care homes. One new targeted service involves providing pharmacy input to people having support from Re-ablement to help them understand and take their medication safely.

Islington Council and Islington CCG are working with local hospitals on their readmission projects to provide joined up support for people after a hospital admission. The majority of Islington residents are admitted to hospital at Whittington and University College London Hospitals, and we work closely with them to ensure safe and timely handover of care.

Commissioners and providers in Islington are currently developing additional initiatives including community wards and hospitals at home to better support people in the transition between hospital and community.

Targets

There are no local or national targets for this indicator.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: The number of finished and unfinished continuous inpatient (CIP) spells that are emergency admissions within 0-29 days (inclusive) of the last, previous discharge from hospital, including those where the patient dies.

Denominator: The number of finished CIP spells within selected medical and surgical specialties, with a discharge date up to 31st March within the year of analysis.

Further information

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4.12i - Preventable sight loss - age related macular degeneration (AMD)

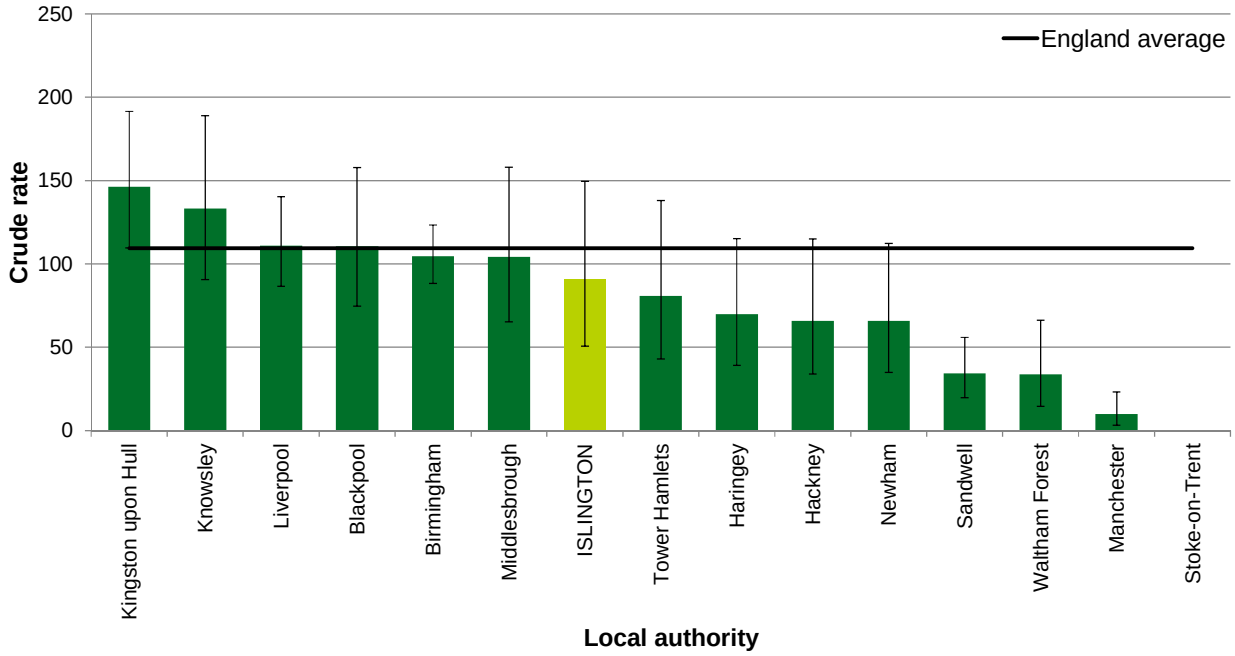
Rationale from DH Technical Specification, 2013

Age related macular degeneration (AMD) is the leading cause of sight loss in England. It is strongly associated with increasing age, although in rare cases may affect younger people. Smoking significantly increases the risk of the condition.

There are two main types—dry AMD and wet AMD. Dry AMD is associated with gradual loss of central vision over many years: there is no cure for the condition, so support is mainly based on helping people make the best of their remaining sight. Wet AMD is a more serious condition associated with rapid deterioration in vision, but there is effective drug treatment available which can either help to improve or prevent worsening of the condition.

The Islington picture

Crude rate of sight loss due to age related macular degeneration, Islington and similarly deprived boroughs compared against the England average, all persons, 65 years old and over, 2010/11



Source: Calculated by West Midlands Public Health Observatory from data provided by Moorfields Eye Hospital and Office for National Statistics.
Note: At time of publication, data were not available for Stoke-on-Trent.

There were 15 new cases of sight loss due to AMD certified in Islington in 2010/11, equivalent to a crude rate of 90 per 100,000 population aged 65 and over. This was similar to the England average rate of 109 per 100,000. However, it should be borne in mind when comparing these figures that Islington's older population has fewer very old people (where the risk of AMD is significantly increased) than England as a whole.

4.12i - Preventable sight loss - age related macular degeneration (AMD)

Locally, the majority of people in receipt of a Certificate of Visual Impairment (CVI, see indicator 4.12iv) have been diagnosed as having an age related macular degeneration condition. With new drug treatments for the wet form of AMD, there may be a reduction in future certifications for this condition.

Equalities and health inequalities

Risk of sight loss is heavily influenced by health inequalities, including ethnicity, deprivation and age.

The risk of AMD is significantly increased with increasing age: among people aged 55-64, the rate is about 1 in 500 but rises to 1 in 8 among people aged 85 and over.

AMD is more common in women than men, although the reason for this difference is not currently understood.

Some ethnic groups have higher rates than other groups: rates are higher in people of White and Chinese ethnicities compared to other ethnic groups.

People with visual impairment are affected by significant inequalities, which include:

- Access to education, training and opportunities for employment impacting on economic wellbeing.
- Ability to mobilise safely and confidently both within their home or in wider society. The incidence of falls, injuries and hospital admissions is high.
- Access to social interaction and support resulting in higher levels of isolation and depression.

4.12i - Preventable sight loss - age related macular degeneration (AMD)

Key programmes in Islington

Prevention

The risk of AMD can be reduced by a range of health improvement services and advice: stopping smoking; moderating alcohol consumption; maintaining a healthy weight; and having a healthy diet, including 5 portions of fruit and vegetables a day.

Services

The Low Vision Clinic provided by Action for Blind People, provides specialist optometry assessment, rehabilitation and low vision equipment aids for daily living for adults with low vision.

A visual impairment pathway has been developed between high street optometrists, GPs, Moorfields Eye Hospital and Social Services supporting the provision of seamless, comprehensive services.

A recent Clinical Commissioning Group Peer Led Ophthalmology event for GPs, Practice Nurses, provided training on wet and dry macular degeneration.

An awareness campaign has been directed at trainees and consultant ophthalmologists at Moorfields Eye Hospital, highlighting the importance of offering Visual Impairment certification to patients whilst in active treatment.

The Map of Medicine will provide an overview of all the local integrated care pathways in place.

Targets

The NHS, Council and other agencies will work together to ensure mainstream services are fully accessible.
Create a pathway of vision impairment support services which promote independence and well being.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Completion of a CVI (certificate of visual impairment) by a consultant ophthalmologist, initiates the process of registration with a local authority and leads to access to services.

Denominator: Local Authority estimates of resident population for 2010, ONS unrounded populations (released 30th June 2011).

Further information

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4.12ii - Preventable sight loss - glaucoma

Rationale from DH Technical Specification, 2013

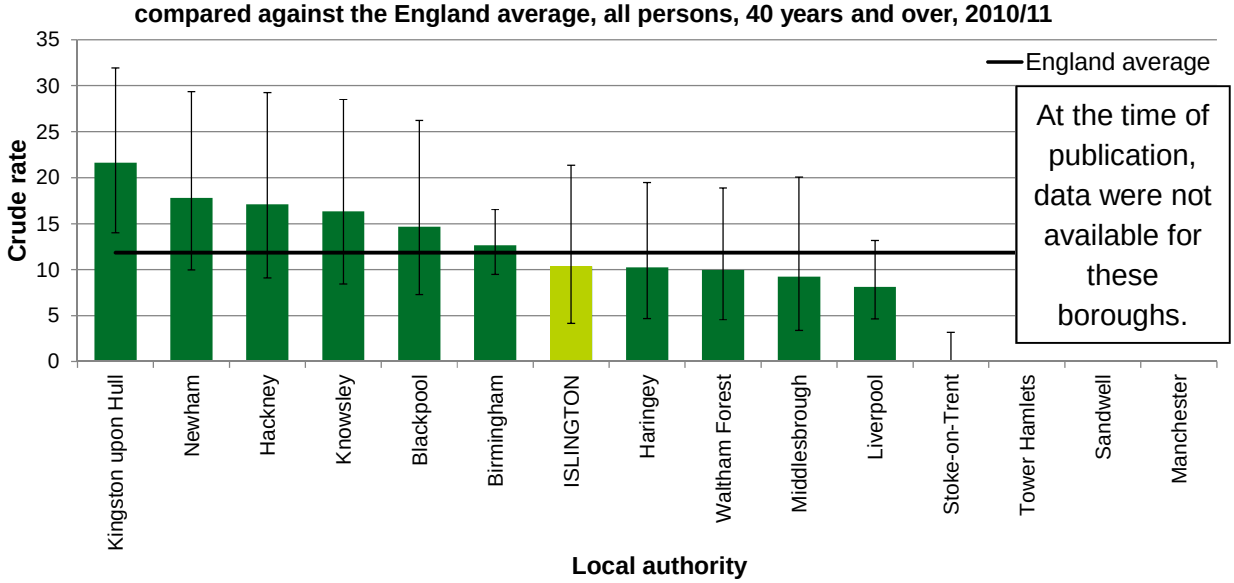
The indicator relates to one of the three main eye diseases that can cause blindness or partial sight if not diagnosed and treated in time. Glaucoma refers to a group of eye conditions caused by raised pressure in the eye which affects vision and can lead to permanent visual impairment if untreated. The raised pressure does not cause pain, and the condition can often go on for a long time, leading to significant visual field loss, without the person being aware.

The most common type of glaucoma is chronic open angle glaucoma, which affects about 480,000 people in England. Prevalence in people from White communities is about 1 in 50 people at age 40 rising to 1 in 10 by age 75. People of Black African or Black Caribbean origin have a higher rate.

Glaucoma can be identified by an eye test which detects raised blood pressure before it causes damage, and can be treated by daily eye drops to prevent or limit any damage. (Laser treatment and surgery may also be indicated in some cases.) Individuals at increased risk (e.g. with a first degree relative with glaucoma) are eligible for a free NHS eye test with regular review by an optometrist from age 40 recommended.

The Islington picture

Crude rate of sight loss due to glaucoma, Islington and similarly deprived boroughs compared against the England average, all persons, 40 years and over, 2010/11



Source: Calculated by West Midlands Public Health Observatory from data provided by Moorfields Eye Hospital and Office for National Statistics.

There were 7 new certifications of sight loss due to glaucoma reported in Islington in 2010/11, which was a crude rate of 10.36 per 100,000 people aged over 40. This was similar to the England average rate of 11.83. Since a crude rate is used, it is important to note that the rate of glaucoma rises significantly with age and that the proportion of older people in Islington is significantly lower than England. It should also be borne in mind that not all cases of sight loss may be reported via the certification system (see indicator 4.12iv for more information about certification).

4.12ii - Preventable sight loss - glaucoma

Equalities and health inequalities

Risk of sight loss is heavily influenced by socioeconomic factors, including age, ethnicity, and deprivation.

The risk of glaucoma is significantly related to increasing age.

People from Black African and Black Caribbean communities have a higher rate of chronic open angle glaucoma, which is the most common type of glaucoma, compared to people from White communities.

People of Asian origin have a higher risk of acute angle closure glaucoma than other groups, although the condition is much less common than chronic open angle glaucoma.

People with visual impairment are affected by inequalities which impact significantly on:

- Access to education, training and opportunities for employment impacting on economic wellbeing.
- Ability to mobilise safely and confidently both within their home or in wider society. The incidence of falls, injuries and hospital admissions is high.
- Access to social interaction and support resulting in higher levels of isolation and depression.

4.12ii - Preventable sight loss - glaucoma

Key programmes in Islington

- Glaucoma Referral Refinement Clinical Pathway Pilot

  Pathway set up September 2012 and will continue until March 2014. Following review, pathway will be re-launched to promote direct referrals from GPs to improve access.

  The Moorfields glaucoma service acts as a referral management system for the scheme.

- Map of Medicine will provide an overview of all the local integrated care pathways in place supporting access by the general public.
- Action for Blind People Low Vision Clinic provides specialist optometry assessment, rehabilitation and low vision equipment aids for daily living
- Low Vision Pathway developed between high street optometrists, GPs, Moorfields Eye Hospital and Social Services

Targets

There are no local or national targets for this indicator.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Completion of a CVI (certificate of visual impairment) by a consultant ophthalmologist, initiates the process of registration with a local authority and leads to access to services.

Denominator: Local Authority estimates of resident population for 2010, ONS unrounded populations (released 30th June 2011).

Further information

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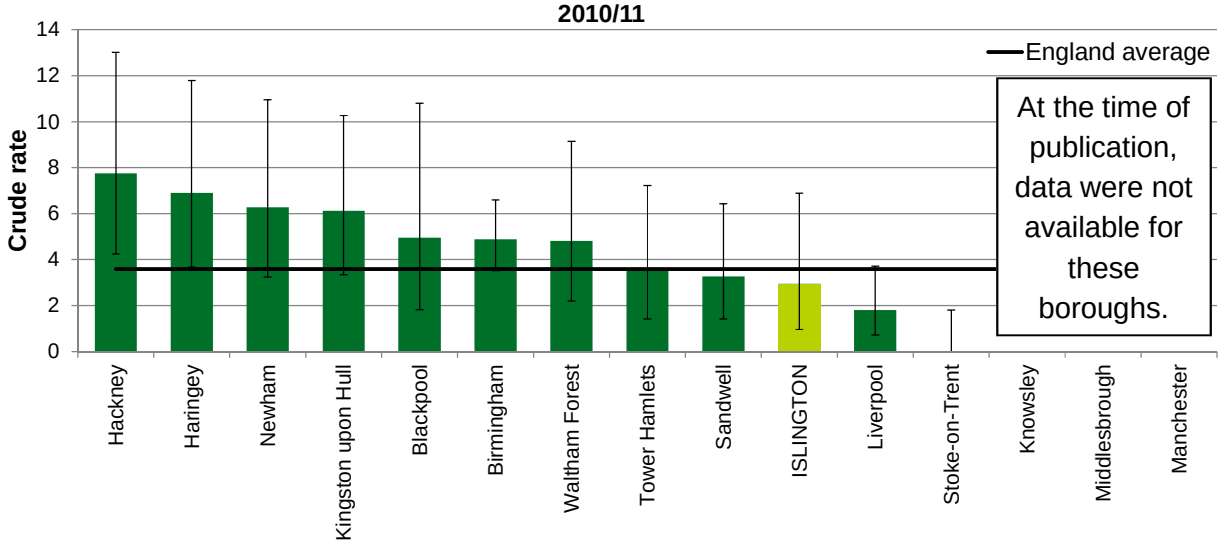
4.12iii - Preventable sight loss - diabetic eye disease

Rationale from DH Technical Specification, 2013

The indicator relates to one of the three main eye diseases which can cause blindness or partial sight if not diagnosed and treated in time. Diabetic retinopathy is the leading cause of preventable sight loss in working age people in the UK. Early detection through screening halves the risk of blindness. By providing data on blindness due to diabetic retinopathy the indicator will also provide valuable information for the national diabetic retinopathy screening programme. Prevention of sight loss will help people maintain independent lives as far as possible and reduce needs for social care support, which would be necessary if sight was lost permanently.

The Islington picture

Crude rate of sight loss due to diabetic eye disease, Islington and similarly deprived boroughs compared against the England average, all persons, 12 years old and over, 2010/11



Source: Calculated by West Midlands Public Health Observatory from data provided by Moorfields Eye Hospital and Office for National Statistics.

In 2010/11, there were new certifications of 5 people in Islington over the age of 12 who had permanent partial or severe sight impairment due to eye disease either caused by diabetes or where diabetes was a contributory factor.

The crude rate of 2.95 per 100,000 was statistically similar to the England average (3.6 per 100,000) and the crude rates in other deprived boroughs.

Indicator 2.21vii covers the uptake of diabetic eye screening for retinopathy which at 70% in Islington in 2012/13, was substantially below the target of 80%.

4.12iii - Preventable sight loss - diabetic eye disease

Equalities and health inequalities

- The number of people with diabetes is rising, and is forecast to continue to rise. This is particularly linked both to increasing levels of obesity and an ageing population in the borough. More men than women are affected by diabetes.
- People from Asian and Black communities are more likely to be diagnosed with diabetes than White groups. However, uptake of the diabetes retinopathy service among people with diabetes is lower among people of Asian and Black ethnicity than amongst people from White population groups.

4.12iii - Preventable sight loss - diabetic eye disease

Key programmes in Islington

Primary prevention

Increase awareness of the Diabetes Eye Screening Programme to increase the number of people screened by:

- Engagement of local GPs to the programme
- Allocation of post cards to local pharmacists for distribution to all diabetic patients collecting medications.

A mobile screening service is also due to start later this year in local community settings (i.e. shopping centres) and GP practices to raise awareness and increase the number of people with Type 1 and 2 diabetes aged 12 or over to be screened.

Case findings/Early diagnosis and Screening

The Diabetic Eye Screening Programme aims to screen people with diabetes annually. This reduces the risk of sight loss from diabetic retinopathy, through early detection and appropriate treatment.

Targets

Key Performance Indicator for Diabetic Eye Disease 3: The proportion of screen positive subjects with referred proliferative diabetic retinopathy receiving consultation within 4 weeks of notification of positive test.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Completion of a CVI (certificate of visual impairment) by a consultant ophthalmologist, initiates the process of registration with a local authority and leads to access to services. Count of certifications with a main cause of sight loss of diabetic eye disease or where no main cause is attributed but where diabetes is a contributory cause.

Local Authority estimates of resident population for 2010, ONS unrounded populations (released 30th June 2011).

Denominator: The number of finished CIP spells within selected medical and surgical specialties, with a discharge date up to March 31st within the year of analysis.

Further information

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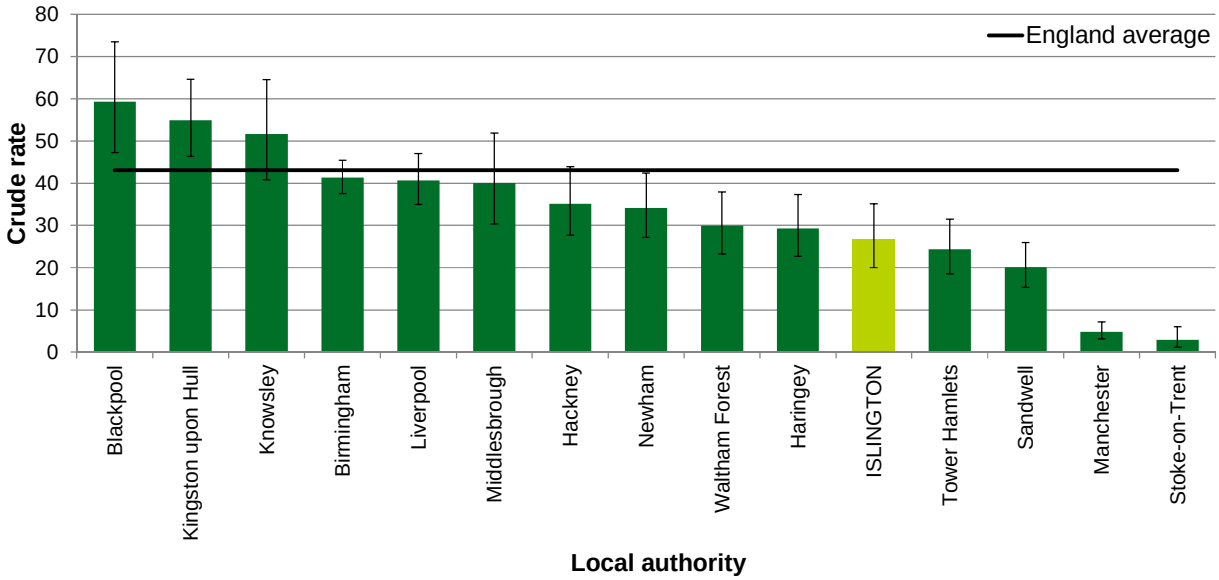
4.12iv - Preventable sight loss - sight loss certifications

Rationale from DH Technical Specification, 2013

Prevention of sight loss will help people maintain independent lives as far as possible and reduce needs for social care support, which would be necessary if sight was lost permanently. National research by the Royal National Institute for Blind People (RNIB) suggests that 50% of cases of blindness and serious sight loss could be prevented if detected and treated in time. Whilst this is mainly due to uncorrected refractive error and untreated cataract, the research implies that the take-up of sight tests is lower than would be expected. This is particularly the case within areas of social deprivation. Low take-up of sight tests can lead to later detection of preventable conditions and increased sight loss due to late intervention. Sight loss can increase the risk of depression, falls and hip fractures, loss of independence and living in poverty.

The Islington picture

Crude rate of sight loss certifications, Islington and similarly deprived boroughs compared against the England average, all persons, all ages, 2010/11



Source: The Database for Epidemiological data on Visual Impairment Certificates (DEVICE), the Certifications Office, the Royal College of Ophthalmologists, at Moorfields Eye Hospital NHS Foundation Trust, supported by a grant from RNIB.The Department of H

Certifications of Vision Impairment (CVI) are completed by consultant ophthalmologists based in hospitals. The certificate confirms that a person is permanently either partially or severely sight impaired (blind). Hospitals forward CVIs to the local Social Services Department who are responsible for registering the person as visually impaired and providing support. This includes advice and counselling, rehabilitation, transport concessions and financial benefits.

The number of people who have received a CVI in Islington is low compared to England and has been declining year on year, reflecting a national trend. Since the figure above shows a crude rate, it does not take account of differences in age structure. In particular, sight loss increases significantly with age and Islington has a much lower proportion of older people than England.

4.12iv - Preventable sight loss - sight loss certifications

Additionally, there may be other factors that contribute to under-certification, for example: consultant ophthalmologists may decide not to complete certificates whilst people are in on-going medical treatment; a person may not be ready to accept they have a permanent impairment or have other personal reasons for not having a certificate; and local referral processes between hospitals and social services may result in delays in people receiving their CVI registration.

Treatment options to prevent or manage sight loss are improving. The majority of people in receipt of a CVI have previously been diagnosed as having an age related macular degeneration (AMD) condition where treatment options have significantly improved in recent years for the wet form of AMD and this may have contributed to a further decline in certification levels.

Electronic hospital records and improvements to information sharing and administrative processes between hospital ophthalmology departments and social services should support an increase in the numbers of people in receipt of a CVI and registered as being visually impaired by Islington Social Services.

Equalities and health inequalities

Risk of sight loss is heavily influenced by inequalities, including ethnicity, deprivation and age.

The prevalence of sight loss increases significantly with age.

Visual impairment is associated with significant inequalities, impacting significantly on people's:

- Ability to access education, training and opportunities for employment impacting on economic wellbeing.
- Ability to mobilise safely and confidently both within their home or in wider society. The incidence of falls, injuries and hospital admissions is high.
- Access to social interaction and support resulting in high levels of isolation and depression.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Completion of a CVI (certificate of visual impairment) by a consultant ophthalmologist, initiates the process of registration with a local authority and leads to access to services.

Denominator: Local Authority estimates of resident population for 2010, ONS unrounded populations (released 30th June 2011).

Targets

There are no local or national targets for this indicator.

4.12iv - Preventable sight loss - sight loss certifications

Key programmes in Islington

Prevention and early detection

Stop smoking support—smoking is a very significant risk factor for Age-Related Macular Degeneration and increases the risks for a number of other eye conditions.

Regular eye tests for older people—can help detect early signs of disease and ensure the correct prescription glasses, which in turn also helps to reduce the risk of falls and hip fractures.

Diabetic eye screening—well managed diabetes and attending regular eye screening which can detect early signs of eye disease, significantly reduces retinopathy.

Rapid referral to treatment services—to help prevent further deterioration in the condition.

Universal services

An Eye Care Liaison Officer and two nurse counsellors are available at Moorfields Eye Hospital (MEH), Islington's main provider, to provide specialist information, advice and professional counselling.

The Sensory Team in Social Services offer any Islington resident with a CVI a comprehensive assessment of their needs in relation to daily living activities and communication skills. Services include specialist equipment, mobility training and a variety of assistive technology aids and adaptions. Specialist advice and information is also provided with signposting to services.

Targeted services

The MEH information and training programme will highlight the value of certification to their clinical team. The benefits of rehabilitative support through registration with Social Services have been publicised in clinics.

An Integrated low vision pathway is being developed from MEH into community health and social care provision.

A Protocol has been agreed with MEH to offer Islington residents with chronic low vision eye conditions a referral to locally commissioned community optometry service.

Further information

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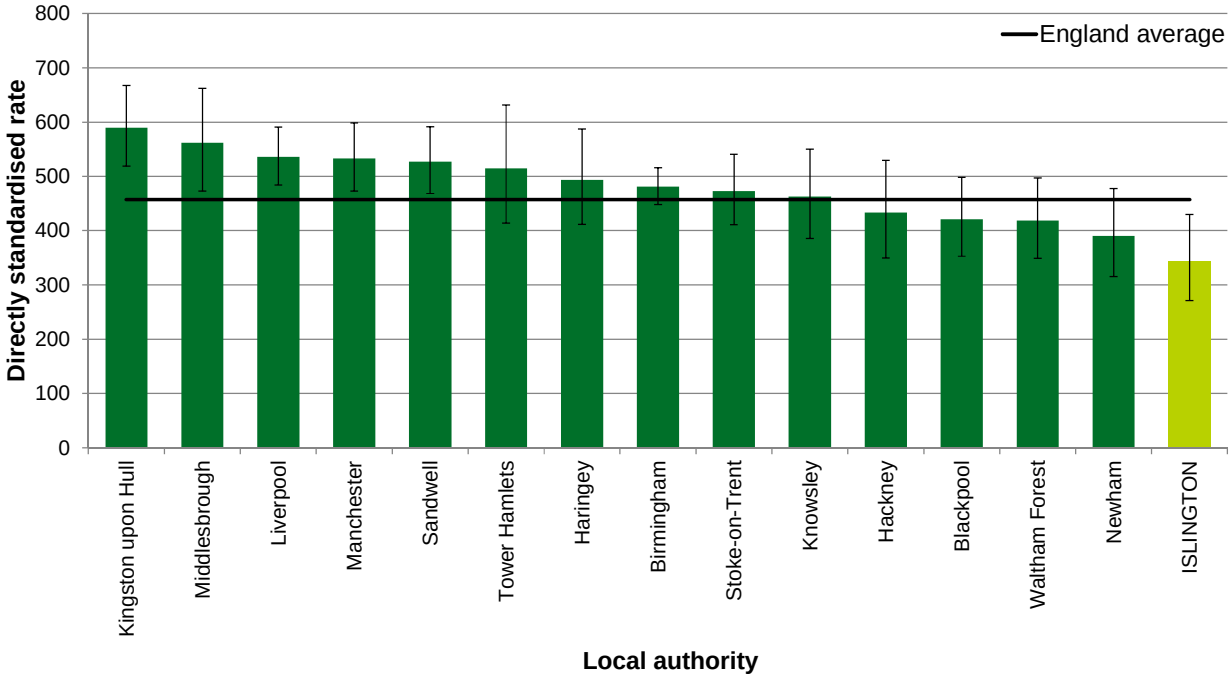
4.14 - Hip fractures in people aged 65 and over

Rationale from DH Technical Specification, 2013

Hip fracture is a debilitating condition – only one in three sufferers return to their former levels of independence and one in three end up leaving their own home and moving to long-term care (resulting in social care costs). Hip fractures are almost as common and costly as strokes and the incidence is rising. There is evidence of interventions to treat osteoporosis, to prevent falls and to prevent fractures in people who have already suffered one fragility fracture. Inclusion of this indicator in the Public Health Outcomes Framework will encourage prioritisation of such interventions.

The Islington picture

Directly standardised rate of hip fractures, Islington and similarly deprived boroughs compared against the England average, all persons, 65 years old and over, 2011/12



Source: Calculated by Public Health England: Knowledge and Intelligence Team (West Midlands) from data from the Health and Social Care Information Centre - Hospital Episode Statistics and Office for National Statistics - Mid Year Population Estimates

Islington has the lowest standardised rate of hip fractures in its comparator group, and its rate is also below the national average.

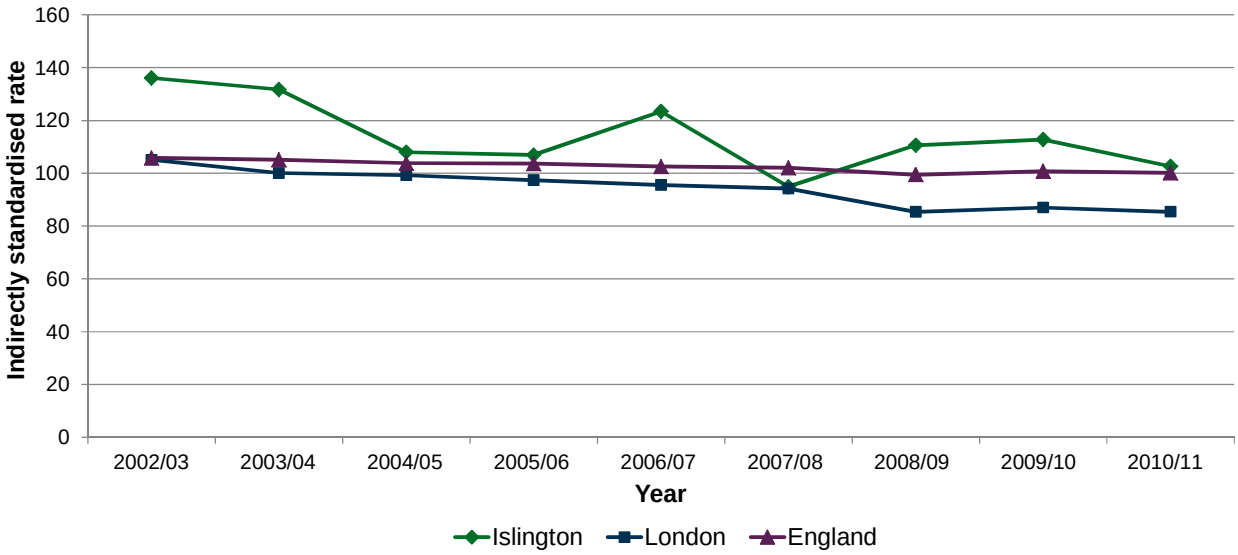
Given Islington's position in related indicators (see 2.24i - Injuries due to falls in persons aged 65 and over) this position is somewhat surprising. Islington has identified further resources to complete a whole pathway review of falls work in 2014. This will aim to improve our understanding of falls, and inform a targeted local response.

In 2011/12, there were 116 emergency admissions for hip fracture in people aged 65 and over in Islington 2011/12. The majority (56%) of these admissions occurred at the Whittington Hospital, with 32% at UCL Hospital.

4.14 - Hip fractures in people aged 65 and over

There has been a decrease in the indirectly standardised rate of emergency hospital admissions for hip fractures since 2002/02. There has been some variation from year to year, but the general trend shows that the gap is narrowing between Islington and both London and England over the period for which data are available.

Indirectly age-standardised rate of emergency hospital admissions for hip fractures, Islington, London and England, standardised against 2006/07 population, per 100,000 population, 2002/03 to 2010/11



Source: NHS Indicators, 2012

Equalities and health inequalities

- The risk of falling, and thereby breaking a bone, increases with age.
- Deprivation may play a role in the risk of falling; one study suggests that within the most deprived Islington wards there was a 10% higher admission rate for falls when compared with the most affluent wards.
- People living alone are more likely to fall and/or be injured than those cohabiting.
- Inadequate nutrition (for example Vitamin D deficiency which can increase the likelihood of falls and subsequent injuries) is often associated with people from the most deprived sections of the community.
- Older age groups are significantly more likely to be admitted for hip fractures; particularly those aged 85+.

4.14 - Hip fractures in people aged 65 and over

Key programmes in Islington

Universal services

Islington has developed an ‘exercise on referral’ service, which provides a 8-week course to increase physical activity and improve self-management.

Islington has developed a Locally Enhanced Service to provide a risk assessment for all people aged over 75 at their GP.

Targeted services

Providing services to prevent or respond to falls requires an integrated approach. Islington has created an Intermediate Care pooled budget, funded by Islington CCG and the London Borough of Islington. This helps us work together to fund services to help people recover from a hospital admission or other period of ill-health.

We support people at home with help from occupational therapists, physiotherapists, social workers and home carers, as well as providing specialist inpatient support at hospitals and care homes.

Islington offers telecare devices to people at risk of falling, including call alarms and fall sensors. These can help mitigate the impact of a fall and increase confidence amongst people living alone.

Targets

There are no local or national targets for this indicator.

Indicator definition: for a full definition please refer to the DH Technical Specification, 2013

Numerator: Emergency admissions for fractured neck of femur classified by primary diagnosis code and an emergency admission method. Age at admission 65 and over. Counted by first finished consultant episode (excluding regular and day attenders) in financial year in which episode ended.

Denominator: Local Authority estimates of resident population, ONS unrounded populations.

Further information

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About Public Health Intelligence

Public health intelligence is a specialist area of public health. Trained analysts use a variety of statistical and epidemiological methods to collate, analyse and interpret data to provide an evidence-base and inform decision-making at all levels. Camden and Islington's Public Health Intelligence team undertake epidemiological analysis on a wide range of data sources.

All of our profiles, as well as other data and outputs can be accessed on the Evidence Hub at: http://evidencehub.islington.gov.uk

FURTHER INFORMATION & FEEDBACK

This profile has been created by Camden and Islington's Public Health Intelligence team. For further information please contact Mandy Guest

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We would also very much welcome your comments on these profiles and how they could better suit your individual or practice requirements, so please contact us with your ideas.