TACKLING HEALTH INEQUALITIES IN ISLINGTON

Final Draft

Community Garden – Caledonian road.
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FOREWORD

We are pleased to introduce the first health inequalities strategy for Islington. This strategy has been developed in association with both local and national partners and in response to formal local consultation.

The first draft of this strategy took a medium term approach to addressing health inequalities, focusing on promoting and developing healthy lifestyle behaviours. In response to consultation feedback and recommendations from the Health Inequalities National Support Team, we have further developed the strategy, bringing together short term actions that address the 2010 national health inequalities target, and medium to longer term actions focusing on lifestyle issues and, importantly, the wider determinants of health.

This strategy is not intended to create new areas of work or increase the performance monitoring burden for partners. Rather, this strategy should be seen as an overarching framework that brings together key strategies and plans that are already underway to address health inequalities in Islington, together with the Joint Strategic Needs Assessment (JSNA).

This programme of action cannot be delivered by one organisation alone. In Islington we are fortunate to work closely with a range of partners through the Islington Strategic Partnership. Many of our partner organisations are already improving the health of local people every day and we want to ensure that this strategy provides opportunities for us to work in a systematic way, ensuring that the most vulnerable people in Islington are getting the right services and that health inequalities are being addressed at every opportunity.

We are committed to ensuring that local people are at the heart of all our work programmes and that everyone is Islington will benefit from this strategy. We will have both universal and targeted actions and ensure robust monitoring, to make sure our programmes are delivering on health improvement. We will achieve this through our many local strategies and policies and primarily through commissioning better services that deliver better outcomes for local people.

The aim of this strategy is to therefore outline our framework for tackling health inequalities. Throughout the sections we have adopted an approach where our services and programmes have the potential to benefit, as well as targeted programmes to reach our most vulnerable communities at the right time.

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EXECUTIVE SUMMARY

NHS Islington and Islington Council have been working in partnership to improve the health and wellbeing of all Islington residents. Islington is a thriving inner city borough with a diverse population. However, there is a gap between the health of Islington residents and the national average. The health of the Islington population is improving, but not as fast as improvements in other areas and there are considerable variations in health outcomes experienced by people across the borough.

The Islington residents experience poorer physical and mental health that results in early deaths from cancer and circulatory diseases (heart disease and stroke). This is mainly because of deprivation across all Islington wards coupled with unhealthy lifestyle choices and poor access to the right services at the right time.

**Deprivation and health inequalities are inextricably linked and deprivation stands out as the main risk factor for early death and poor health in Islington.** Islington is the eighth most deprived borough in England and fourth in London. Health inequalities in Islington are stubborn and because of the diffuse nature and spread of deprivation a comprehensive systematic approach over the short, medium and long term is required.

This strategy has been developed to confirm our commitment to reducing inequalities and improving health outcomes for the population as a whole as well as the communities in Islington who have the greatest health need. To achieve this, our approach is to prevent early deaths in the short term, promote healthy lifestyles over the medium term and tackle the socioeconomic determinants in the longer term.

We look forward to working with our partners to implement this Health Inequalities Strategy to improve health outcomes for all our residents.
INTRODUCTION

What are health inequalities?
Health inequalities describe the differences in health status between different groups or communities within the population\(^1\). At both community and individual level, poor health is linked to social and economic disadvantage and deprivation. Differences in income, employment, education, housing, social environment and access to services all produce inequalities in health outcome. Living in areas of low income, poor employment and poor infrastructure increases the risk of ill health above and beyond factors on an individual level\(^2\).

Within communities, individuals experience different health outcomes depending on social status (figure a). For example, employed routine and manual workers have worse health outcomes than employed white collar workers, with the long term unemployed likely to experience even worse health outcomes. Different population groups also respond differently to the same public health intervention. Smokers from routine and manual groups who access the Islington Stop Smoking services are less likely to succeed at quitting successfully than smokers from higher socioeconomic groups, despite the desire to quit being the same. Socioeconomic inequalities health typically take the form of a ‘social gradient’, in which those in higher socioeconomic groups have better health and longer life expectancy than the groups below them\(^3\).

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What are the determinants of health?

Health inequalities are influenced by many factors known as the determinants of health, all of which are interlinked. This is demonstrated in the “rainbow” model of health (Figure 1). The determinants of health include:

1. **Biological determinants** - age, gender, ethnicity
2. **Behavioural determinants** - lifestyle behaviours such as smoking, alcohol consumption diet, physical activity
3. **Psychosocial determinants** – such as stress, isolation, social exclusion and lack of social support
4. **Social determinants** - the physical and social environment, including housing quality, the workplace and the wider urban and rural environment; as well as access to and the distribution of income and resources in society.

It is likely that the forthcoming Strategic Review of Health Inequalities in England (Marmot Review⁴) will stress the importance of addressing the wider determinants of health.

Figure 1 – “Rainbow” model of health

Islington is one of 70 Spearhead areas in England⁵: the eighth most deprived borough in England and the fourth most deprived borough in London⁶. Two thirds of Islington residents living in the 20% most deprived areas in England (Figure 2).

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⁴ Strategic Review of Health Inequalities in England post 2010 (Marmot review) [http://www.ucl.ac.uk/gheg/marmotreview/](http://www.ucl.ac.uk/gheg/marmotreview/)

⁵ These are the 70 local authority areas in the bottom fifth of districts nationally for three or more of the following five indicators:
- Male life expectancy at birth
- Female life expectancy at birth
- Cancer mortality rate in under 75s
- Cardiovascular disease mortality rate in under 75s; and
- Index of Multiple Deprivation 2004 average score.

⁶ The IMD 2007 contains seven domains of deprivation:
1. income deprivation,
2. employment deprivation,
3. health and disability deprivation,
4. education, skills and training deprivation,
5. barriers to housing and services,
6. living environment deprivation
7. crime
Figure 2: Percentage of residents by Index of Multiple Deprivation (IMD) quintiles, Islington, London and England, 2007.

Source: APHO Islington Health Profile, 2009.
In contrast to many Spearhead areas, wealth and poverty sit alongside one another, with no clear geographical boundaries, and people with very different characteristics living on the same street. Mosiac™ profiling (Map 1) shows that over 85% of Islington’s residents can be described by four dominant Mosaic™ types. Around 38% are transient singles (type E28), 28% are those living in high-density social housing (type F36), 11% are economically successful singles (type E29), and 8% are financially successful people (type A01).

Of all Islington wards, Highbury East has the largest percentage of financially successful people (type A01) and the smallest percentage of people living in high-density housing (type F36) (8%). Finsbury Park has the largest percentage of those living in high-density social housing (type F36) (44%) and contains no financially successful people (type A01).

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7 geodemographic tool which classifies the UK population into 11 lifestyle groups and 61 types based on different characteristics.

Source: Experian, Mosaic™, 2007; analysis by NHS Islington Public Health Intelligence.
Life expectancy and deprivation

There is a national target to reduce health inequalities by 2010, as measured by infant mortality and life expectancy at birth. Life expectancy in Islington is lower than the national average. Men in Islington have the lowest life expectancy in London at 75.1 years, and women have the fourth lowest life expectancy, at 81.0 years. Although life expectancy in Islington is increasing, the gap between Islington and the rest of London and England is widening as life expectancy is increasing elsewhere at a faster rate (Figure 3).

There are differences in life expectancy within Islington, by ward and by deprivation level. Between 2003 and 2007 Clerkenwell had the highest for men at 77.8 years and Tollington had the lowest at 72.6 years, a difference of 5.2 years. For women, St George's had the highest life expectancy at 82.5 years and Finsbury Park had the lowest at 78.1 years, a difference of 4.4 years. (Appendix 1 – Table1). There are further differences in life expectancy depending on deprivation level. This is measured using the slope index of inequalities, which gives the gap in life expectancy in number of years between the best-off and worst-off deciles (tenths of the population). For males in Islington, there was a difference of 6.7 years between the best-off and worst-off in 2004-08, while the equivalent figure was 4.4. years for females (Appendix 1 - Figures A & B).

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8 Reduce health inequalities by 10% by 2010 as measured by infant mortality (from a 1997-99 baseline) and life expectancy at birth (from a 1995-97 baseline).
The main contributors to the gap in life expectancy between Islington and the rest of England are circulatory diseases and cancer (Figures 4 and 5), which together account for a large proportion of deaths before 75 years, that are potentially preventable.

**Figure 4:** Breakdown of life expectancy gap between Islington and England Spearhead Group for men, 2005-07.

[Graph showing percentage of deaths by cause for men, with Islington and England Spearhead Group compared.]

**Figure 5:** Breakdown of life expectancy gap between Islington and England Spearhead Group for women, 2005-07.

[Graph showing percentage of deaths by cause for women, with Islington and England Spearhead Group compared.]

Source: Dept of Health, Health Inequalities Intervention Spearhead Tool, LHO, July 2009.
Death rates from CVD, cancer, smoking related diseases and mental health are all higher in Islington than the rest of the country. This is reflected in the high rates of illness and disease. The health of Islington residents is improving, but not as fast as we would like it to and it is not improving equally for all our residents. This strategy therefore sets out our key priorities and work programmes to tackle health inequalities, identified through the Joint Strategic Needs Assessment and NHS Islington’s Commissioning Strategy Plan.

The fundamental and deep rooted causes of health inequalities mean they can only be addressed by working in partnership. This requires joined up working, shared vision and effective collaboration across all partners to tackle the root causes, especially poverty and deprivation.

This strategy is divided into three sections.

- **Section one** examines actions that contribute to the 2010 target as highlighted by the NST.
- **Section two** considers the major lifestyle behaviours that contribute poor health and early deaths in Islington.
- **Section three** examines the socioeconomic factors that have the greatest impact on poor health and health inequalities over the long term, as identified in Islington’s JSNA (2009/10) and in the recent Strategic Review of Health Inequalities in England post 2010 [10].

Appendix two highlights the work programmes with performance indicators, to monitor progress on inequalities. This framework identifies the actions across all partners to improve health in the borough and will be monitored by the Islington Strategic Partnership, through the LAA process and sub groups (Appendix 2).

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**The NHS Islington vision**

In 2014 local people are healthier and live longer, living independently and participating in society. Local people know their voice is heard in how health services are provided. There are more services delivered closer to people’s homes; the quality is higher and the standards more consistent; fewer practices provide a wide range of services; targeted and tailored services are provided to particular groups in the population and those with specific needs; and hospitals only do what they do best. All local people have easy access to services and make choices about their care.

**Islington Sustainable Community Strategy vision for Islington 2020 is to:**

“create a stronger, more sustainable community in which everyone has access to excellent services and is able to fulfil their potential.

To achieve this vision for Islington, the strategy focuses on three key objectives:

1) Reducing poverty, 2) Improving access for all and 3) Realising everyone’s potential

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SECTION 1

SHORT TERM ACTION ON INEQUALITIES

PREVENTING EARLY DEATHS

THE 2010 HEALTH INEQUALITIES TARGET

CARDIOVASCULAR DISEASE

CANCER

INFANT MORTALITY

SEASONAL EXCESS DEATHS
THE 2010 HEALTH INEQUALITIES TARGET

Tackling health inequalities is a national priority. The overall national target on health inequalities was set in the Government’s 2001 Public Service Agreement (PSA) to:

- Reduce health inequalities by 10% by 2010 as measured by infant mortality (from a 1997-99 baseline) and life expectancy at birth (from a 1995-97 baseline).

Underlying this overall target, there are specific targets to reduce the difference in infant mortality between social classes and reduce the gap in life expectancy for men and women between the most deprived areas and the rest of the country.

- Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap in life expectancy at birth between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and the population as a whole

- Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between the routine and manual group and the population as a whole

A recent Department of Health review on the progress of Spearhead local authorities, 2010 target shows that Islington is currently “off track” to meet the 2010 target. In May 2009 the Health Inequalities National Support Team visited Islington and made a series of recommendations on how to focus effort to increase life expectancy in the short term. They identified four areas:

1. Cardiovascular Disease (CVD) – including secondary prevention of CVD, TIA and stroke
2. Cancers - early intervention, prevention, case finding and scaling up the tobacco control programme.
3. Infant Mortality – in particular implementing national inequalities guidance on infant mortality
4. Seasonal Excess Deaths - focusing mainly on excess winter deaths.

Section one identifies action to prevent early deaths from CVD, Cancer, Infant Mortality and SED.

CARDIOVASCULAR DISEASE

Cardiovascular disease (CVD) is the major killer in Islington, accounting for 35% of all deaths in 2006-08 and 29% of deaths under the age of 75. Deaths from CVD are one of the biggest contributors to the inequalities gap in life expectancy between Islington and England (Figure 4 and 5). Although the death rate from CVD in Islington is decreasing, rates in London and England have been decreasing at a faster rate, leading to a widening of the gap (Figure 6).

In keeping with the rest of the country, more men in Islington die early from CVD than women. There are also inequalities among different ethnic groups, with south Asian and Irish groups more at risk of coronary heart disease and black African and Caribbean groups more likely to die from stroke. Local modelling of CVD prevalence suggests that recorded prevalence in Islington is lower than would be expected for CHD, stroke, blood pressure and diabetes. This means that there are a large number of undiagnosed people in Islington, not receiving appropriate treatment and care. However, when compared with other areas, Islington’s population profile (age, gender, and ethnicity) and low levels of recorded CVD prevalence, does not fully explain higher CVD in Islington.

Lifestyle factors (smoking, unhealthy diet, differences in physical activity levels between routine and manual and non routine groups), linked with deprivation, explain most of the differences in CVD mortality between Islington compared with other areas, with deprivation standing out as the greatest risk factor. Medium

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13 Public health annual report 2007, Reducing early deaths from Cardiovascular disease in Islington.
term actions to improve lifestyle behaviours such as reducing smoking, healthy eating and physical activity will have an impact on the cardiovascular health of the local population.

In the short term, and in addition to lifestyle modifications, improving primary prevention, improved case finding and early diagnosis of CVD will also help reduce inequalities in CVD mortality. The NHS Health Checks Programme is a national programme that assesses individuals’ risk of heart disease, stroke, diabetes and kidney disease and give support and advice to reduce or manage that risk. By doing so it will improve primary prevention, case finding and early diagnosis. In the short term, general practices in Islington are targeting those thought to be at greatest risk of CVD. NHS Health Checks in the community will focus on high risk groups as well as those who are not registered with a GP.

The Health Inequalities National Support Team identified a number of other measures to reduce CVD inequalities in the borough, including improving practice records of patients who have established CVD or who are at high risk of CVD. This is being tackled through an enhanced service provided by general practices which includes monitoring and control of hypertension and cholesterol.

<table>
<thead>
<tr>
<th>The NST identified that for CVD, the key risk factors and priorities for action are:</th>
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<tbody>
<tr>
<td><strong>Key risk factors</strong></td>
</tr>
<tr>
<td>• Undiagnosed CVD across the population.</td>
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<tr>
<td>• Lifestyle factors such as smoking, unhealthy diet, physical activity</td>
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<tr>
<td>• High blood pressure and cholesterol</td>
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<td>• Deprivation</td>
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<tr>
<td><strong>Short term priorities for action are</strong></td>
</tr>
<tr>
<td>• Prevention and population risk factor reduction (Cholesterol, smoking and blood pressure)</td>
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<tr>
<td>• Systematically management and monitoring of CVD disease and risk registers</td>
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<tr>
<td>• Promote systems of medicines utilisation review for patients with CVD, and link with acute CVD management and CVD care pathways.</td>
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<tr>
<td>• Improvements in lifestyle behaviours, particularly smoking cessation and obesity management.</td>
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<tr>
<td>• Promote programmes to reduce Islington’s overall deprivation status</td>
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</table>
CANCER

Islington has the third highest death rate from cancer in London, and premature deaths from cancer are significantly higher in Islington than London and England (Figure 7). The main lifestyle risk factors for cancer are smoking and tobacco use, poor diet and lack of physical activity, alcohol, and exposure to ultraviolet radiation (for example, sun beds).

![Figure 7: Age-standardised premature cancer mortality in Islington, London and England, 1995-97 to 2006-08, with Islington plans for 2011-13 to 2014-16.](image)

Ethnicity data for cancer mortality are not available, as death records only provide data on place of birth. However, local records show that people born in the Republic of Ireland have significantly higher death rates from cancer compared to people born in the UK and all other groups. There is no significant difference in cancer mortality by Islington wards.

The most common cancers in Islington are lung, breast and bowel. Compared to all other London boroughs, Islington has significantly higher presentations of new cases and deaths from lung cancer, which is likely to be a consequence of the high smoking prevalence and widespread deprivation. Uptake of national cancer screening programmes in Islington (breast, cervical and bowel) are all lower than the national averages.
To address premature deaths from cancer, NHS Islington is prioritising health promotion programmes, using social marketing techniques to improve awareness and increase participation in cancer screening. This aims to improve the quality of cancer screening services through improved commissioning, access, appropriateness and acceptability of services and by incentivising GPs to increase screening uptake locally. Improvements in outcome measures, audit methods and data collection is also prioritised.

The NST identified that for cancer, the key risk factors and priorities for action are:

**Key risk factors**
- Unhealthy lifestyle behaviours, particularly smoking and poor diet.
- Late detection and presentation of cancer.
- Being born in the Republic of Ireland.

**Priorities for action**
- Reducing smoking prevalence is the single most important contributor towards reducing inequalities’ from cancer mortality.
- For all cancers, promoting early detection through case finding and national screening programmes is a priority.
- Sustained population health promotion and prevention programmes promoting healthy lifestyles behaviours with targeted communities (E.g. Irish).
INFANT MORTALITY

National Infant Mortality Target: Starting with children under one year, by 2010 to reduce the gap in mortality by at least 10% between "routine and manual" groups and the population as a whole

Infant mortality refers to the death of a baby before his or her first birthday, excluding stillbirths. Between 2005 and 2007, there were 43 deaths of infants under one year in Islington; a rate of five per 1,000 live births (similar to London and England).

Although the infant mortality rate is similar to London, there are inequalities between social classes and ethnic groups. There are no detailed ethnicity data on infant mortality in Islington, and although Hospital Episode Statistics record mothers’ ethnic origin, coverage is not always complete. Groups who are at risk of poverty and socioeconomic disadvantage (Pakistani, Bangladeshi, black Caribbean and black African families) are high risk groups for infant mortality.

Analysis by the London Health Observatory did not identify infant mortality as a major contributor to lower life expectancy in Islington compared with the rest of the country; however, there are significant risk factors for infant mortality locally including high levels of exposure to second hand smoke in the home, low immunisation coverage, and deprivation. Although the infant mortality rate is decreasing, the local deprivation profile and the widespread nature of deprivation in Islington mean that it should remain a priority.

The NST identified that for infant mortality, key risk factors and priorities for action are:

Key risk factors

- Risk factors associated with infant mortality relate primarily to living in deprivation, in particular, child poverty, overcrowding, teenage conceptions, late booking for antenatal care and maternity services and unhealthy lifestyle behaviours, particularly smoking and obesity.

Priorities for action

- Promote joined-up delivery of services to high risk groups in line national guidance, prioritising early booking and post natal support for routine and manual groups and teenage parents (including immunisation, breast feeding).
- Deliver coordinated programmes of work with local partners to reduce Islington’s overall deprivation status
- Sustained population health promotion and prevention programmes promoting healthy lifestyles behaviours with targeted groups, particularly on stopping smoking and maternal obesity.
SEASONAL EXCESS DEATHS

Seasonal excess deaths are deaths that are greater than the annual average. The term is usually used to describe winter deaths. These deaths are called Excess Winter Deaths (EWD). However, seasonal deaths also occur in very hot weather conditions, like heat waves.

There were 71 excess winter deaths (mostly from respiratory diseases) in Islington in 2005-07, similar to London and England. Data on summer deaths are not routinely reported at local level. Excess winter deaths are most common in the over 65 aged group and in vulnerable groups such as those at risk of poverty (in particular fuel poverty) and socioeconomic disadvantage, social isolation and people with pre-existing long term conditions, such as like CVD and / or respiratory disease (including influenza) / and or restricted mobility.

Addressing seasonal excess deaths requires action from a range of services, from accessing housing and fuel benefits, through to flu vaccinations for at risk groups. Currently there is no systematic mechanism in Islington to address seasonal excess deaths. However the Islington Affordable warmth group has prioritised this as an area for development.

<table>
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<tr>
<th>The NST identified that for SED’s, the key risk factors and priorities for action are:</th>
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**Key risk factors**

- Being over 65 years
- Living with a long term condition (CVD, Respiratory disease, diabetes and disability)
- Living with and experiencing deprivation particularly in relation to housing tenure and fuel poverty.
- Social isolation

**Priorities for action**

- Systematically analyse SED’s to include winter and summer deaths.
- Develop a Seasonal Excess Deaths strategy, to encompass actions related to affordable warmth.
- Identify Islington’s at risk vulnerable groups through systematic caseloads.
SECTION 2

MEDIUM TERM ACTION ON INEQUALITIES

PROMOTING HEALTHY LIFESTYLES

THE IMPACT OF HEALTHY LIFESTYLES ON HEALTH INEQUALITIES.

SMOKING

HEALTHY EATING

PHYSICAL ACTIVITY

MENTAL HEALTH

ALCOHOL

SUBSTANCE MISUSE

TEENAGE PREGNANCY

SEXUAL HEALTH
THE IMPACT OF HEALTHY LIFESTYLES ON HEALTH INEQUALITIES

The lifestyle choices we make have a major impact on our health and wellbeing. Deprivation and poverty has a direct correlation with unhealthy lifestyle behaviours. The major lifestyle factors that contribute to early deaths in Islington are; smoking, healthy eating, physical activity, mental health, alcohol and substance misuse, teenage pregnancy and sexual health.

This section examines the major lifestyle factors that contribute to health inequalities in Islington. Each lifestyle area is supported by a local strategy, the majority of which have been developed in partnership by a number of lead agencies in Islington. All the lifestyle programmes have targeted and universal actions, with an outline of the work programme. (Figure 8).
Figure 8. Tackling health inequalities by promoting healthy lifestyle behaviours
SMOKING

Smoking is the main contributor to the gap in inequalities in health between the disadvantaged and the better off. Smoking related illneses (heart disease, stroke, cancers and respiratory diseases) are the main preventable cause of early death in Islington.

Approximately, 28% of Islington adults smoke (about 44,000 Islington residents aged 16 years and over), compared to the London and England averages of 23.5% and 23.3%. Most smokers start in childhood and develop a lifelong smoking habit. The main risk factors that influence the uptake and continuation of smoking relate to social deprivation. Issues like homelessness, unemployment, low income, routine and manual employment, lone parenthood are associated with high rates of smoking and very low rates of quitting.

Smoking rates are higher among some BME groups, such as Asian men (Bangladeshi and Pakistani), Turkish, Somali and Irish men and Irish women. Smoking rates are particularly high among people with mental illness and this is likely to be one of the reasons why the severely mentally ill die younger from CVD and cancer. Up to 80% of prisoners in UK correctional facilities smoke. This is important for Islington due to the two prisons in the borough.

The key risk factors related to smoking prevalence are:

Key risk factors

- Deprivation and socioeconomic disadvantage.
- Poor mental health
- Prisoners, as there is high smoking prevalence among prisoners.
- BME communities where smoking prevalence is high.
- Smokers with established smoking related diseases (CVD and respiratory disease).

Priorities for action.

- Implement a coordinated borough wide tobacco control programme.
- Develop the advocacy role of the Smoke free Alliance, particularly around areas of high local concern, e.g. second hand smoke, illicit and counterfeit tobacco.
- Develop and implement joint communications activities ensuring consistent messaging and planned and coordinated activity across all strategic partners.
- Develop and industrial scale approach to stop smoking services, by linking with a range of programmes aimed at reducing Islington’s overall deprivation status - e.g. lifestyle health promotion programmes, education and workplace programmes.
- Appropriate scaled up and targeted stop smoking support using stop smoking pathways within acute and primary care linked to CVD and respiratory disease registers.
To reduce smoking prevalence in Islington we will prioritise a number of UNIVERSAL (across the whole population) and TARGETED (specific groups within Islington) actions across the borough through our Smokefree Strategy (2010 - 2020).

Through implementation the borough wide Smokefree strategy, universal actions across the whole population will focus on preventing young people from starting to smoke, keeping Islington free of counterfeit cigarettes and making sure that every smoker has an opportunity to access the Islington stop smoking services as soon as possible and at a location that is convenient for them.

The Smokefree strategy has a series of targeted actions for those groups most at risk of starting to smoke and those less likely to quit without extra support. For example, young people who may have other health and social care needs, people from communities where smoking is common place (Somali and Turkish, including action on shisha smoking for women) and groups who may find it more difficult to quit smoking, like lone parents, routine and manual groups and heavy dependant smokers with mental health problems and smokers with existing long term conditions (CVD, respiratory diseases).

HEALTHY EATING

A poor diet, high in saturated fat and low in fruit and vegetables is associated with obesity in younger children, and obesity and chronic illness (cardiovascular disease, colorectal cancer and diabetes) and early deaths in adults. Low levels of fruit and vegetable consumption (< five portions per day) is a key indicator for a poor diet. Approximately 42,100 Islington residents (27%) consume five portions of fruit and vegetables per day. Although this is broadly similar to the England average, it is still low. About one quarter of Islington year 6 children (11 years) are obese with a further 15% overweight. 10.6% of children in reception year (5 years) were obese and 12.5% overweight. This is significantly higher than the England average.

Low-income communities and those living in areas of deprivation have high rates of obesity. People with mental health problems and learning disabilities are also more at risk of obesity, exacerbated by a sedentary lifestyle and a restricted range of opportunities to exercise or eat healthily. Diabetes prevalence is particularly high among Bangladeshi and Black Caribbean ethnicities. Islington GP practices data showed a higher prevalence of obesity among female patients compared to males; among those aged 55-74; and among Black African or Black Caribbean groups.

Key risk factors for early deaths associated with poor diets

- Deprivation and associated unhealthy lifestyle behaviours activity and, particularly diet high in saturated fat and low in fruit and veg.
- Communities at high risk of obesity, including people with mental health and learning disabilities and established chronic diseases – CVD, diabetes.
- BME groups with high diabetes prevalence, like Bangladeshi and Black Caribbean ethnicities.
- Limited access to a variety of affordable healthy food choices due to geographical location and / or limited skills (cooking) to makes healthy food choices.

Priorities for action.

- Continue to implement the Islington food strategy and action plan.
- Sustained population health promotion and prevention programmes promoting healthy lifestyles particularly around weight management and healthy food choices including skills to enable healthy food choices.
- Target high risk children and adults for obesity prevention and weight management initiatives.
- Support the local population to access healthy food choices through ensuring a sustainable food culture in Islington by supporting local enterprise to provide a range of seasonable foods choices.
To promote healthy eating in Islington, there are a number of UNIVERSAL (across the whole population) and TARGETED (specific groups within Islington) multi agency actions identified in the Islington Food strategy.

Universal actions include prioritising health eating in maternal health and early years for children and young people, through promoting breast feeding as normal, as well as integrating oral health and health eating, through healthy food choices. We will continue to promote Change4life\(^{14}\) across all front line staff.

Out targeted work will focus on preventing obesity and developing obesity care pathways. We will use social marketing techniques to gather more insight into food choices and dietary habits within the diverse communities in Islington. We will also evaluate the impact of the Islington “Free school meals program”, to ensure that children in most need gain the most benefit.

The Islington Food strategy is available at

\(^{14}\) http://www.nhs.uk/change4life/Pages/default.aspx
PHYSICAL ACTIVITY

Regular physical activity is associated with a reduced risk of coronary heart disease, diabetes, obesity, and osteoporosis and colon cancer; and with improved mental health. For adults the recommended level is

“a minimum of 30 minutes a day of at least moderate intensity physical activity on five or more days of the week”\(^\text{15}\).

Overall physical activity levels among adults in Islington are estimated at 24%, broadly similar to London and England averages. There are however, marked inequalities in activity rates between groups. Levels for Islington men and women from routine and manual groups are very low at 9.8%, with non-white (particularly Asian communities at 20.0%).

Fewer people who are overweight and/or obese achieve recommended levels of physical activity. There is a sharp decline in physical activity among older age groups particularly after 65 years. People with mental health problems and/or learning disabilities are less likely to achieve recommended physical activity levels because of a restricted range of opportunities to exercise.

All of the above groups are high risk groups for premature deaths from CVD and cancer. Routine and manual group are particularly at risk from CVD related to low levels of physical activity as well as other unhealthy lifestyle behaviours like smoking and poor diet.

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**Key risk factors for early deaths associated with low levels of physical activity**

- Socioeconomic deprivation and associated with unhealthy lifestyle behaviours and particularly low levels of physical activity in routine and manual groups.
- People with mental health problems and/or learning disabilities and established chronic illness, particularly those with diabetes and cardiovascular diseases.
- Older adults (over 65 years).
- Limited access to safe physical activity opportunities and environments (e.g. access to green space / local physical activity programmes).

**Priorities for action.**

- Review and refresh the Islington ProActive physical activity action plan to increase everyday activities (walking / cycling), as well as sport related activities across the whole population.
- Promotion of a supportive built environment to encourage physical activity through Section106 planning applications and appropriate use green spaces to facilitate active lifestyles in a safe environment.
- Improve the understanding of the barriers to and potential motivating factors for physical activity within high risk sedentary groups, especially the routine and manual groups, through social marketing programmes.

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To promote physical activity in Islington, there are a number of UNIVERSAL (across the whole population) and TARGETED (specific groups within Islington) multi agency actions underway that will be implemented through the ProActive physical activity strategy.

Universal actions include promoting every day activities as well as sport related activities, particularly in the lead up to 2010 Olympic Games. We will promote activity friendly and safe environments through appropriate good use of green space and linked with our planning applications and commitment to affordable housing. Active travel will be promoted across all agencies.

Targeted actions will focus on those in most need and those most likely to benefit from easy access to physical activity opportunities. Groups with physical, sensory and mental health disabilities, older people, obese and over weigh groups, individual with long term conditions and routine and manual groups are our priority groups for extra support to become more physically active.

The ProActive physical activity strategy is available at http://www.islington.gov.uk/Leisure/Sports/getinvolved_sports/proactive.asp
MENTAL HEALTH

Mental ill health is very common in Islington with approximately 28,900 Islington residents (or about 31,000 of the GP registered population experiencing depression and anxiety during any week. Depression and anxiety are more common in women, while men are more vulnerable to psychotic disorders and suicide. In Islington the high risk communities are the Black Caribbean, Black African and Irish communities. Other risk groups are those living and experiencing socioeconomic disadvantage, e.g. single parent families, older people linked to social isolation, the unemployed, carers, prisoners and youth offenders.

Mental health problems are linked to less healthy lifestyle behaviours and poorer physical health. People with mental health problems are therefore more likely to have poorer diets, take less exercise, smoke more heavily, and have drug and alcohol misuse problems, which increases their risk of CVD and cancers.

There is an inequality in death rates from CVD amongst people with mental health problems. The CVD report (2007) showed that 43% of people with mental ill health had established CVD and were not on appropriate risk registers. This is in part due to “diagnostic over shadowing; where the mental health illness is prioritised over general physical health.

Key risk factors for early deaths associated with mental health

- Family history of mental ill health.
- Black Caribbean, Black African and Irish communities.
- Lesbian, gay and bisexual people, transsexual (LGBT) groups are at higher risk.
- Economic downturn / recession creating social and financial instability - e.g. increased unemployment
- Social isolation and poor community networks.
- A culture of stigma and discrimination
- Inadequate CVD risk assessment and incomplete CVD risk register data for people with mental ill health who have established, untreated CVD.

Priorities for action.

- Implementation of the Islington mental health promotion strategy.
- Early identification of CVD (through completing of risk register data) in clients with mental ill health.
- Sustained health promotion and prevention programmes promoting healthy lifestyles behaviours for patients with mental ill health, particularly around physical activity, stopping smoking, healthy eating to reduce early deaths from CVD and cancer.
- Improve understanding of the barriers to accessing mental health services for patients, carers and families through social marketing programmes.
- Addressing stigma and discrimination through Improving Access to Psychological Therapies and Mental Health First Aid training programmes.
To promote positive mental health in Islington, there are a number of UNIVERSAL (across the whole population) and TARGETED (specific groups within Islington) multi agency actions that we have committed to, currently being implemented through our Mental Health Promotion Strategy.

Across the whole population, actions to address stigma and discrimination raise awareness about mental health problems and support services, and suicide prevention will remain our population priorities. Our targeted actions will prioritise those groups in Islington in most need of support. This involves providing mental health support for individuals who find themselves in the criminal justice system, certain BME groups where prevalence of mental health problems are high, like Irish, Black African and Black Caribbean communities, as well as carers, people with learning difficulties and older people and families living with dementia.

Islington Mental Health Promotion strategy available at
ALCOHOL

Alcohol misuse is becoming an increasing problem in Islington. Heavy alcohol consumption is associated with poor mental and physical health outcomes, such as depression, anxiety and suicide, cancer, cardiovascular disease, accidents and trauma. Local alcohol profiles (2009) show that men in Islington have a shortened life expectancy (12.3 months) from alcohol related illness, which is worse than London and England averages. For women life expectancy from alcohol related ill health is shortened by 3.9 months. Islington also has higher hospital admissions for alcohol-related harm compared to London and England. In 2009, 21% of Islington adults were estimated to engage in hazardous drinking, similar to London (19%) and England (20%). Prevalence of binge drinking was 15%, similar to London and England averages.*

Islington has the sixth highest rate of alcohol related crime among the London boroughs, and 12th highest in the country. In 2009, 330 people in Islington were on incapacity benefits due to alcohol dependence. This is significantly than other parts of the country. Islington was the fourth most densely saturated borough in London for alcohol licences in 2007/8.

There are a number of vulnerable groups which are at higher risk of problematic alcohol use. These include:

- Children and Young People
- Women
- Older people
- Social Class (men in manual classes and professional women)

Key risk factors for alcohol misuse

- Living in deprivation and social disadvantage and isolation
- Routine and manual groups.
- Young people particularly associated with binge and harmful drinking.
- A vibrant night time economy with easy access to alcohol.

Priorities for action.

- Development and implementation of the Islington Alcohol Harm reduction strategy.
- Improve coverage of alcohol treatment services, alcohol screening and brief interventions for hazardous and harmful drinking in key settings (primary care, acute trust and criminal justice settings).
- Promoting sensible drinking and implement appropriate interventions using a social marketing approach across all partner agencies to explore the differing needs of various target audiences.
- Explore use of the Sustainable Communities Act to restrict alcohol licences in Islington, especially for specific geographical locations where alcohol related crime is high
- Improve local data links between A&E and police intelligence to build a local picture on alcohol related harm in the borough.

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To promote sensible drinking in Islington, there are a number of UNIVERSAL (across the whole population) and TARGETED (specific groups within Islington) multi agency actions prioritised across partners. Actions will be delivered in the forthcoming Islington Alcohol Strategy, due in May 2010.

As alcohol play a significant role in our society and economy, universal actions across the whole population need to focus on promoting safe, sensible and sociable alcohol consumption. This requires working with the trade on responsible retailing linked to safer communities and a reduction in alcohol related crime. Our universal actions will use a social marketing approach to increases awareness about the harms of alcohol and promote early access to services through a borough wide alcohol brief interventions programme.

Our targeted actions will focus on groups where alcohol causes most harm, in particular, alcohol related violence, problem hot spots, young people at risk of hazardous and harmful drinking, older people and improving treatment services for chronic dependant drinkers.

Islington Alcohol Strategy available in May 2010 at www.islingtonpct.nhs.uk
SUBSTANCE MISUSE

Substance misuse is strongly associated with poverty and deprivation. Rates of substance misuse are particularly high in London compared with other regions. A range of problems are linked to substance misuse including death, poor physical and mental health including depression, anxiety, personality disorders and psychotic disorders, crime and poor family and social functioning. Home office estimates suggest Islington has a high prevalence of problem drug users aged 15-64 years (2006/07). The Islington estimate was nearly twice the rate for London and represented 3,575 problem drug users. Amongst Spearhead PCT’s in London, Islington had the fourth highest rate of problematic drug use17.

The most vulnerable groups for substance misuse in Islington are the homeless, prisoners and disadvantaged young people. Levels of drug misuse are particularly high among the prison population.

Key risk factors associated with substance misuse

- Living in deprivation and social disadvantage
- Involvement in the criminal justice system (prisoners)
- Inappropriate drug treatment service provision, resulting in poor access and uptake and retention, particularly for younger people.

Priorities for action.

- Implementation of Islington substance misuse strategy and action plan
- Following a services review embed the new drug treatment system, ensuring smooth working and pathways through the system, including key worker arrangements. Monitoring and delivery for the new services is a priority.
- To increase awareness of substance misuse services for young people in Islington particularly amongst BME and Lesbian, Gay, Bisexual and Transgender communities
- To ensure all Islington children and young people receive drugs prevention advice and education, through a variety of settings - schools, youth services etc.

To prevent substance misuse in Islington, there are a number of UNIVERSAL (across the whole population) and TARGETED (specific groups within Islington) multi agency action points identified in the Islington Substance Misuse Strategy.

Universal actions to tackle substance misuse in Islington will focus on ensuring that the correct services are available based on local need. The introduction of new data collection systems and service reorganisation will inform more efficient and equitable local service provision across the whole population.

Our targeted actions are linked towards prevention and education for “at risk” groups, particularly children and young people. This will be delivered through appropriate training for all those who work with children and young people to, identify problematic behaviour early and provision of appropriate information, advice and support.

Islington substance misuse strategy is available at (to confirm)
TEENAGE PREGNANCY

Like all other inequalities teenage pregnancy and teenage parenthood is strongly associated with socioeconomic deprivation. Most common risk factors are low educational attainment (early school leavers); risk taking behaviours like alcohol, drug misuse and early onset of sexual activity, being a teenage mother already, living in care and being the daughter of a teenage mother.

Analysis of ethnicity of “at risk” groups is not straightforward, however local analysis shows that young women from White and Black communities are at higher risk of teenage pregnancy, while Asian communities are at lower risk. Information on fathers is more limited, but suggests that young Black males are at greater risk.

The teenage (<16 and 18 years) conception rate in Islington is higher than London and England, although overall rates have been reducing. The highest under 18 conception rates were in Finsbury Park and Tollington wards in the north and Mildmay and Bunhill in the south.

Key risk factors associated with teenage conceptions

- Low education attainment and leaving school with no qualifications is associated with a significantly increased risk of teenage pregnancy for both boys and girls over and above the impact of deprivation.
- Living and experiencing socioeconomic deprivation.
- Risk taking behaviours among young people
- Living in care, being the daughter of a teenage parent and being a teenage parent already.
- Children born to teenage parents are at greater risk of infant mortality.

Priorities for action.

- Continue to implement and update the local teenage pregnancy strategy and action plan.
- Specifically target and improve educational and life aspirations for “at risk” young people by promoting easy access to suitable education, training, life skills and employment opportunities.
- Increase availability and access to contraception and contraceptive services in a range of settings (e.g. youth centres, GUM practices, schools, Pupil Referral Units (PRU), community pharmacies), with signposting to specialist services where appropriate.
- Link up all programmes to reduce Islington’s overall deprivation status with teenage pregnancy action plans especially the Islington Child Poverty pilot.
To reduce teenage conceptions in Islington, there are a number of UNIVERSAL (across the whole population) and TARGETED (specific groups within Islington) multi agency action points identified in the local Teenage Pregnancy Action plan 2009-2011.

Population actions to reduce teenage pregnancy in Islington focus on ensuring all young people receive good quality sex and relationship education at a relevant ages plus improving access to and availability of a range of contraception choices, including condoms and Emergency Hormonal Contraception (EHC) across a range of settings both NHS and non NHS, that are appropriate for young people.

Our targeted actions focus on ensuring that young people identified as being at most risk of teenage pregnancy are provided with appropriate tailored support though education programs, individual support, easy access to contraception and post-termination follow up. Further targeted actions support teenage parents to access a range of support services, from health care through to housing needs and to continue in education or training.

Islington teenage pregnancy action plan (2009 - 2011) is available at www.islington.gov.uk
SEXUAL HEALTH

Poverty, deprivation, social exclusion and sexual health are inextricably linked. Sexual health is influenced by many factors, from sexual behaviours, attitudes and societal factors, quality of sex and relationship education and access to services, to biological risk and genetic predisposition.

Over recent years sexual health has deteriorated across the population, with increases in sexually transmitted infections (STIs) and the prevalence of human immunodeficiency virus (HIV). Young people and young adults, gay and bisexual men and men and women from African and Caribbean communities are the groups most at risk of poorer sexual health in Islington.

Borough specific data are somewhat limited as Islington services provide open access clinics, treating many non-Islington patients, with some Islington residents choosing sexual health services in other areas. However, in 2007, the two local GUM clinics reported 4,447 new cases of STIs. 1,110 Islington residents were living with diagnosed HIV, significantly higher than the London average and the third highest across all London PCTs. In 2008/09, 19% of 15 to 24 year olds in Islington were tested for Chlamydia, with 8% of those testing positive.

### Key risk factors for poor sexual health

- Living and experiencing socio economic deprivation.
- Young ethnically diverse population.
- Large LGBT population, particularly HIV risk for gay men.
- Poor access to an availability of appropriate sexual health services.

### Priorities for action.

- Delivery of the Joint Commissioning Strategy for Sexual Health and HIV Services (2009), which encourages collaborative working across services, the development of a sexual health network, and systematic collection and analysis of sexual health and HIV data locally.
- Delivery of high quality, age-appropriate sex and relationship education and treatment services across the borough, as well as targeted interventions to groups with specific needs or higher risks.
- Link up sexual health promotion programmes with other healthy lifestyle approaches and link to programmes to reduce Islington’s overall deprivation status.
To promote positive sexual health in Islington, there are a number of UNIVERSAL (across the whole population) and TARGETED (specific groups within Islington) multi agency action points identified in the Sexual Health Strategy.

Our universal actions will focus on raising the profile of positive sexual health across all partner agencies and promote and early access to a range of Sexual and Reproductive Health Services across the whole population.

Our targeted actions will focus on delivering high quality Sex and Relationships Education (SRE) to children and young people, particularly focusing on vulnerable young people in a range of settings - (e.g. Pupil Referral Units, Youth Offending Services, Detached Youth work, work with teenage parents, etc). We will use social marketing approaches to deliver more appropriate services, by gaining insight from key groups more at risk of poor sexual health, like gay and bisexual men; men and women from black minority ethnic communities; young people and younger adults, particularly from more deprived communities.

Islington sexual strategy available at (to confirm)
SECTION 3
LONG TERM ACTION ON INEQUALITIES

THE SOCIOECONOMIC DETERMINANTS OF HEALTH

THE IMPACT OF THE SOCIAL DETERMINANTS ON HEALTH INEQUALITIES

ENVIRONMENT
ECONOMY & EMPLOYMENT
HOUSING
EDUCATION AND LIFE LONG LEARNING
COMMUNITY SAFETY
THE IMPACT OF THE SOCIAL DETERMINANTS ON HEALTH INEQUALITIES

The wider determinants or socioeconomic determinants of health refer to the social, economic and environmental circumstances where people live, that impact on their. For example, people who experience poverty, poor housing, homelessness, lower educational attainment, insecure employment are more likely to suffer poorer health and earlier deaths compared with the rest of the population. Poor social and economic circumstances affect health throughout life and contribute to health inequalities across society. This section looks at the environment, economy & employment, housing, education and life long learning and community safety, and how they influence the health of our residents.

“Good health involves reducing levels of educational failure, reducing insecurity and unemployment and improving housing standards. Societies that enable all citizens to play a full and useful role in the social, economic and cultural life of their society will be healthier than those where people face insecurity, exclusion and deprivation”\(^{19}\).

THE ISLINGTON ENVIRONMENT

The environment where people live has a big impact on the types of lives they lead, the lifestyles they choose and their opportunities to succeed. Where a person lives influences the type of house people live in, types of employment, links to transport and access to a range of services and opportunities – like schools, transport links, shops, health care services.

Islington is the smallest and most built up of all London boroughs, covering 14.86 km². The dense, urban environment presents both challenges and opportunities. While access to local shops, services and public transport is generally good, Islington suffers high levels of air pollution from traffic, and the amount of green space is amongst the smallest amount per person of all London boroughs.

In 2009, the population was estimated at 195,489, almost half of whom were aged 20 to 39 years. The population is increasing, and is anticipated to reach over 213,000 by 2019. There is considerable movement in and out of the borough every year.

Three quarters of the population is white and 32% of residents were born outside the United Kingdom. There are a range of ethnic groups living in Islington, including Irish, Somali, Bengali, Turkish, Arabic, Albanian, Portuguese, Spanish, Nigerian and Ghanaian communities. In 2009, there were 40,728 people on the disability service register in Islington, the majority (67%) having a physical disability.

Just over half of the Islington population is categorised as “educated, young, single people”. One third are categorised as “people living in social housing”, higher in Islington, compared with London and England and 9% are “career professionals living in sought after locations”. The most striking difference between Islington and other London boroughs is the low percentage of residents in the “close –knit inner city community” and “older suburban families” group (Mosiac™)⁰. This may be a consequence of the limited supply of affordable family homes.

ECONOMY & EMPLOYMENT

⁰ geodemographic tool which classifies the UK population into 11 lifestyle groups and 61 types based on different characteristics. Islington Profile Mosaic™, 2009.
Poverty and employment are inextricably linked, and exclusion from sustained employment is a strong predictor of both poverty and ill health. Poverty has been described as the most important determinant of health, and also one of the most difficult areas in which to achieve change. Levels of disposable income affect the way people live, the quality of the home and work environment, and the ability of mothers to provide the kind of care for their children they want to. The relationship between health and low income exists across almost all health indicators.

Islington is the eighth most deprived local authority in England and the fourth most deprived local authority in London. The child poverty rate (52% of children) is the second highest in London.

Worklessness is a major issue within the borough - 18% of residents (approximately 25,090 people) are dependent on out of work benefits, including jobseeker’s allowance, incapacity benefit and income support, compared with 13.5% for England. 14% of those claiming jobseekers allowance have been claiming for over one year - the longer people are out of work, the more difficult it becomes to return to the work environment, which limits life chances and opportunities.

One quarter of businesses in Islington employ three quarters of the workforce. The majority of these businesses are Small and Medium sized Enterprises (SME), many of which are in the hospitality sector and which experience high turnover, particularly during periods of economic downturn. A large proportion of the workforce in Islington commutes into the borough every day. Local jobs for local people, particularly vulnerable groups (lone parents, long term unemployed returning to work, carers) is important to maximise opportunities for local people and to improve life chances and health outcomes.

45.2% of Islington children live in workless households. This excludes households in low paid work (below 60% median income), and therefore underestimates the scale of child poverty locally. Although the population is young, 11% are pensioners. 50% of older people in Islington are dependent on pension credit (a measure of pension poverty). In 2008, to 6% (10,400) of Islington residents were receiving disability living allowance.

Key risk factors for poor health outcomes from economic deprivation

- Unemployment, particularly out of work for over one year.
Decent affordable housing is a cornerstone of good health and a major determinant of health inequalities. Badly designed and poorly built houses with inadequate heating, damp, lack of space, poor lighting and shared amenities are a major contributor to poor health. Poor housing and homelessness are not just a housing problem. They have profound implications for the health and wellbeing of the people affected, and for society as a whole.

Housing within Islington is a market of extremes. At one end, the borough contains properties at the high end of London prices occupied by high income households, whilst at the other end many residents live on low incomes in social housing. 44% of Islington’s housing stock is in the social rented sector, compared to the England average of 18%. In spite of recent falls across the country and in London, average property prices in Islington are still significantly higher than the national average: in July 2009 the average property price in Islington was £380,628, compared to the national average of £155,885.

In March 2009, 75% of council homes had met the national decent homes standard. A survey of private sector dwellings showed that 26.4% failed the decent homes standard, with older dwelling much more likely to fail, mainly because of a category 1 hazard (excess cold, fire hazards, risk of falling on stairs damp and mould and leaking roofs).

Overcrowding and access to affordable housing are particular issues in Islington. The accommodation profile in Islington is high density semi-detached houses and flats. The Islington Housing Needs Assessment (2008) estimated that 4,344 affordable housing units are needed over the next five years to meet current and future housing needs. To alleviate overcrowding, more family sized homes will be needed, particularly in the social rented sector. All of the borough’s current affordable housing is obtained through Section 106 agreements.

Key risk factors for poor health outcomes associated with housing need

- Potentially fewer new homes and fewer affordable housing units as a consequence of the economic downturn
- Increased housing repossessions and homelessness as a result of economic downturn
- Houses that are unsuitable and or not reaching national Decent Homes Standards
Educational attainment and health status are inextricably linked - the longer an individual spends in education and the higher their educational attainment, the better their overall health and wellbeing. Promoting educational attainment at all stages is crucial, to secure future socioeconomic opportunity and health and wellbeing outcomes. Young people most at risk of leaving education early are those from deprived socioeconomic backgrounds, teenage parents, children with physical and mental disabilities, young offenders and children living in care.

In Islington, educational outcomes for Foundation stage children are lower than national averages, although outcomes at Key Stage 1 and 2 are broadly similar to the national average. The percentage of 16 year olds achieving more than 5 A* to G GCSEs and ≥5 A* to C GCSEs or equivalent grades has increased over the past five years, but is below national averages.

The Islington school population is extremely diverse, with 70% from BME communities. Hornsey had the highest proportion of BME child populations at 77%, while Canonbury has the lowest at 64%. There are approximately 120 different languages spoken by children at home in Islington. Hornsey and Barnsbury have the largest numbers of children with English as an additional language. Approximately 30% of Islington school children have special educational needs (SEN), with a small proportion of Looked after Children (LAC) at each key stage in Islington schools.

### Key risk factors for poor health outcomes associated with education and life long learning

- Living in socio economic deprivation.
- Low educational and life aspirations that impact on leaving education early without qualifications
- Physical and or mental disabilities that limit opportunities to remain in education.

### Priorities for action

- To provide the best start in life for young children and support their learning, development and achievement through an outstanding range of early years settings with associated excellent children’s services building on the Children’s Centre model and best practice.

- To raise standards of achievement and attainment; to narrow the gap in attainment between different groups in the borough and meet or exceed the best performance nationally. To achieve this through effective partnership between schools, children’s services, pupils, parents and the wider community.

- To positively change the life chances of the most disadvantaged members of the community with a specific emphasis on improving the pathways into education, employment and training for young people.

- To support community capacity, social cohesion and well being through schools and children’s centres that are ‘fit for purpose’ and provide centres of learning for their communities

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24 Area Children and Young People’s Partnership Profile (2008).
http://www.islington.gov.uk/DownloadableDocuments/CommunityandLiving/Pdf/Area_Children_and_Young_Peoples_Partnership_Profile.pdf
Instances of crime and disorder, intimidating behaviour and community perceptions of crime have detrimental effects on the quality of life and the health of individuals and communities. Inner city deprived boroughs like Islington, with high density residential and transient populations (particularly commuters and students) and major transport routes are likely to experience high crime rates. High rates are also linked to frequent episodes of alcohol and substance misuse.

Over the last four years, Islington has seen a continual decline in crime figures, with notable reductions in violent crime, sexual offences and racially motivated crime. Although overall levels of crime have dropped, the rate of decline in Islington is slower compared to other boroughs across the Metropolitan Police Service area.25

Crime records alone do not capture the full extent of crime in Islington. Domestic violence, hate crime and alcohol related crimes are often unrecorded - three quarters of assaults that result in hospital treatment do not appear on police records.26

<table>
<thead>
<tr>
<th>Key risk factors for poor health outcomes associated with community safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Living in socioeconomic deprivation and hardship.</td>
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<tr>
<td>• High density residential and transient populations linked to major arterial transport routes.</td>
</tr>
<tr>
<td>• A vibrant night time economy, linked to alcohol related crime.</td>
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<tr>
<td>• Current high level of crime</td>
</tr>
<tr>
<td>• Low levels of public confidence, disengagement and dissatisfaction.</td>
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<table>
<thead>
<tr>
<th>Priorities for action.</th>
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</thead>
<tbody>
<tr>
<td>• Implement the Islington Multi Agency Partnership Plan and the priorities identified in Islington’s Crime and Disorder Strategic Assessment</td>
</tr>
<tr>
<td>• Lead, implement and evaluate Islington’s Victims of Violence programme, identifying vulnerable victims (domestic violence, alcohol related violence and hate crime) in the Whittington hospital, who are not on police records and provide care pathways to appropriate support services.</td>
</tr>
<tr>
<td>• Restore public confidence by communicating more effectively with the diverse local population through the community engagement strategy, identifying local perceptions of need and safety.</td>
</tr>
<tr>
<td>• Linkup community safety programmes with other health and social work streams to tackle root causes of inequality – deprivation and social disadvantage, community disengagement and low aspirations.</td>
</tr>
</tbody>
</table>

25 (I-Quanta Database - Performance Strategy Directorate of Home Office)
SECTION 4

CONCLUSION AND RECOMMENDATIONS
Tackling health inequalities in Islington must remain a priority and it is not the responsibility of one organisation alone. It can only be achieved across partners.

- **The short term**, actions on CVD and cancer are primarily the responsibility of the NHS. This requires early prevention and detection of disease together with improving access to and availability of the correct services at the right time. This will remain a NHS priority.

- **In the medium term**, promoting healthy lifestyles should be priority across all agencies. A lifestyle approach should range from information and education sessions right through to creating a healthy environment through our strategies and policies, where making the healthy choice is the easier choice.

- **In the long term**, this strategy shows that tackling the root causes of inequalities are linked to deprivation and poverty. Supporting the local population to become economically independent through life long education and learning, affordable housing and the provision of a safe and prosperous borough should remain a long term priority for all agencies across Islington, as identified in the Sustainable Community Strategy.

The key risk factors and priority actions identified throughout all the sections of this strategy provide a valuable tool to inform the commissioning of world class services that will improve health and well being and reduce unacceptable inequalities in Islington.
SECTION 5

APPENDICES

APPENDIX 1  Life Expectancy at by wards and slop index of deprivation in Islington
APPENDIX 2  Local performance indicators
APPENDIX 1
Life Expectancy by wards and slop index of deprivation in Islington.

Table 1: Life Expectancy at Birth by wards in Islington, 2003-2007

<table>
<thead>
<tr>
<th>MEN</th>
<th>Life Expectancy</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower</td>
<td>Upper</td>
</tr>
<tr>
<td>Ward</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerkenwell</td>
<td>77.8</td>
<td>80.1</td>
</tr>
<tr>
<td>Barnsbury</td>
<td>76.2</td>
<td>78.4</td>
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<td>Highbury East</td>
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<td>76.8</td>
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<td>Hillrise</td>
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<td>Junction</td>
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<td>76.1</td>
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<td>Canonbury</td>
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<td>Finsbury Park</td>
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<td>75.9</td>
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<td>Highbury West</td>
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<td>Mildmay</td>
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<td>St George's</td>
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</tr>
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<td>Holloway</td>
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<tr>
<td>Tollington</td>
<td>72.6</td>
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<tr>
<td>Islington average</td>
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<table>
<thead>
<tr>
<th>WOMEN</th>
<th>Life Expectancy</th>
<th>95% Confidence Interval</th>
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<tr>
<td></td>
<td>Lower</td>
<td>Upper</td>
</tr>
<tr>
<td>Ward</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St George's</td>
<td>82.5</td>
<td>85.0</td>
</tr>
<tr>
<td>Highbury West</td>
<td>82.4</td>
<td>84.5</td>
</tr>
<tr>
<td>Bunhill</td>
<td>82.3</td>
<td>84.5</td>
</tr>
<tr>
<td>Canonbury</td>
<td>82.0</td>
<td>84.4</td>
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<tr>
<td>Junction</td>
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<td>Barnsbury</td>
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<tr>
<td>Highbury East</td>
<td>80.5</td>
<td>82.3</td>
</tr>
<tr>
<td>St Mary's</td>
<td>80.4</td>
<td>82.3</td>
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<tr>
<td>Mildmay</td>
<td>80.1</td>
<td>81.8</td>
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<tr>
<td>Caledonian</td>
<td>79.9</td>
<td>81.8</td>
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<td>Clerkenwell</td>
<td>79.5</td>
<td>82.0</td>
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<td>Tollington</td>
<td>79.5</td>
<td>81.5</td>
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<td>Holloway</td>
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<td>81.2</td>
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<td>St Peter's</td>
<td>78.7</td>
<td>80.4</td>
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<tr>
<td>Hillrise</td>
<td>78.4</td>
<td>80.0</td>
</tr>
<tr>
<td>Finsbury Park</td>
<td>78.1</td>
<td>79.6</td>
</tr>
<tr>
<td>Islington average</td>
<td>80.3</td>
<td>80.7</td>
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Life expectancy and deprivation².

There are further differences in life expectancy depending on deprivation level. The extent of inequalities in life expectancy can be calculated using the slope index of inequalities, which gives the gap in life expectancy in number of years between the best-off and worst-off within the PCT. Rather than comparing e.g. only the top and bottom deprivation deciles, the slope index is based on a robust statistical model of the life expectancy and deprivation scores across the whole PCT[1].

For males in Islington, there was a difference of 6.7 years between the best-off and worst-off in 2004-08, while the equivalent figure was 4.4 years for females (Figures A & B). This can be compared to the England average, which was 8.6 years for males and 5.8 years for females in the same period. However, the values for both males and females in Islington were not significantly different from those in England overall.

NOTE: the majority of the population in Islington is deprived and life expectancy is low overall. Therefore, the difference between the best-off and worst-off is likely to be comparatively limited in Islington compared to England.

Figure A: Life expectancy at birth by deprivation deciles showing the slope index of inequality for Islington, males, 2004-08. One is the most deprived and ten the least deprived decile. Slope Index of Inequality = 6.7 years (95% Confidence Interval: 3.4 to 9.9)

[1] The slope index is based on local deprivation deciles (tenths) within a PCT and is calculated by taking the life expectancy for each deprivation decile and then fitting a regression line through those points. Local deprivation deciles are calculated by ranking all Lower Super Output Areas (approximately 1500 households) within a PCT by the Index of Multiple Deprivation (2007) score and then dividing them into ten roughly equal groups. Further information on the slope index of inequalities can be found at: http://www.apho.org.uk/resource/view.aspx?RID=75050
Figure B: Life expectancy by deprivation deciles showing the slope index of inequality for Islington, females, 2004-08. One is the most deprived and ten the least deprived decile. Slope Index of Inequality = 4.4 years (95% Confidence Interval: 1.2 to 7.6)
Appendix 2 – Performance indicators.

Table 1. Improving health outcomes in Islington.

Islington has chosen 21 National Indicators (NI) as targeted priorities including locally developed indicators. There are 16 statutory education NI’s. Vital Signs are national NHS performance indicators.

| SHORT TERM ACTIONS ON INEQUALITIES - PREVENTING EARLY DEATHS (2009-2015) |
|-----------------|-----------------|-------------------|-----------------|-----------------|-----------------|
| Priority areas  | Actions          | Who delivers locally | NHS Commissioning Strategy Plan. | Other NHS Islington programs | Local Area Agreement | National Indicators (NI) & NHS Vital Signs indicators (VS) |
| 1 Cardio Vascular Disease. | Vascular Risk Assessment programme. | Primary Care GP Pharmacy Linked to ISP Theme group - Health and Wellbeing Partnership Board | 1. Number of new entrants onto the risk register (qtly and annual) 2. Risk assessments undertaken per Practice relative to expected prevalence (qtly and annual) 3. Risk assessments undertaken per Pharmacy against target (qtly and annual) 4. % gap in prevalence per Practice against expectations (annual) 5. % eligible population with vascular risk score relative to expected prevalence (annual) | 1. CVD - Smoking and dentists 2. CVD and obesity LIS (Local Incentive Scheme) 3. Vascular Risk Assessments Development of outreach and community models 4. Expansion of capacity of cardiac rehab 5. CHD - Commissioning Angina Plan 6. CVD and obesity LIS (Local Incentive Scheme) 7. Pilot "Vascular risk" case finding scheme in pharmacy | Health and Wellbeing Partnership Board target Smoking cessation programme – number of quitters per quarter | NI 121: Mortality rate from all circulatory diseases at ages under 75. VSA14 - Stroke Care VSB01 - AAACM VSB02 - CVD Mortality VSB05 - Smoking quitters VSC NHSI local priority - Percentage of eligible population with risk score |
| 2 | Cancer prevention, case finding & early diagnosis | National Cancer Screening programmes. Bowel Cervical, Breast | Primary care Linked to Health and Wellbeing Partnership Board. | 1. Percentage screened cancer cervical by Practice (quarterly and annual)  
2. Percentage screened cancer bowel by Practice (quarterly and annual)  
3. Percentage screened cancer Breast by Practice (quarterly and annual). | 1. Smoking - smokefree and cessation  
2. COPD - Social marketing campaign (cough and breathlessness)  
3. COPD - case finding & management in primary care/LES  
4. Prescribing costs associated with COPD case finding  
5. COPD - pilot and evaluation of targeted spirometry in smoking clinics  
6. Cancer Screening - Static site for Breast screening  
7. Cancer Screening - Primary care  
8. Cancer - Prevention & early diagnosis | **VSC23** - Numbers of practices with PCT-validated registers of patients without symptoms of cardiovascular disease but who have an absolute risk of CVD events greater than 20% over the next 10 years  
**VSA08** - Breast Symptom Two Week Wait  
**VSA09** - Extension of NHS Breast Screening Programme to women aged 47-49 and 71-73  
**VSA10** - Extension of NHS Bowel Cancer Screening Programme to men and women aged 70 up to 75th birthday (75)  
**VSA11** - 31-Day Standard for Subsequent Cancer |
<table>
<thead>
<tr>
<th></th>
<th>3 Infant mortality(^6)</th>
<th>Reducing infant mortality through the related work streams and Acute trust's maternity units NHS Islington, Children's services,</th>
<th>Children and Young People - CAMHS &amp; Parenting - Solihull Model. 1. Percentage of early NI 112: Under 18 conception rate</th>
<th>VSB05 - Smoking quitters</th>
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Treatments (Chemotherapy and Surgery) National requirement

**VSA12** - 31-Day Standard for Subsequent Cancer Treatments (Radiotherapy)

**VSA13** - Extended 62-Day Cancer Treatment Targets (National Requirement)

**VSA15** - All women to receive results of cervical screening tests within two weeks

**VSB01** - AAACM

**VSB03** - Cancer Mortality

**VSB05** - Smoking quitters
<table>
<thead>
<tr>
<th>Actions plans</th>
<th>Social services</th>
<th>Maternity service</th>
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<tbody>
<tr>
<td>e.g. reducing teenage conceptions, increasing immunisations, promoting breastfeeding &amp; safeguarding children</td>
<td>antenatal booking (by 12 weeks and &gt; 22 weeks) among disadvantaged groups, specifically teenage mothers and routine and manual groups (quarterly and annual).</td>
<td>VSB08 - Teenage Pregnancy</td>
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<td></td>
<td>2. No of preterm births (babies born &lt; 37 weeks gestation). (annual)</td>
<td>VSB11 - 6-8wks breastfeeding</td>
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<td>3. Percentage of infant immunisation coverage.</td>
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<td>4. Percentage/ number of pregnant smokers and new parents offered stop smoking support (annual).</td>
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<td>5. Number of teenage conceptions &amp; completed pregnancies (annual)</td>
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<td>6. Number of teenage parents supported to continuing education (annual).</td>
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<td>7. Percentage of families with infants living in overcrowded conditions (annual).</td>
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<td>8. Number of above families rehoused (quarterly and annual)</td>
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<td>9. Percentage of families with infants claiming benefits</td>
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<td>Seasonal excess deaths</td>
<td>Islington Affordable Warmth Strategy</td>
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<td>4</td>
<td>1. Number of excess winter deaths as measured through 'winter deaths' (Dec-Mar) minus average of 'non-winter deaths'.</td>
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<td></td>
<td>2. Number of Older People admitted to hospital with falls</td>
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<tr>
<td>Priority areas</td>
<td>Actions areas/programmes</td>
<td>Who delivers locally</td>
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</table>
| 1 Smoking     | Tobacco control programme | Primary care GP & Pharmacy linked to ISP Theme group - Health and Wellbeing Partnership Board | 1. Number of 4 weeks quits (annual)  
E.g.  
2010/11 - 2218 quits.  
2011/12 - 2068 quits.  
2013/14 - 2000 quits.  
2. No of referrals to the service by source (qnty and annual)  
3. Annual health equity audit of the stop smoking service.  
4. Annual health equity audit smoking-related diseases – e.g. coronary heart disease, stroke & respiratory disease.  
5. No of smoking related domestic fires (qnty and annual)  
6. No of workplaces non compliant with Smokefree | 1. Oral Health – Various  
2. Smoking - smokefree and cessation  
3. CVD - Smoking and dentists  
4. No of “education and prevention” sessions within young peoples educational settings (including PRU’s, children’s centres, primary, secondary and colleges)  
5. Evaluation of smokefree “Smokefree” social marketing campaigns  
6. Annual record of “test purchases” and illicit sales | Health and Wellbeing Partnership Board  
Smoking cessation programme – number of quitters per quarter | NI 121: Mortality rate from all circulatory diseases at ages under 75 (see cardiovascular disease)  
VSA14 - Stroke Care  
VSB01 - AAACM  
VSB02 - CVD Mortality rate  
VSB03 - Cancer Mortality rate  
VSB05 - Smoking quitters. |
<table>
<thead>
<tr>
<th></th>
<th>Healthy Eating</th>
<th>Islington Food Strategy</th>
<th>legislation (qly and annual)</th>
<th>seizures.</th>
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</thead>
<tbody>
<tr>
<td>2</td>
<td>PCT, Council, Community &amp; Voluntary sector linked to ISP Theme group - Health and Wellbeing Partnership Board.</td>
<td><strong>1.</strong> Proportion of adults measured in GP Practice with BMI greater than or equal to 30 (annual)</td>
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<td><strong>2.</strong> Percent of above patients with an intervention in last year (annual)</td>
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<td><strong>3.</strong> Proportion of overweight and obese children in year 6 (annual source: NCMP)</td>
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<td><strong>4.</strong> Numbers of children in MEND and mini MEND (quarterly)</td>
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<td><strong>5.</strong> Proportion of eligible and non eligible children consuming school meals (quarterly and annual)</td>
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<td><strong>6.</strong> Number of “fast food” outlets in proximity to Islington schools (annual)</td>
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<td><strong>7.</strong> Percent of above patients with a healthy eating related intervention in last year (annual)</td>
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<td><strong>8.</strong> HCOP8 Increase in uptake and duration of breastfeeding</td>
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<td><strong>Health and Wellbeing Partnership Board</strong></td>
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<td></td>
<td></td>
<td>Breastfeeding Peer Support Network &amp; Baby Friendly Initiative – target of 54.2% prevalence</td>
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<td></td>
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<td>Healthy Schools – 60 schools to achieve Healthy School Status</td>
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<tr>
<td></td>
<td></td>
<td><strong>HCOP8 Increase in uptake and duration of breastfeeding</strong></td>
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<td><strong>HCOP4</strong></td>
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<td>The proportion of the population having at least 5 portions of fruit / vegetables daily as measured through the LAA Residents’ Survey</td>
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<td></td>
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<td>NI 056: Obesity in primary school age children in Year 6</td>
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<td>VSB09 - Childhood Obesity</td>
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</tbody>
</table>
|   | Physical activity | Proactive Islington physical activity strategy | PCT, Council, Community & Voluntary Sector linked to ISP Theme group - Health and Wellbeing Partnership Board | 1. Numbers of referrals to exercise on prescription (qtrly) | 1. Health promotion behaviour change -prisons / workplace health | Health and Wellbeing Partnership Board  
**REWARD GRANT**  
HCOP6  
The percentage of Islington schools achieving national expectations in Healthy schools Scheme for each of the themes:  
(1) PSHE  
(2) Healthy eating  
(3) Physical activity  
(4) Emotional health and wellbeing  
HCOP7  
Percentage of Islington school pupils participating in at least 2 hours of high quality PE/sport/physical activity in a typical week compared with national performance | 2. Numbers of people supported by Health trainers (qtrly) | 2. Obesity - Public Health Interventions – Children and Young People  
HCOP9 | 3. Proportion of adults undertaking 30 minute or more of moderate exercise at least 3 times a week Sport England active people survey (Annual Estimate) | 3. Health Promotion and Behaviour Change - Provider Side incl. Co-creating health  
HCOP9 | 4. Number of referrals to Workfit (quarterly) | 4. Health Promoting – hospitals  
HCOP9 | 5. Percent of above patients offered a physical activity related intervention in last year (annual) | 5. No of adult cycle training sessions provide by Islington council (annual). |
<table>
<thead>
<tr>
<th>No.</th>
<th>Category</th>
<th>Description</th>
<th>Objectives</th>
<th>Grants</th>
</tr>
</thead>
</table>
| 4   | Mental health     | Islington Mental Health Promotion strategy                                                       | PCT, Council, Community & Voluntary Sector linked to ISP Theme group - Health and Wellbeing Partnership Board                                                                                               | Local: Promote early intervention and improved outcomes for adults with mental health problems.  
Health and Wellbeing Partnership Board  
Enhanced IAPT website - Measured on how many hits on the website and target of 240 people accessing IAPT  
Enhancing Mental Health First Aid – target of 400 people completing MHFA training.  
Mental Wellbeing Champions Programme  
**REWARD GRANT HCOP6**  
The percentage of Islington schools achieving national expectations in Healthy schools Scheme for each of | VSB12 - Emotional health and well being and child and adolescent mental health services (CAMHS)  
VSC02 - People with depression and/or anxiety disorders with access to psychological therapies.  
**NHSI local priority** - Improving the quality of the patient experience and health outcomes |

1. Number of patients entering IAPT (qtly)  
2. Percentage of patients from each GP Practice (qtly)  
3. Numbers of patients from underserved groups (qtly)  
4. % patients using IAPT from each GP Practice (qtly)  
5. Number of patients who move of benefits (annual)  
6. Number of MHFA Islington trainees (qtly and annual)  

---

Number of older people taking moderate intensity physical activity measured through number of attendees (over 50 week period) at Everactive classes in Islington
|   | Alcohol | Alcohol harm reduction strategy | PCT, Council, Community & Voluntary Sector linked to ISP Theme groups - Health and Wellbeing Partnership Board & Safer Islington Partnership | 1. Number of emergency admissions for alcohol related harm (qtly) | 1. Alcohol - alcohol harm minimisation  
2. Alcohol - Full expansion of LIS  
3. Health Promotion and Behaviour Change - Health Trainers  
4. Health Promotion and Behaviour Change - Provider Side incl. Co-creating health  
5. Health Promoting – hospitals | the themes:  
(1) PSHE  
(2) Healthy eating  
(3) Physical activity  
(4) Emotional health and wellbeing  
HCOP12  
Number of older people having active and fulfilling lives in the community as measured through LAA Residents' Survey | 5  
Alcohol - alcohol harm minimisation  
2. Alcohol - Full expansion of LIS  
3. Health Promotion and Behaviour Change - Health Trainers  
4. Health Promotion and Behaviour Change - Provider Side incl. Co-creating health  
5. Health Promoting – hospitals | NI 017: Perceptions of anti-social behaviour  
VSB01 - AAACM  
VSB02 - CVD mortality rate  
VSB03 - Cancer mortality rate |
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<tbody>
<tr>
<td>6</td>
<td>Substance misuse</td>
<td>Substance misuse strategy</td>
<td>PCT, Council, Community &amp; Voluntary Sector</td>
<td>1. Health promotion behaviour change -prisons</td>
<td></td>
<td></td>
<td></td>
<td>NI 038: Drug related (Class A) offending</td>
</tr>
</tbody>
</table>
| 7 | Teenage pregnancy | Islington Teenage pregnancy action plan | PCT, Council, Community & Voluntary Sector linked to ISP Theme groups - Health and Wellbeing Partnership Board | 1. Numbers on long acting contraception (qtly and annual)  
2. Numbers of teenagers seen through community services (qtly and annual)  
3. Number of under 18 conceptions (annual)  
4. Number of terminations in under 18s (annual)  
5. Numbers of repeat terminations of pregnancies (annual)  
6. Number of teenage parents supported to continuing education (annual). | 1. Teenage Pregnancy - Condom Distribution scheme and outreach (Brook)  
2. Teenage Pregnancy - PULSE - IPCT - Admin Lead  
3. Teenage Pregnancy - PULSE - Camden PCT  
4. Teenage Pregnancy - EHC expansion  
5. Work with parents on addressing SRE with their children  
6. Sexual Health - Chlamydia - improvement uptake of screening levels | NI 112: Under 18 conception rate |
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<tr>
<td>8</td>
<td>Sexual</td>
<td>Islington’s Joint</td>
<td></td>
<td>1. Teenage</td>
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<td>VSB13 -</td>
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</table>

**VSB14** - Number of Drug Users recorded as being in effective treatment
| Health Commissioning Strategy for Sexual Health and HIV Services | Pregnancy - Condom Distribution scheme and outreach (Brook) |
| | 2. Teenage Pregnancy - PULSE - IPCT - Admin Lead |
| | 3. Teenage Pregnancy - PULSE - Camden PCT |
| | 4. Teenage Pregnancy - EHC expansion |
| | 5. Work with parents on addressing SRE with their children |
| | 6. Sexual Health - Chlamydia - improvement uptake of screening levels |

<p>| Workplace health* | Workplace health promotion strategy (in progress) | This programme of work is being developed over 2010/2011. |
| | | 1. Health promotion behaviour change -prisons / workplace health |
| | | 2. Number of |</p>
<table>
<thead>
<tr>
<th></th>
<th>Oral health</th>
<th>NHS Dentist</th>
<th>Islington based workplaces (annual)</th>
<th>3. Number of people employed in Islington based businesses.</th>
<th>4. Number of Islington based employees on low income / minimum wage/ irregular/ insecure employment.</th>
<th>5. Proportion of employees on long term sick leave</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td></td>
<td>1. Number of Islington children and adults accessing NHS dental services locally (qty)</td>
<td>1. Oral Health - Oral Health – Various</td>
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<td>2. Number of residents accessing NHS dental services locally (qty)</td>
<td>2. CVD - Smoking and dentists</td>
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<td>3. Units of dental activity (qty)</td>
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<td>4. Number of children receiving fluoride varnish brushing for life packs (qty)</td>
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<td>5. Referrals to secondary care for adults/children (qty)</td>
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<td>6. Staff in community setting trained in promoting oral health for adults and children (qty)</td>
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<td>1. Oral Health - Oral Health – Various</td>
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<td>2. CVD - Smoking and dentists</td>
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<td>VSB18 - Dental Services</td>
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<td>NHSI local priority</td>
<td>Improving the quality of the patient experience and health outcomes.</td>
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<tr>
<td>Priority areas</td>
<td>Actions areas/programmes</td>
<td>Who delivers locally</td>
<td>NHS Commissioning Strategy Plan</td>
<td>Other NHS Islington programs</td>
<td>Local Area Agreement</td>
<td>National Indicator (NI)</td>
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<tr>
<td>Environment including Green space</td>
<td>Sustainable communities strategy, Islington Core Strategy</td>
<td>ISP Theme group. Environment and Sustainability</td>
<td></td>
<td></td>
<td>SSC21** The difference in reported use of Islington parks and open spaces by residents with a long-term illness or disability as compared to all other residents</td>
<td>NI 186: Per capita reduction in CO2 emissions in the LA area</td>
</tr>
<tr>
<td>Climate Spatial planning</td>
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<td>SSC22 (a) Percentage of household waste arisings which have been sent by the authority for recycling and composting</td>
<td>NI 188: Planning to Adapt to Climate Change</td>
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<td>(b) Increase in the percentage of municipal waste recycled</td>
<td>NI 195: Improved street and environmental cleanliness (levels of litter detritus graffiti and fly-posting)</td>
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<td>SSC23 a) Total reductions in CO2 emissions from Islington Climate Change Partnership members (% reduction on 2005/6 baseline)</td>
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<td>(b) Borough wide CO2 emissions from gas and electricity usage and transport</td>
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<td>(c) The percentage annual increase in the number of schools with an approved school travel plan (STP) required to achieve 100% STP coverage by March 2010</td>
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<td>SSC24</td>
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<tr>
<td>Enhancement in bio-diversity as demonstrated by the area of land approved for improved nature conservation within the LDF SSC24</td>
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<tr>
<td><strong>STRETCH TARGET</strong></td>
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<tr>
<td>The number of Green Flag or Green Pennant Accredited parks and open spaces in Islington at 31.03.09</td>
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<td><em>At least four of the parks which contribute to the enhancement are within, or within a straight line distance of 100m of the boundary of, one of the 10% most deprived SOAs nationally</em></td>
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<tr>
<td><em>Of these four, at least one of the parks which contributes to the enhancement is within, or within a straight line distance of 100m of the boundary of, one of the 10% most deprived SOAs in Islington</em></td>
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<td>SSC26</td>
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<td>Increase in residents' use of parks - as measured through the annual LAA survey</td>
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<td>(1) Percentage of residents who say they use parks and open spaces in Islington,</td>
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<td>(2) Percentage of residents who say they are satisfied with the quality of parks and open spaces</td>
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<td>(3) Resident satisfaction with parks and open spaces as measured by the three yearly BVPI survey (BV119e) (%)</td>
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<td>SSC27</td>
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<td>Number of hectares of publicly accessible parks and open spaces</td>
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</table>

**SSC28**
**STRETCH TARGET**
The proportion of relevant land and highways (expressed as a percentage) in the London borough of Islington's land use areas contained within the named (1) high and (2) low density social housing estates that fall wholly or partly within the five SOAs that are the most deprived in Islington as at 31.03.05 that is assessed as having combined deposits of litter and detritus that fall below an acceptable level.

**SSC29**
Environmental quality as measured through:
(a) Average Local Environmental Quality Standard score for the borough – BVPI199a
(b) BV89 – satisfaction with the cleanliness of public land (measured by the three yearly BVPI survey (BV89) (%)
(c) Resident satisfaction with cleanliness (annual proxy measure of (b) derived from LAA Residents’ Survey)

**SSC30**
(a) Percentage of residents reporting increased satisfaction with their neighbourhoods, and
(b) In disadvantaged areas, showing
| 2 | Economy | Sustainable communities' strategy\(^{12}\).  
Islington Council Business support managers.  
Child poverty pilot. | ISP Theme group. Business, Jobs and Training | 1. Number of teenage parents supported to continuing education (annual). | Workplace health promotion programme | EDE4  
Average total household income in households with an income of less than £40,000 per annum in the 10% most deprived SOAs in Islington  
EDE6  
Number of business start up rates by BME entrepreneurs  
EDE7  
The amount of Islington council's expenditure spent in the Islington economy  
EDE8  
The value of contracts to provide goods and services generated by major developments in Islington won by Islington based businesses  
EDE9  
The number of people resident in the 10% most deprived SOAs in Islington who have been unemployed for at least six months who gain sustainable employment  
EDE5  
STRETCH TARGET | a narrowing of the gap between these areas and the rest  
**SSC31**  
An increase in the percentage of abandoned vehicles removed within 24 hours from the point where the local authority is legally entitled to remove the vehicle (BVPI 218b) |  
NI 004: % of people who feel they can influence decisions in their locality.  
NI 116: Proportion of children in poverty |
<table>
<thead>
<tr>
<th>ISP Theme group</th>
<th>Sustainable communities’ strategy</th>
<th>1. Number of teenage parents supported to continuing education (annual).</th>
<th>Improve household income for pensioner households through increasing uptake of benefits. As measured through (1) Claimant caseload for Pension Credit to Islington residents aged 60 and over (2) Claimant caseload for Attendance Allowance to Islington residents aged 65 and over (3) Claimant caseload for Council Tax Benefit to Islington residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>ISP Theme group. Children's Board</td>
<td>EDE1 STRETCH Number of people with no existing qualifications who achieve a full Level 2 qualification through enrolment and attendance at City and Islington College EDE2 The number of people completing a Skills for Life course</td>
<td>NI 080: Achievement of a Level 3 qualification by the age of 19 NI 111: First time entrants to the Youth Justice System aged 10-17</td>
</tr>
<tr>
<td>3</td>
<td>Children's Board</td>
<td>EDE3 STRETCH Number of people who have been in receipt of Incapacity Benefit for a minimum of 26 weeks, supported by the Business, Jobs and Training Partnership into sustained workforce</td>
<td>NI 152: Working age people on out of work benefits</td>
</tr>
<tr>
<td>Employment</td>
<td>ISP Theme group. Business, Jobs and Training</td>
<td>Workplace health promotion programme. Mental Health - Talking therapies promoting return</td>
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<tr>
<td>EDE11</td>
<td>Increase the number of people with mental health problems supported into: employment; placements; training and volunteering.</td>
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<tr>
<td>EDE12</td>
<td>Number of Islington residents employed in the construction phase and end use of major developments in Islington</td>
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<tr>
<td>EDE13</td>
<td>(a) A reduction by 2007-08 of at least 2 percentage points in the overall benefits claim rate for those living in the Finsbury Park ward*</td>
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<td></td>
<td>(b) A reduction in the overall benefits claimant rate for Islington</td>
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<td></td>
<td>(c) A reduction by 2007-08 of at least 2 percentage points in the difference between the overall benefits claimant rate for England and the overall rate of Finsbury Park*</td>
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<td>(*NB: These two indicators target the 532 local authority wards identified by DWP as having the worst initial labour market position – Finsbury Park is the only Islington ward on this list)</td>
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<tr>
<td>SSC17</td>
<td>a) Number of people volunteering through ISP-funded volunteering</td>
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</tbody>
</table>
projects in Islington
b) Number of Islington residents involved in the following specific volunteering activities, which will empower them to have a greater voice and influence over local decision making and delivery of services:
   - Membership of an Islington school governing board
   - Membership of an Islington parks "friends of" group
   - Being an "Eye for Islington"
   - Participation in the Islington Citizens' Panel

(c) An increase in the number of people recorded as or reporting that they have engaged in formal volunteering on an average of at least two hours per week over the past year

SSC18
Percentage of organisations funded by the ISP-funded Community Chest programme active in the 10% most deprived SOAs in Islington

<table>
<thead>
<tr>
<th></th>
<th>Crime &amp; safety</th>
<th>Islington Multi Agency Partnership Plan (2008-2011)</th>
<th>ISP Theme group. Safer Islington Partnership</th>
<th>Health promotion prison programme. Mental Health first Aid training in prisons</th>
<th>Local: Number of incidents of domestic violence reported to the police</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Crime &amp; safety</td>
<td>Islington Multi Agency Partnership Plan (2008-2011)</td>
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<td>Local: Number of incidents of domestic violence reported to the police</td>
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<td>Local: Number of incidents of domestic violence reported to the police</td>
<td>Local: % of reported domestic violence incidents which resulted in sanctioned detections</td>
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<td>Local: % Home Fire Safety visits</td>
<td>NI 001: % of people who believe people from different backgrounds get on well together in their local area</td>
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<td></td>
<td>Local: % Home Fire Safety visits</td>
<td>NI 015: Serious violent crime rate</td>
</tr>
</tbody>
</table>
|   | Housing | Islington Core Strategy\textsuperscript{17} Islington Housing Strategy 2009 - 2014\textsuperscript{18} ISP Theme group. Environment and Sustainability | Local: Number of severely overcrowded households moved to more suitable accommodation within a 3 year period | Health and Wellbeing Partnership Board  
- Overcrowding – To assist 160 severely overcrowded households moved to a more suitable accommodation within a 3 year period  
- Rent Guarantee Scheme – 70 clients successfully supported into private rented sector accommodation 2009-11  
- Young People's Rent Guarantee | NI 017: Perceptions of anti-social behaviour  
NI 030: Re-offending rate of prolific and other priority offenders  
NI 004: % of people who feel they can influence decisions in their locality  
NI 006: Participation in regular volunteering  
NI 038: Drug related (Class A) offending rate  
NI 111: First time entrants to the Youth Justice System aged 10-17  
NI 141: Percentage of vulnerable people achieving independent living (see Seasonal excess deaths) |
|---|---|---|---|---|---|
| 6 | Housing | Islington Core Strategy\textsuperscript{17} Islington Housing Strategy 2009 - 2014\textsuperscript{18} ISP Theme group. Environment and Sustainability | Local: Number of severely overcrowded households moved to more suitable accommodation within a 3 year period | Health and Wellbeing Partnership Board  
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NI 030: Re-offending rate of prolific and other priority offenders  
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NI 006: Participation in regular volunteering  
NI 038: Drug related (Class A) offending rate  
NI 111: First time entrants to the Youth Justice System aged 10-17  
NI 141: Percentage of vulnerable people achieving independent living (see Seasonal excess deaths) |
References

4 http://www.islington.nhs.uk/vital-signs.htm
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17 http://www.islington.gov.uk/Environment/planning/PlanningPolicy/localdevelopmentframework/CoreStrategy/